

Northwestern

Health & Welfare Benefits Summary Plan Description Handbook

Plan Year 2025

Restated 1/1/2025

Introduction/Contents

This Summary Plan Description (SPD) Handbook provides important information about the health & welfare and tuition assistance benefits that Northwestern University sponsors for eligible employees, retirees, and family members. This information includes:

- **Eligibility, Enrollment & Contributions** – presenting eligibility guidelines for employees, retirees, and family members, enrollment information (including when coverage begins and ends), and contributions information. (While some health & welfare benefits are automatic with their costs paid entirely by the University, others are optional with the employee and the University either sharing their cost or the employee paying their full cost.) See [Section 1: Eligibility, Enrollment & Contributions](#).
- **Medical, Dental & Vision Plans** – providing eligible employees the opportunity to choose medical, dental, and vision coverage from among a variety of options so each employee may choose a personalized package of health care benefits based on their needs and preferences. This section also includes state and federal notices regarding your health benefits. See [Section 2: Medical, Dental & Vision Plans](#).
- **Spending & Savings Accounts** – providing a number of tax-favored accounts eligible employees may use to pay eligible health and dependent care expenses. See [Section 3: Spending & Savings Accounts](#).
- **Disability Benefits** – providing income continuation benefits in the event an employee becomes Disabled due to illness or injury and is unable to work. See [Section 4: Disability Benefits](#).
- **Life Insurance & Other Financial Protection Plans** – providing automatic basic life insurance, business travel insurance, and the opportunity to choose supplemental life insurance coverage for themselves and their eligible family members. See [Section 5: Life Insurance & Other Financial Protection Plans](#).
- **Tuition Benefits** – providing different types of tuition benefits for eligible employees, retirees, and family members. For more information, see [Section 6: Tuition Benefits](#).
- **Employee Assistance Program** – providing free and confidential access to a variety of mental health and well-being services and resources, including short-term counseling. See [Section 7: Employee Assistance Program](#).
- **Filing Claims** – providing guidelines for filing claims under the various benefit plans. See [Section 8: Filing Claims](#).
- **Important Terms** – providing definitions of key terms that are used within this handbook. See [Section 9: Important Terms](#).
- **Administrative Information** – providing a summary of administrative facts and details for each plan. See [Section 10: Administrative Information](#).
- **Your ERISA Rights** – summarizing your rights as a program participant, as guaranteed under the Employee Retirement Income Security Act of 1974, as amended. See [Section 11: Your ERISA Rights](#).

This summary is for informational purposes and is not intended as an offer of employment or to establish the terms and conditions of employment in any way. While every attempt has been made to ensure the accuracy of this summary, it is only a summary of the key provisions of these plans. If there is a conflict between the legal plan documents and this summary, the legal plan documents will control. If you have any questions about this summary, call Benefits at 847-491-4700.

1 Eligibility, Enrollment & Contributions

Starting in this section – and throughout the rest of this handbook – “you” and “your” are used to refer to an employee who is in a Benefits-eligible Employee classification. As outlined in this section, eligibility guidelines may vary from plan to plan. If you have any questions regarding your eligibility for a particular plan refer to this section or call Benefits at 847-491-4700.

Eligibility

Employees

Staff

- Regular status staff must be scheduled to work at least 18.75 hours per week.
- Exempt staff must be appointed on at least a half-time (50%) basis.
- An employee must hold an appointment that is full-time for 6 months or at least half-time for 1 year to be benefits-eligible. University salary must be sufficient to cover benefit plan deductions.
- Eligible staff may participate in the medical, dental, vision, group term and optional term life insurance, long term disability, Flexible Spending Account (FSA), Employee Assistance Program, tuition benefits (full-time only), and retirement plans.

Faculty

- Faculty must be appointed on a full-time or part-time basis for the entire academic year or on a full-time basis for half the academic year.
- The University defines half the academic year as either one semester or two quarters.
- Eligible faculty may participate in the medical, dental, vision, group term and optional term life insurance, long term disability, Flexible Spending Account (FSA), Employee Assistance Program, tuition benefits (full-time only), and retirement plans.

Academic Full-Time and Half-Time Faculty

- You must be compensated by the Northwestern University or be a Faculty Physician with Northwestern Medical Group (NMG).
- Your University salary must be sufficient to cover the amount of monthly Premium deductions.
- Eligible academic year faculty may participate in the medical, dental, vision, group term and optional term life insurance, long term disability, Flexible Spending Account (FSA), Employee Assistance Program, tuition benefits (full-time only), and retirement plans.

Contributed Service Faculty

- Medical School faculty who volunteer to participate in the academic activities of the Medical School without direct financial compensation are eligible to participate in the dependent reduced tuition educational assistance plans.

ROTC Faculty

- If you serve as full time faculty for ROTC and NROTC programs on campus, while not paid by the University, you are eligible to participate in the University tuition plans.

Visiting Predoctoral Fellows

- Visiting and International Predoctoral Fellows are eligible for a separate benefit plan offered through the [Office of Risk Management](#). Domestic Visiting Predoctoral Fellows who are not employees or students should obtain coverage from their home institution. Visiting Predoctoral Fellows who are not employees are not eligible to participate in the tuition educational assistance plans.

