Guide to Your TIAA Retirement Healthcare Savings Plan

Effective January 1, 2018

TIAA RETIREMENT HEALTHCARE SAVINGS PLAN

TABLE OF CONTENTS

INTRODUCTION

This summary plan description ("SPD") summarizes the major features of the TIAA Retirement Healthcare Savings Plan (referred to in this SPD as the "Plan"). The Plan has been established to provide retiree health benefits to participating employees of TIAA and certain of its subsidiaries and affiliates that have adopted the Plan with approval from TIAA by providing reimbursement of certain healthcare costs that are incurred by employees and their dependents. The Plan was originally effective as of January 1, 2009.

If you are an eligible employee, the Plan allows you to make after-tax contributions and become eligible for reimbursement from the Plan of certain medical expenses generally equal to the amount of your contributions and any matching employer contributions that may be added (as adjusted for notional investment returns).

Contributions to the Plan are held in a trust that qualifies as a Voluntary Employees' Benefit Association (the "VEBA") under Section 501(c)(9) of the Internal Revenue Code.

In this SPD, "Your Employer" means either TIAA (if you are employed by TIAA) or the Participating Employer that employs you.

IMPORTANT NOTICES

This document is intended to meet requirements for a Summary Plan Description under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), for the Plan. This SPD supersedes any prior Plan SPD documents (whether printed or electronic). The SPD is shorter and less technical than the underlying legal documents that establish the Plan including the Plan document and the TIAA Retirement Healthcare Savings Plan Trust. As a result, the SPD may not describe every situation that may affect every eligible employee or their beneficiary. The SPD is not meant to modify the terms of the plan document or any legal instrument related to the Plan's creation, operation, funding or benefit payment obligations.

If there is any conflict or inconsistency between the SPD and the documents constituting the Plan (including, but not limited to, the meaning of defined terms), or with respect to any provision that is not discussed in the SPD, the documents constituting the Plan will control. No one speaking on behalf of the Plan, TIAA or Your Employer can alter the terms of the Plan.

TIAA reserves the right to modify, amend, or terminate any or all of the benefits under the Plan at any time and for any reason. Each Participating Employer reserves the right to terminate participation in the Plan at any time and for any reason.

The terms "you" and "your" as used in this document refer to an individual who is otherwise eligible to participate in the Plan. Receipt of this SPD does not guarantee

that the recipient is a participant under the Plan and/or is otherwise eligible for benefits under the Plan. This SPD, and the Plan, including any changes to it, or any payments to you under its terms, does not constitute a contract of employment with Your Employer and does not give you the right to be retained in the employment of Your Employer.

Some of the terms used in this SPD have a certain meaning when used herein. These terms are defined in the Glossary.

ELIGIBILITY AND PARTICIPATION

All employees of TIAA and other Participating Employers are eligible to participate in the Plan (except employees included in a unit of employees covered by a collective bargaining agreement, individuals providing services to the Company who the Company does not treat as employees). Those individuals who are deemed by the Plan Administrator, in its sole discretion, to be independent contractors are not eligible to participate in the Plan. Those individuals who are classified as interns are subject to a 90-day waiting period before being eligible to participate in the Plan.

If you are an eligible employee, you can contribute to the Plan from the latest of your first day of employment, becoming an eligible employee, if later or the effective date of this Plan, until your termination from employment, except for any periods when you are not receiving eligible compensation from Your Employer. To participate in the Plan, you must elect to make a voluntary contribution from eligible Compensation by entering into a salary reduction agreement in a manner provided by Your Employer.

CONTRIBUTIONS

Eligible Employees may elect to make contributions to the Plan through either (or both) of the following methods: (a) salary reduction during each pay period based on your eligible Compensation (generally, base salary, shift differential and effective as of January 1, 2017, sales commissions paid to you) and/or (b) reduction of a portion or all of your annual cash award.