Postdoctoral Fellows

- Postdoctoral Fellows appointed on at least a half-time basis are eligible to participate in the medical, dental, group term and optional term life insurance, administered by [Gallagher Benefit Services](#); and long term disability, FSA, Employee Assistance Program, tuition benefits, and retirement plans from the University.
- Postdoctoral Fellows must hold an appointment that is full-time (2 quarters or 1 semester) for half the academic year or at least half-time for the entire academic year to be benefits-eligible.
- University salary must be sufficient to cover benefit plan deductions.

NRSA Postdoctoral Fellows

- Postdoctoral Fellows funded by a National Research Service Award (NRSA) from the National Institutes of Health (NIH) are not eligible to participate in the University's benefit plans. They are eligible for a separate benefit program through [Gallagher Benefit Services](#).

Visiting Scholars

- International Visiting Scholars should obtain benefits through the [Office of Risk Management](#). Domestic Visiting Scholars should obtain coverage from their home institution.

Visiting Faculty

- Individuals with academic appointments of half time or greater at the rank of professor, associate professor and assistant professor paid by the University are eligible to participate in the medical, dental, group term and optional term life insurance, long term disability, FSA, and retirement plans. University salary must be sufficient to cover benefit plan deductions. All other professor, associate professor and assistant professor are eligible for a separate benefit program through [Gallagher Benefit Services](#).

Students

- Undergraduate and graduate students in degree seeking program should obtain student insurance through [Student Affairs](#).

Disabled Employees

- If you become permanently and totally Disabled while working for Northwestern University, and are receiving University-sponsored Long Term Disability benefits, you are eligible to participate in the medical, dental, and group term and optional term life insurance plans.

Retirees

- If you retire from University employment you may elect to convert Optional Term Life, and Group Term Life to an individual policy directly with the sponsoring insurance company.
- You may also continue medical and dental coverage through the legacy retiree plans.

Family Members

Spouse

- A spouse must be legally married to the eligible employee.

Surviving Spouse and Child(ren) of a Deceased Employee/Retiree

- An eligible spouse or dependent child of a deceased employee or retiree is eligible only for medical, dental, and vision coverage.
- The spouse or dependent child must be enrolled in the University sponsored plan at the time of the employee/retiree's death.

The University requires eligibility verification to confirm the eligibility of any family member you enroll in health insurance coverage. No individual may be covered both as an employee and as a spouse, partner or child under the University's benefit plans.

If you go on a Leave of Absence, become Disabled, or retire from University employment – or if your University employment is terminated – your coverage may continue. For details, see the separate plan descriptions in this handbook.

If you are an employee located in:

- Miami, New York, and Washington, DC – you are only eligible for the BlueCross BlueShield of Illinois PPO medical plans and dental plan; you are not eligible for HMO Illinois, or Cigna International health insurance, or Guardian dental insurance.
- Doha, Qatar – you are only eligible for Cigna International medical, dental, and vision insurance.

Partner

- You and your same or opposite-gender partner must obtain a civil union in order to qualify for coverage under University plans.
- Your partner and your partner's children are eligible for medical, dental, vision, life, and accident coverage, and tuition benefits.
- Insurance Premiums will be charged on either an after-tax or pre-tax basis in accordance with federal and state regulations and based on your individual situation.
- FSAs may not reimburse an employee for partner medical care or for the care of a partner's dependents unless they are an Internal Revenue Code Section 152 dependent.

Dependent Child(ren)

- Dependent children include natural, step, foster, legally adopted children, and any children who are in your custody under an interim court order prior to the finalization of adoption proceedings.
- Your dependent children may be covered under medical, dental, vision, and life plans until the end of the month in which they turn 26.
- Your dependent children may be covered under dependent tuition educational assistance plans until the end of the month in which they turn 24.

Any children who are dependent upon you for financial support and maintenance because of disability are covered regardless of age if they were covered by the plan prior to reaching the limiting age. Supporting documentation is required.

Enrolling for Coverage

You must complete your initial enrollment process within 31 days from your date of hire or the date you first become eligible. If you do not enroll or waive coverage within this 31-day period, your coverage will be waived automatically and your next opportunity to enroll will be during the next annual Open Enrollment.

During Open Enrollment, you will have an opportunity each year to enroll in or waive coverage for yourself and to add or drop coverage for your eligible family members, including your spouse or partner and/or your eligible child(ren). You will receive information and instructions for completing the annual Open Enrollment process during the Fall each year.

If you experience a qualifying change in family or employment status, you may elect to add or drop eligible family members and/or add or drop coverage within 31 days following the date on which the change in status occurs.

For more information about your enrollment options when you experience a change in status – including instructions for making any changes to your coverage – see Benefit Changes. Note: When a change in status occurs you will be able to add or drop coverage, but you will not be able to change coverage from one plan to another. For example, if currently enrolled in the Select PPO medical plan you will be able to drop that coverage, but you will not be able to change coverage to the HMO Illinois medical plan.