One hundred percent of the first $750 of your contribution to the Plan will be matched for a Plan Year. Matching contributions will be made during the same pay period with respect to contributions from your eligible Compensation. With respect to contributions from your annual cash award payment, matching contributions will be provided as of the final pay period of the year. In deciding on the amount to contribute, you should consider your health and the health of your eligible spouse, domestic partner, or dependents and anticipated health needs in retirement. You may start, change or suspend contributions at any time.

All contributions become the trust assets of the TIAA Retirement Healthcare Savings Plan Trust. These contributions may only be used by the Plan to reimburse out-of-pocket eligible medical expenses. By law, contributions made to the Plan cannot be refunded to you or Your Employer or TIAA.

Following your initial contribution, a notional account under the Plan will be established on your behalf and credited with your contributions (plus any investment experience on your contributions), any matching contributions and any other allocations. Your account currently is not charged a fee for claims administration or Plan Administration expenses. However, the Plan Administrator may charge your account for all or a portion of reasonable expenses of administration of the Plan, including any taxes.

You control the investment of your Plan contributions (including any matching contributions). As a default, your account will be notionally invested in the TIAA-CREF Lifecycle Fund with a target date nearest your 65th birthday. You can reallocate your balance at any time into any of the other available funds.

VESTING

Your voluntary contributions to the Plan are fully vested immediately.

The matching contributions become vested upon the completion of three "Years of Service" (as defined in the plan document). Years of Service does not include any work with Your Employer prior to you reaching age 18. In addition, matching contributions will become fully vested sooner: (a) if your employment with the Company terminates after you reach age 65; (b) upon your death; or (c) if your employment is terminated due to a job elimination, job relocation or a change in job responsibilities, as determined by the Plan Administrator), in its sole discretion.

If your employment with the TIAA Family of Companies ends before you are vested in the matching contributions, such contributions will be forfeited and removed from your account balance. If you resume employment, you will be credited with your past service and an amount equal to the forfeited contributions will be restored as of the date of your re-employment, subject to your satisfaction of the vesting requirements. If you transfer employment within the TIAA Family of Companies, you will continue to accrue service credit for vesting while employed by such entity as though you remained employed by Your Employer.

Even if your contributions or the matching contributions are vested, they remain subject to potential forfeiture in certain situations described below under *Benefits => Forfeiture of Accounts*.

YEARS OF SERVICE

For all employees, you are credited with a Year of Service for each consecutive 12-month period of employment with TIAA (and any other company within the TIAA Family of Companies) starting with the later of your date of employment (or anniversary date of re-employment) or the date you reach age 18.

LEAVE OF ABSENCE & DISABILITY

During a period of absence, you may be able to continue your contributions to the extent that you receive Compensation during your leave of absence. Please contact 1-844-4-TIAAHR (844-484-2247) to understand Your Employer's policies and how they affect your ability to continue contributions under the Plan.

BENEFITS

Reimbursed Medical Expenses
Medical care expenses that are incurred by you and your eligible spouse, domestic partner and dependents can be reimbursed under the Plan. For purposes of this Plan, "medical care" is defined under Section 213(d) of the Internal Revenue Code (see IRS Publication 502, Medical and Dental Expenses, for more information on qualifying medical expenses). Only eligible expenses that are incurred on or after the date you become eligible for reimbursement (as determined under the Plan) can be reimbursed through the Plan. Expenses cannot be reimbursed to the extent covered by insurance.

Availability of Reimbursement
You will be eligible for reimbursement of medical expenses incurred following your termination of employment with the TIAA Family of Companies.

If you die, your eligible spouse will immediately become eligible for reimbursements of medical expenses of your eligible spouse, domestic partner or dependents. If you do not have an eligible spouse or if he or she dies at the same time or following your death, your eligible domestic partner and dependents will be immediately eligible for reimbursement of medical expenses. Any residual amounts in the account balance following the death of a surviving eligible spouse, domestic partner or dependent will be forfeited and such forfeited amounts may be used to reduce future employer contributions or for Plan administrative costs.

All reimbursements may be made solely from vested contributions in your account balance. Reimbursement of medical expenses incurred by your domestic partner may only be made from the employee contribution portion of your account balance. Reimbursements will end on the earlier of (1) once your vested account balance reaches zero or (2) once you and any eligible spouse, domestic partner and dependent has died.