When enrolling a family member for health coverage for the first time, you must submit [acceptable documentation](#) to verify the family member's eligibility. If you do not provide acceptable documentation within 31 days, the family member's health insurance coverage will not take effect and the family member will be dropped from any University-sponsored medical, dental, vision, and life insurance coverage in which they were enrolled.

Dropping Coverage

You may elect to drop medical, dental, vision, and/or any optional term life insurance coverage you may have elected – and/or end contributions to a spending or savings account – during the annual Open Enrollment process or within 31 days following the date on which you experience a qualifying change in family or employment status.

When Coverage Begins

The date your coverage takes effect is based on when your enrollment (or enrollment change) occurs. If you:

- **Enroll during an initial enrollment period** – your coverage choices will take effect the first of the month following your date of hire or initial benefits eligibility, or your first day of employment if you start working on the first day of the month
- **Add or drop coverage during an annual Open Enrollment period** – your new coverage choices will take effect the next January 1.
- **Add or drop coverage following a qualifying change in family or employment status** – your new coverage choices will take effect retroactive to the Qualifying Event. For details, see [Benefit Changes](#).

When Coverage Ends

Termination of Employment

In general, coverage for you and your covered family members under University-sponsored benefit plans will end on the last day of the month in which termination of your University employment occurs. However, if you or an eligible family member is currently enrolled in a course under one of the University-sponsored educational assistance plans, coverage under the plan will continue until the end of the study term in which your termination occurs.

As provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA), following termination of your University employment you may elect to temporarily continue your medical, dental and vision plan coverage and continue to make contributions to a Health Care Flexible Spending Account (FSA). For more information about COBRA coverage continuation and instructions for enrolling in this coverage, see [COBRA Benefits](#) and [Terminated Employees and COBRA](#).

In addition, you may convert or port your life insurance coverage to an individual policy. Information and instructions for converting or porting your life insurance coverage are available in [Terminated Employees and COBRA](#).

Retirement

Your University-sponsored benefits coverage will end automatically at the end of the month in which you retire unless you are eligible and elect to continue your participation in certain benefits after you retire. For details, see [Benefit Program Information for Retirees](#).

Note: If you return to University employment after you retire, you will remain in retiree benefits unless you return to a benefits-eligible appointment.

Rehire

If you terminate your University employment and are subsequently rehired into a University position:

- **Within 31 days from the date of termination** – your coverage in effect on your termination date will be reinstated with no break in coverage.
- **More than 31 days from your date of termination** – you may enroll in coverage no later than 31 days from your rehire date.

Contributions

The amount you pay in Premiums will be based on the following (see table).

For coverage under...	Your Premiums will be based on...
Medical Plans	<ul style="list-style-type: none">• The medical plan in which you choose to enroll• Your employment status – whether you're full-time or part-time• Your Annual Base Benefits Rate (see below)• The Coverage Tier you choose – You, You + Spouse/Partner, You + Child(ren), or You + Spouse/Partner + Child(ren) , and• Your income
Dental Plans	<ul style="list-style-type: none">• The dental plan in which you choose to enroll• Your employment status – whether you're full-time or part-time, and• The Coverage Tier you choose – You, You + Spouse/Partner, You + Child(ren), or You + Spouse/Partner + Child(ren)

For coverage under...	Your Premiums will be based on...
Vision Plan	<ul style="list-style-type: none"> The Coverage Tier you choose – You, You + Spouse/Partner, You + Child(ren), or You + Spouse/Partner + Child(ren)
Long Term Disability	<ul style="list-style-type: none"> Your age – as of December 31 in the current year, and Your income
Supplemental Term Life Insurance	<ul style="list-style-type: none"> Your age – as of December 31 in the current year, and The amount of Supplemental Term Life Insurance coverage you elect
Spouse Term Life Insurance	<ul style="list-style-type: none"> Your spouse's age – as of December 31 in the current year, and The amount of Spouse Term Life Insurance coverage you elect
Child Term Life Insurance	<ul style="list-style-type: none"> The amount of Child Term Life Insurance coverage you elect

For purposes of determining your medical insurance premium, the Annual Base Benefits Rate (ABBR) is the University salary you are receiving on an annual basis as of September 1 of the preceding year (or, if newly hired, your new hire salary). Your ABBR does not include any bonus payments, honoraria, summer salary, or overtime pay you may receive. The ABBR is only calculated once per year and will only change if you transition from full-time to part-time or part-time to full time. Otherwise, any other salary adjustment will not change your ABBR.

For purposes of determining your life insurance coverage, Annual Base Salary is the University salary you are receiving on an annual basis as of September 1 of the preceding year (or, if newly hired, your new hire salary). Your Annual Base Salary does not include any bonus payments, honoraria, summer salary, or overtime pay you may receive. Note: If you are paid on a bi-weekly basis, the benefits base amount is your bi-weekly scheduled hours multiplied by your hourly rate and multiplied by 26.1 (because there are 26.1 bi-weekly pay periods in a calendar year). The ABBR is only calculated once per year and will only change if you transition from full-time to part-time or part-time to full time. Otherwise, any other salary adjustment will not change your ABBR. Basic Term Life Insurance and Business Travel Insurance are provided automatically and at no cost to you.

No Premiums apply to your participation in a Health Care FSA, Limited Use FSA, Dependent Care FSA or Health Savings Account; you make contributions ONLY if you elect to participate in one or more of these accounts. No Premiums apply to your participation in an educational assistance plan.

You are considered a:

- Full-time employee** – if you are a Staff employee scheduled to work a minimum of 37.5 hours per week or a Faculty or Staff employee with a 100% appointment.
- Part-time employee** – if you are a Staff employee scheduled to work at least 18.75 hours but less than 37.5 hours per week or a Faculty or Staff employee with a 50% or greater (but less than 100%) appointment.

Premium Tax Status

The Premiums you pay toward the cost of your benefit coverage are deducted on a:

- Pre-tax basis** – for any medical, dental, and vision coverage you elect, as well as any voluntary contributions you choose to make to a Flexible Spending Account and/or Health Savings Account.
- After-tax basis** – for any optional (buy-up) disability or life insurance, as well as Premiums you pay for any coverage in which you may enroll your civil union partner.

Pre-tax Premiums are deducted from your pay before your taxes are calculated, so they reduce your taxable income. After-tax Premiums are deducted from your pay after your taxes are calculated, so they have no impact on your taxable income. Note: Determination of whether Premium deductions are pre-tax or after-tax will be done in accordance with state and federal regulations and will change as regulations change.

Deduction Schedule

If you are paid on a:

- **Bi-weekly basis** – your Premium deductions are taken from the first and second payroll of each month.
- **Monthly basis** – your Premium deductions are taken from the paycheck issued the last working day of each month.

Premiums pay for coverage in the month during which they are deducted (for example, Premiums deducted in March pay for March coverage).

Note: If you complete the enrollment process after the normally scheduled paycheck date, retroactive Premiums will be deducted from a future paycheck.

Special Payment Situations

For more information about special payment situations that may apply if you go on a Leave of Absence, become Disabled or retire, see the separate plan descriptions within this handbook.

2 Medical, Dental & Vision Plans

You have the following benefit options to choose from for medical, dental, and vision insurance for yourself and your eligible family members, including your spouse or partner and your child(ren).

Medical Plans

You may choose medical coverage under one of three types of plans:

- **PPO** – as provided under the [Premier, Select or Value PPO](#) coverage options, or
- **HMO** – as provided under the [HMO Illinois](#) coverage option, or
- **ACA Value PPO** – as provided under the [ACA Value PPO](#) coverage option for eligible temporary staff, adjunct faculty, and staff who do not meet the “benefits eligible” definition per this handbook but who do meet the definition of “full time” per the Affordable Care Act.

The opportunity to participate in a tax-favored Health Savings Account (HSA) is available ONLY to participants of the Value PPO coverage option; participants in the ACA Value PPO coverage option are NOT eligible to participate in an HSA. Coverage in a high deductible health plan outside of Northwestern does not qualify you to enroll in Northwestern’s HAS.

You and Northwestern share the cost of the any medical coverage you elect based on group insurance rates.

BlueCross BlueShield of Illinois (BCBSIL) administers all medical coverage options and maintains the PPO and HMO provider Networks available through these plans.

Dental Plans

You may choose dental insurance under one of two types of plans:

- **PPO** – as provided under the [Dental PPO](#) coverage option, or
- **HMO** – as provided under the [Dental HMO](#) coverage option.

You and Northwestern share the cost of the any dental coverage you elect based on group insurance rates.

Blue Cross Blue Shield of Illinois administers the Dental PPO coverage option; Guardian administers the Dental HMO coverage option. Both administrators maintain their own provider Network.

Vision Plan

As a Benefits-eligible Employee, you may choose to participate in the Blue Cross Blue Shield of Illinois Vision Care Plan.

You pay the full cost of any vision coverage you elect based on group insurance rates.

BlueCross BlueShield of Illinois (BCBSIL) administers this vision care option and offers the provider Network.

The options listed above are not available to employees on the Qatar campus. If you are an employee on the Qatar campus, you may choose coverage under the following three plans:

- [CIGNA International Medical Plan](#).
- [CIGNA International Dental Plan](#).
- [CIGNA International Vision Plan](#).

The options listed above are not available to employees classified as Postdoctoral Fellows or Postdoctoral Scholars, with the exception of Mellon Postdoctoral Fellows. If you are a Postdoctoral Fellows or Postdoctoral Scholars, you may choose coverage [Postdoctoral Benefits Plans](#).

This section includes important information about [State & Federal Notices](#) that may affect coverage for you and your family members – and the benefits you receive – under the University’s health insurance plans.

Medical Plans

Premier, Select, Value, or ACA Value PPO

The Premier, Select, Value, and ACA Value PPO plans offer a type of coverage known as Preferred Provider Organization, or PPO. A PPO plan enables members to choose to receive care from any licensed doctor, hospital or facility, but will pay higher benefits for “In-Network” services (that is, services performed by members of a “preferred” provider Network – in this case, the BlueCross BlueShield of Illinois (BCBSIL) PPO provider Network).