Eligible Spouse, Domestic Partner and Dependents

An eligible spouse means a person of the same or opposite gender whom you have legally and validly married under the laws of any state or foreign jurisdiction. (Note that a spouse does not include an individual with whom you are in a domestic partnership, civil union or other relationship not identified as a marriage under applicable law.)

An eligible domestic partner is a same-sex partner who has established a committed relationship with the participant as defined by state law or as verified by the participant in writing on a form provided by the Plan Administrator.

An eligible dependent is defined under Section 152 of the Internal Revenue Code and includes (1) any child of you or your eligible spouse who is a minor or a student, (2) any other child residing with you, or (3) anyone else who the Plan Administrator believes to be a "dependent" under the Internal Revenue Code.

Claims for Benefits
Once you incur qualified medical expenses following after becoming eligible for medical expense reimbursement, you can submit a claim by completing a form provided by the claims administrator, together with appropriate receipts, bills or other documentation of the expenses.

If you are eligible for reimbursement, claims may be made at any time during your life and the lives of your eligible spouse, domestic partner and/or dependents. However, if your account is inactive for five consecutive years, your account balance may be forfeited if the Plan Administrator cannot locate you or your eligible spouse or dependents. (The account balance will be reinstated if you or your eligible spouse or dependents are located).

Any remaining balance following your death and the death of your eligible spouse, domestic partner and dependents will be forfeited and may be used to reduce future employer contributions or to pay for the Plan's administrative costs.

Taxation
Your contributions are made on an after-tax basis. The Company's matching contributions are made on a pre-tax basis (although this treatment may vary by state). Any earnings on your contributions will not be taxable if used to reimburse qualified medical expenses.

Reimbursement of an eligible domestic partner's medical expenses will be subject to tax to the extent it reflects the matching contributions or the earnings on your after-tax contributions.

This tax treatment is based on the Plan trust continuing to qualify as a VEBA. Any change in the qualified status of the VEBA may impact tax treatment of the distribution of earnings on contributions.

Forfeiture of Account
Once your employment ends, you will become eligible for reimbursement of medical expenses incurred going forward. Your vested account balance will remain available for reimbursement until the earlier of:

(1) the date your vested account balance is reduced to $0; and
(2) the date you and your eligible spouse, domestic partner (to the extent eligible for reimbursement) and dependents have died.

In addition, if your account is inactive for five consecutive years, your account balance may be forfeited if the Plan Administrator cannot locate you or your eligible spouse or dependents. (In only this case, the account balance will be reinstated if you or your eligible spouse, domestic partner or dependents are located).

Domestic Relations Orders

The Plan recognizes domestic relations orders that meet certain requirements similar to the qualified domestic relations order ("QDRO") rules applicable to retirement plans. In the event of a divorce or other domestic relations situation, a court might order that your Account be divided between you and your spouse or other family member. If this happens, this alternate payee can use his or her divided Accounts for Reimbursement Benefits. Contact the Plan Administrator at the number provided in the *Additional Information* section to request information regarding the Plan's domestic relations order rules.

Qualified Medical Child Support Orders ("QMSCO")
In certain circumstances, you may be able to enroll a child of a Plan participant by filing a QMCSO with the Plan Administrator. A QMCSO may only be filed with respect to a child of a Plan participant. If you are interested in more information relating to QMCSO and the procedures for filing them with this Plan, please contact the Plan Administrator at the number provided in the *Additional Information* section.

PLAN ADMINISTRATION

The Plan Administrator is the Senior Vice President, Total Rewards. The name, business address, and business telephone number are provided under the section below entitled "Additional Information." In general, the Plan Administrator is the sole judge of the application and interpretation of the Plan, and has the discretionary authority to construe the provisions of the Plan, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits. However, the Plan Administrator has the authority to delegate certain of its powers and duties to a third party. The Plan Administrator has delegated certain administrative functions under the Plan to various service providers. As the Plan Administrator's delegate, these service providers have the authority to make decisions under the Plan relating to benefit claims, including determinations as to whether the medical expense is a qualified medical expense under the Internal Revenue Code. The decisions of the Plan Administrator (or its delegate) in all matters relating to the Plan (including, but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of fact) will be final and binding on all parties.