All four of these coverage options are self-insured plans, which means they:

- Are funded by both employee and employer contributions deposited to a Trust,
- Pay claims and other expenses from the Trust, and
- Are exempt from covering services mandated by state law.

Eligibility and benefit provisions for the PPO plans are established by the University and have no relationship to other Blue Cross group (employer-sponsored) or individual plans in Illinois or in other states.

Note: The ACA Value PPO coverage option is available only to eligible temporary staff, adjunct faculty, and other faculty and staff who do not meet the “benefits eligible” definition per this handbook but who do meet the definition of “full time” per the Affordable Care Act. Those eligible will receive an offer letter from Benefits.

Prescription drug benefits for PPO plan members are administered by [Express Scripts](#).

Health Savings Account (HSA)

If you elect coverage under the Value PPO medical plan – the University’s “high-deductible PPO” – you may participate in a Health Savings Account (HSA). An HSA is designed to help you set aside tax-free dollars you can use to pay your share of qualified health care expenses today or save this money to pay your share of these expenses in the future.

Important! If you have a Health Savings Account, you cannot participate in a [Health Care Flexible Spending Account](#), but you can participate in a [Limited Use Flexible Spending Account](#).

For details about this type of account and how it can work for you, see [Health Savings Account](#).

Note: The opportunity to participate in an HSA is NOT available to participants in the ACA Value PPO coverage option.

HMO Illinois

This plan offers coverage through a “Health Maintenance Organization,” or HMO. As an HMO, this plan pays benefits only for health care services received from a Network of physician and hospital providers and only for services approved in advance by your Primary Care Physician (PCP) – except in the case of an emergency.

If you enroll in this coverage option, you – and each eligible family member you include under your coverage – must choose a physician who is a member of the HMO provider Network as your PCP. A list of the physicians who are members of the BCBSIL HMO provider Network is available at bcbsil.com. (Northwestern Medical Group (NMG) physicians are NOT part of the HMO Illinois provider Network. Northwestern employees located outside of Illinois should not enroll in this coverage option.)

Like most HMO plans, HMO Illinois is a fully insured plan. As a fully insured plan it:

- Is funded by both employee and employer contributions paid directly to it
- Pays plan expenses, and
- Must provide coverage mandated by state law.

Prescription drug benefits for HMO Illinois members are administered by [Express Scripts](#).

How PPO and HMO Coverage Differ

While all five medical plans assure financial protection against the cost of care in the event of a catastrophic illness or injury, they differ in three important ways:

- How much you pay in monthly Premiums toward the cost of your coverage
- How much flexibility you have in choosing the physician and hospital providers you go to for health care services, and
- How much you pay out of pocket at the time you receive a health care service or the amount you will owe once a claim is processed.

If you choose a plan with lower monthly Premiums, you will likely pay more in out-of-pocket costs – through Copayments, Coinsurance, Deductibles, and the like – than you would if you choose a plan with higher monthly Premiums. That’s why it’s important to carefully consider your personal situation – and the amount and type of expenses you will pay – before choosing your coverage.

Note: You can use a decision support tool – available on the myHR Benefits enrollment platform – to estimate the cost of each of the medical plans based on different assumptions regarding usage that you can direct.

What You May Pay

Whichever medical plan you choose, you will pay a portion of the cost of any health care services you receive – either at the time the service is received or after a health care claim is processed by the sponsoring insurance company.

For details about key plan features – including current-year Deductibles, Copayments, Coinsurance, out-of-pocket expense limits and Premiums – see the individual [plan highlights](#) and certificates of coverage at [Medical, Dental & Vision Plans](#). For a side-by-side comparison of these features for the PPO and HMO plans, refer to the materials provided during annual Open Enrollment and the decision support tool in the myHR Benefits enrollment platform. For more information about Premiums and what they are based on, see [Contributions](#) in this handbook.

The different ways you may pay for health care services are:

- **Copayment** – The portion of the total expense you pay for a specified service, while the plan pays the balance of the cost. A Copayment is usually a flat-dollar amount that applies to doctor office visits, emergency room visits and prescription drugs. You pay a Copayment – which is typically a small fraction of the total cost of the service to which it applies – at the time the service is received.
- **Deductible** – The flat-dollar amount you pay out-of-pocket – either each year (under any one of the PPO coverage options) or for selected services (under the HMO Illinois coverage option) – before the plan will pay benefits toward the cost of these services.
- **Coinsurance** – A percentage of the cost of a service that you and a PPO plan share once you have met the annual Deductible. The share you pay will vary from 0% to 40% based on the PPO coverage option you choose and whether you receive services from an In-Network or Out-of-Network provider. The plan pays the remaining share of the cost. If you receive services:
 - **In-Network** – that is, from a provider who is a member of the BCBSIL provider Network – your benefits will be based on the “allowable amount” that applies to each service. The *allowable amount* for these services is based on a negotiated rate with the provider and is typically less than the billed charge. You will not be responsible for the difference between the total charge and the allowable amount, as agreed to by the provider.
 - **Out-of-Network** – that is, from a provider who is not a member of the BCBSIL provider Network – your benefits will be based on the allowable amount (as defined above) or, if less, the provider’s actual charge; if the provider’s actual charge is greater than the allowable amount, you will pay the difference between the provider’s charge and the allowable amount in addition to any Coinsurance for which you may be responsible.

Coinsurance begins only after you have met the annual Deductible; it does not apply under the HMO Illinois medical plan.

The amount you will pay under a PPO coverage option in Deductibles and Coinsurance during a year is subject to an annual Out-of-pocket Maximum.

Express Scripts

Whether you elect coverage under a PPO or HMO medical plan, benefits toward the cost of prescription drugs are provided through Express Scripts.

The program covers most of the commonly prescribed medications approved by the Food and Drug Administration (FDA). The list of prescription drugs for which a plan provides benefits is called the formulary; certain medications may be included or excluded on a plan's formulary. In general, this program does not provide benefits toward the cost of:

- Over-the-counter medications and other items
- Vitamins and other prenatal medications requiring a prescription
- Topical acne medications
- Weight loss medications
- Blood and blood products
- Cosmetic products, and
- Experimental or investigational medications.

To confirm whether or not a specific medication is included on your plan's formulary, go to [express-scripts.com](https://www.express-scripts.com).

Prescription Drug Benefits Under Premier or Select PPO or HMO Illinois

If you elect coverage under the Premier or Select PPO or HMO Illinois, the prescription drug program provides benefits based on a four-tier Copayment structure:

- **Generic drugs (Tier 1)** – Drugs in this tier are identical (or bioequivalent) to a brand name drug in dosage form, safety, strength, route of administration, quality, performance characteristics, and intended use. Although chemically identical to their brand name counterparts, generic drugs are typically sold at substantial discounts. To gain FDA approval, the manufacturer of a generic drug is subject to strict guidelines and standards.
- **Preferred brand name drugs (Tier 2)** – Drugs in this tier are patent-protected and trademarked.
- **Non-preferred brand name drugs (Tier 3)** – Drugs in this tier are typically newer or highly advertised medications, many of which have a brand or generic equivalent.
- **Specialty (Tier 4)** – Drugs in this tier require special handling, administration, or monitoring. These drugs are used to treat complex, chronic, and often costly conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia. This tier is limited to a 30 day supply.

What you pay – and what the program pays – toward the cost of your prescription drugs differs based on whether you purchase the medication at a retail pharmacy or via mail order. In either case you pay a flat-dollar Copayment, but:

- You pay a higher Copayment for preferred brand name drugs than you do for generic drugs, and
- You pay the highest Copayment for specialty drugs.

Your prescription drug expenses are subject to an annual “stop-loss” of \$1,500 that limits the amount you may pay toward the cost of prescription drugs in any given year. This stop-loss feature applies separately to you and to each family member included under your coverage.

Note: While the Copayment that applies to each tier for drugs purchased via mail order is twice the Copayment that applies for drugs purchased at a retail pharmacy, it's important to remember that you get a three-month

(90-day) supply when you buy via mail order while you get just a one-month (30-day) supply when you buy at a retail pharmacy. Filling prescriptions for maintenance medications via mail order can save you money over time. Specialty (Tier 4) drugs are limited to a 30 day supply.

Prescription Drug Benefits Under Value and ACA Value PPO plans

If you elect coverage under the Value or ACA Value PPO, you pay the full cost of prescription drugs for you and your covered family members until you meet the plan's annual Deductible. Once you do, you pay Coinsurance toward the cost of each prescription until your share of covered expenses for the year reaches the plan's out-of-pocket maximum. Once you do, the plan pays the full cost of prescription drugs for you and your family for the rest of the year.

According to the Congressional Budget Office, generic drugs save consumers an estimated \$8 to \$10 billion a year at retail pharmacies alone...a number that doesn't include the cost-savings that accrue when generic drugs are used in a hospital.

Generics Preferred

Under this program, if a brand-name drug is dispensed rather than an available chemically equivalent generic drug, an ancillary charge is applied in addition to the member's generic Coinsurance. Ancillary charges are the responsibility of the employee, whether or not the prescribing physician checks the "Dispense as Written" box on the prescription form. The ancillary charge is 50% of the difference in cost between the brand and the generic product.

Ancillary charges do not apply towards the maximum cost per prescription or the \$1,500 per person Out-of-pocket Maximum. It is important to remember that this program still allows you the choice between treatment options but not at an increased cost to the plan and its participants.

If you have questions about the ancillary charge for a particular brand medication you are prescribed, contact Express Scripts.

Note: Prior authorization may be required for certain medications. When you are prescribed one of these medicines, your physician will be consulted. The prior authorization telephone number is **800-417-1764**. If a prior authorization is required for your medication, provide this number to your physician.

Accredo

All specialty medications must be filled exclusively through Accredo mail order. A prescription for a specialty medication cannot be filled at a retail pharmacy.