CLAIMS PROCEDURES

If the claims administrator denies your claim in whole or in part, you will be notified within 30 days after receipt by the claims administrator of your claim. If the claims administrator determines that an extension of time is necessary, written notice shall be furnished to you prior to the end of the initial 30 day period and the extension shall not exceed 15 days from the original 30 day period. The extension notice shall indicate the special circumstances requiring an extension and the date by which the claims administrator expects to render a determination. The claims administrator shall notify you of the specific reasons for the denial with specific references to pertinent Plan provisions on which the denial is based and shall notify you of any additional material or information that is needed to perfect the claim and explanation of why such material or

information is necessary. At that time you will be advised of your right to appeal that determination, and given an explanation of the Plan's review and appeal procedure including time limits, and a statement regarding your right to bring a civil action under ERISA § 502(a) following an adverse determination on appeal. You may appeal from the determination or denial by providing a written submission to the Plan Administrator within 180 days after receiving a denial notice:

(a) Requesting a review by the Plan Administrator of the claim;
(b) Setting forth all of the grounds upon which the request for review is based and any facts in support thereof; and
(c) Setting forth any issues or comments which you deem relevant to the claim.

You may submit written comments, documents, records and other information relating to your claim. Upon request, you may review all documents and records relevant to your claim.

The Plan Administrator shall act upon the appeal taking into account all comments, documents, records and other information submitted by you without regard to whether such information was submitted or considered in the initial benefit determination and shall render a decision within 30 days or 60 days in special circumstances after receipt of the appeal. If the Plan Administrator determines that an extension of time is necessary, written notice of the extension shall be furnished to you prior to the end of the initial 30-day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render a determination. The Plan Administrator shall review the claim and all written materials submitted by you and make an independent determination of your eligibility for benefits and the amount of such benefits under the Plan. The decision of the Plan Administrator on any claim shall be final and conclusive upon all persons. If the Plan Administrator denies a claim on review in whole or in part, he or she shall give you written notice of his or her decision setting forth the following: (a) the specific reasons for the denial and specific references to the pertinent Plan provisions on which the decision was based; (b) notice that you may obtain free of charge, copies of all documents, records and other information relevant to your claim; and (c) a statement of your right to bring a civil action under § 502(a) of ERISA. If the decision on review is not made within the 30-day (or 60-day in special circumstances) period, the claim will be considered denied.

You or your legal representative may appeal any final decision by filing an action in a federal court of competent jurisdiction, provided that such action is filed no later than 90 days after receipt of a final decision by you or your legal representative.

PLAN TERMINATION AND AMENDMENT

While it is expected that this Plan will continue indefinitely, TIAA may, by action of the TIAA Board of Trustees, the Human Resources Committee of the TIAA Board of Trustees, or a person so authorized by resolution of the TIAA Board of Trustees or the Human Resources Committee to modify or discontinue the Plan at any time and for any

reason with respect to any participants or eligible spouses, domestic partners or dependents. The TIAA Compensation & Benefits Committee has been delegated the authority to amend and modify the Plan. Such changes may include, but are not limited to, the right to change or eliminate benefits, increase or decrease employer contributions, change the class(es) of employees and/or eligible dependents covered by the Plan, and change providers. A Plan amendment may not reduce your account balance.

MISCELLANEOUS

Overpayment of Claims
In the event of any overpayment to you or your spouse, domestic partner or dependent, the claims administrator may collect from the amount of any overpayment, regardless of the cause of the overpayment. The claims administrator may request repayment directly from the party that received the overpayment, offset the amount of the overpayment against other approved claims on the same account or notify the Plan Administrator, who may pursue repayment on behalf of the Plan.

Non-Alienation/Assignment
You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void. The payment of benefits directly to a healthcare provider, if any, shall be done as a convenience to the covered person and will not constitute an assignment of benefits under the Plan.