Accredo is a wholly owned subsidiary of Express Scripts and is a mail order specialty pharmacy, whose sole purpose is patient management with specialty medications. Accredo provides specialty prescriptions, defined as injectable, oral, and infused medications.

As one of the nation's leading providers of specialty medications, Accredo nurses and pharmacists are able to support patients who need to take these complex and expensive medications. Since many specialty medications require refrigeration, Accredo takes every precaution to ensure that medications are packaged in temperature-controlled materials to ensure preservation. Since the medications are dispensed by mail order, Accredo will work with you to make arrangements to receive the package. If you will not be home to receive your medications, you can request that they be mailed to your office, doctor's office, or a family member's address.

Smart90: Required 90-Day Supply

This program will apply to select long-term medications, which will now require a 90-day supply. With [Smart90](#), you can conveniently fill these prescriptions with a 90-day supply either through home delivery from the Express Scripts Pharmacy or from any CVS, Walgreens or Duane Reade pharmacies.

SaveOnSP

Northwestern University's prescription drug plan has partnered with [SaveOnSP](#) and Express Scripts to provide a copay assistance program, which takes advantage of the funds available from drug manufacturers to lower your cost. Your specialty pharmacy (Accredo) will determine whether your specialty medication is eligible for the SaveOnSP copay assistance. If it is, you will be contacted by SaveOnSP to enroll and lower your cost to \$0. SaveOnSP will only contact you if your specialty medication is eligible for the copay assistance program. If you choose not to participate in the SaveOnSP copay assistance program, you will pay a significant copay for your specialty medications.

The specialty medications covered by the SaveOnSP copay assistance program are considered non-essential health benefits and will not be applied toward your annual deductible or annual out-of-pocket maximum. For a full listing of medications or to determine whether a specific medication is part of this program, call SaveOnSP at 800-683-1074.

Covered Services – Premier, Select, Value, and ACA Value PPOs

The Premier, Select, and Value PPO plans cover the following services. Additional information regarding Covered Services is available in the appropriate Certificate of Coverage at [Medical, Dental & Vision Plans](#).

Preventive and Wellness Care Services

All three PPO plans cover the full cost of preventive and wellness care services performed by an In-Network provider.

Preventive Care services that will not be subject to Deductible, Copayment, Coinsurance or Out-of-pocket Maximum features of the plans include:

- Routine annual physicals
- Immunizations – for diphtheria, haemophilus influenza type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, COVID-19 and other immunization(s) as may be required by law for children
- Well child(ren) care
- Cancer screenings – including screenings for prostate cancer and colorectal cancer
- Mammograms
- Women’s Preventive Care (including, but not limited to: well-woman visits, FDA-approved contraceptives for women, female sterilization, breast feeding support, supplies, and counseling).
- Bone density tests
- Smoking cessation services
- Healthy diet counseling, and
- Obesity screenings and counseling.

Wellness care services that will not be subject to Deductible, Copayment, Coinsurance, or Out-of-pocket Maximum features of the plans include routine diagnostic medical procedures, EKG, x-ray, ovarian cancer screenings, and colorectal cancer screening x-ray.

Note: While these services will be covered and eligible for benefits when performed by an “Out-of-Network” provider – that is, a doctor or hospital that is not a member of the plan’s specified provider Network – the Deductible, Copayment, Coinsurance, and/or Out-of-pocket Maximum features of the plans will apply.

Hospital Services – Inpatient Care

- Bed, board and general nursing care – provided in a semi-private or private room or in an intensive care unit.
- Ancillary services – including (but not limited to) operating rooms, drugs, surgical dressings and lab work.
- Preadmission testing – preoperative tests performed on an outpatient basis.
- Partial hospitalization treatment – therapeutic treatment in a hospital for patients with mental illness.
- Coordinated home care.

Hospital Services – Outpatient Care

- Surgery and any related diagnostic services received on the same day as the surgery.
- Radiation therapy treatments.
- Chemotherapy.
- Electroconvulsive therapy.

- Renal dialysis treatments – if received in a hospital, a dialysis facility, or in your home under the supervision of a hospital or dialysis facility.

Medical Services Advisory Program

If you elect PPO coverage, certain services will be subject to preadmission and length of service review by BlueCross BlueShield's Office of the Medical Services Advisor (MSA). This program will help maximize the benefits you can receive through your PPO coverage.

MSA is staffed by trained registered nurses and consulting physicians who work under the supervision of a Medical Director.

Important! If you are Medicare-eligible and have secondary coverage under a PPO plan, this program does not apply to you.

Preadmission Review. You must contact MSA in the following situations:

- **Inpatient hospital preadmission** – at least one business day prior to admission
- **Emergency admission** – within two business days after admission (or as soon as reasonably possible)
- **Pregnancy/maternity admission** – within two business days after admission
- **Skilled nursing facility preadmission** – at least one business day prior to scheduling the admission
- **Coordinated home health care preadmission** – at least one business day prior to the scheduling of the admission
- **Private duty nursing service** – at least one business day prior to receiving services.