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the US. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

PRIVACY OF PROTECTED HEALTH INFORMATION

In the administration of this Plan, TIAA or of one of its Business Associates may be required to use or disclose Protected Health Information as defined by HIPAA for purposes of paying or causing to be paid benefits under this Plan or for purposes of

administering the Plan. TIAA has established the following policy regarding the use and disclosure of protected information. TIAA hereby agrees to:

- Not use or disclose Protected Health Information other than as permitted or required by law;
- Ensure that any agents to whom it provides Protected Health Information agrees to the same restrictions and conditions that apply to TIAA;
- Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of TIAA;
- Report to the Plan any use or disclosure of Protected Health Information inconsistent with Plan provisions;
- Make Protected Health Information available as required under HIPAA privacy rules;
- Make internal practices and records regarding Protected Health Information available to the HHS Secretary;
- Where feasible, return or destroy all Protected Health Information received from the Plan then no longer needed for the purpose for which disclosure was made; and
- Establish security rules for protection of Protected Health Information it stores or transmits electronically in compliance with the HIPAA Security Rule.

A complete description of your rights under HIPAA can be found in the TIAA HIPAA privacy notice. You can obtain a copy of the HIPAA Privacy Notice by calling Your Benefits Center at 844-4-TIAAHR (844-484-2247) option 4 then option 1.

ADDITIONAL INFORMATION

Plan Name:	TIAA Retirement Healthcare Savings Plan
Type of Plan:	Welfare benefit plan (Group health plan)
Plan Year:	January 1 through December 31
Plan Number:	519
Administration:	Contract administration
Funding:	VEBA Trust (employee and employer contributions).
Plan Sponsor:	Senior Vice President, Total Rewards TIAA 730 Third Avenue New York, New York 10017 (212) 916 4000
Other Participating Employers:	Set forth on Schedule A A full list of Participating Employers may be obtained upon written request to the Plan Administrator.
Plan Administrator:	TIAA 730 Third Avenue New York, New York 10017 (212) 916 4000
Plan's Sponsor's Employer Identification Number:	13-1624203
Plan Trustee	TIAA-CREF Trust Company, FSB 211 North Broadway, Suite 100 St. Louis, MO 63102-2733
Agent for Service of Legal Process: (Service may also be made on The Trustee or the Plan Administrator)	TIAA Office of the General Counsel 730 Third Avenue New York, New York 10017

GLOSSARY

“Plan” means the TIAA Retirement Healthcare Savings Plan.

“Compensation” is defined in the Plan and generally means your base salary, shift differential, and, effective as of January 1, 2017, sales commissions paid to you up to $300,000 in any Plan Year, in each case, prior to the application of (i) contributions made pursuant to a salary reduction agreement which are not includable in your gross income under the Plan or a plan or program of your employer that meets the requirements of Section 125 or Section 132(f)(4) of the Internal Revenue Code (e.g., a cafeteria plan or a commuter benefits program); and (ii) any lump sum or single sum salary advance agreement.

“Internal Revenue Code” means the Internal Revenue Code of 1986, as amended.

“Participating Employer” refers to any eligible company that has adopted the Plan with approval from TIAA. A full list of Participating Employers may be obtained upon written request to the Plan Administrator.

“TIAA” means Teachers Insurance and Annuity Association of America.

“TIAA Family of Companies” refers to TIAA and any Related Employer (as defined in the Plan document) and which generally includes corporations of which TIAA owns at least 80%). Note that all Participating Employers are included in TIAA Family of Companies.

“Your Employer” means TIAA (if you are employed by TIAA) or the Participating Employer that employs you.

SCHEDULE A – LIST OF PARTICIPATING EMPLOYERS
As of January 1, 2018

TIAA, FSB*

Nuveen Services, LLC

*Only those employees that perform legacy TIAA-CREF Trust Company, FSB roles with TIAA, FSB are eligible to participate in the Plan.

This list may be updated from time to time. A full list of Participating Employers may be obtained upon written request to the Plan Administrator.