Upon notification, MSA will review the medical information provided and discuss the benefits available to you. The admitting physician may receive a recommendation from MSA to have care performed on an outpatient basis or, if surgery has been recommended by a physician, to obtain an additional surgical opinion. **Note:** While you may be asked by a hospital representative for a Blue Cross ID Card, this request is for registering the type of insurance (which will expedite submission of the hospital bill to Blue Cross for payment); you (or your spouse, partner, or other individual) must still notify MSA – at **800-635-1928** – once it is determined that you will be admitted. (If the person being admitted is your child, you or your spouse or partner must notify MSA on their behalf.)

If you do not contact MSA – or do not comply with the MSA's recommendations – the benefits you receive toward the cost of your inpatient services will be reduced. For example, if you do not contact MSA following an emergency admission, your benefits will be reduced by \$500.

Length of Stay Review. Upon completing the preadmission or emergency review, the MSA will assign a length of stay for the proposed admission. An extension of this length of stay will be subject to review and approval based solely on whether the extension is medically necessary, as determined by the MSA.

- Diagnostic services – when you are an outpatient and these services are related to surgery or medical care.
- Emergency accident care – for treatment within 72 hours of the accident (or as soon as reasonably possible).
- Emergency medical care.

Physician Services

- Surgery.
- Anesthesia services – if administered at same time as covered surgical procedure.
- Assist at surgery – when performed by a physician, dentist, or podiatrist.
- Sterilization procedures – even if elective.

- Additional surgical opinion – under PPO plans only.
- Medical care visits – physician’s office visit or if your physician comes to your home, or while an inpatient in a hospital, skilled nursing facility, or abuse treatment facility, or a patient in a partial hospitalization treatment program or coordinated home care program.
- Consultations – as requested by your doctor for another doctor’s advice in the diagnosis or treatment of a condition that requires special skill or knowledge.
- Diabetes self-management training and education.
- Diagnostic services.
- Emergency accident care – for treatment within 72 hours of the accident (or as soon as reasonably possible).
- Emergency medical care.
- Electroconvulsive therapy.
- Allergy injections and allergy testing.
- Chemotherapy.
- Occupational therapy.
- Physical therapy.
- Chiropractic and osteopathic manipulation.
- Speech therapy.
- Clinical breast examinations.
- Mammograms.
- Pap smear test.
- Human papillomavirus vaccine.
- Shingles vaccine.
- Prostate test and digital rectal examination.
- Ovarian cancer screening.
- Colorectal cancer screening.
- Bone mass measurement and osteoporosis.
- Amino acid-based elemental formulas.
- Outpatient contraceptive services.
- Leg, back, arm, and neck braces.
- Prosthetic appliances.

Other Covered Services

- Blood and blood components.
- Private duty nursing services.
- Ambulance transportation.
- Dental accident care.
- Oxygen and its administration.
- Medical and surgical dressings, supplies, casts, and splints.
- Naprapathic services.

Special Conditions and Payments

- Human organ transplant services.
- Cardiac rehabilitation services.
- Skilled nursing facility care:
 - Bed, board and general nursing care
 - Ancillary services – including (but not limited to) drugs, surgical dressings, and supplies.
- Ambulatory surgical facility care.
- Substance abuse rehabilitation treatment.
- Mental illness services.
- Maternity services.
- Infertility treatment – see [Illinois Infertility Mandate](#).
- Temporomandibular joint dysfunction and related disorders.
- Mastectomy-related services – as required under the [Women’s Health and Cancer Rights Act](#).

Hospice Care

- Coordinated home care.
- Medical supplies and dressings.
- Medication.
- Nursing services – skilled and non-skilled.
- Occupational therapy.
- Pain management services.
- Physical therapy.
- Respite care services.

Prescription Drugs

- Drugs that are self-administered and that require – by federal law – a written prescription.
- Self-injectable insulin and insulin syringes.
- Diabetic supplies – including test strips, glucagon emergency kits and lancets.

Additional terms and provisions that apply to Covered Services may affect whether a specific service is covered and/or the benefits you may receive toward the cost of that service. For details regarding your plan’s Covered Services, refer to the plan’s [Benefits Booklet or Certificate of Coverage](#).

Covered Services – HMO Illinois

The HMO Illinois plan covers the following services, so long as they are performed with an approved referral from the patient’s Primary Care Physician (PCP). Additional information regarding Covered Services is available in the Certificate of Coverage at [Medical, Dental & Vision Plans](#).

Blue365

Blue365 is a program sponsored by participating local Blue Companies that help you stay healthier for less. Blue365 offers discounts for members to save on products and services for a well-balanced lifestyle. When you are enrolled for coverage under one of the University sponsored PPO or HMO medical plans, you can take advantage of discounts offered through Blue365. Some discounts include:

- Dental, vision and hearing products and services
- Fitness gear and apparel
- Gym memberships
- Family Activities
- Healthy eating options

For details about how these programs work and how they can save you money, visit [Blue365 Deals](#).

Preventive and Wellness Care Services

The HMO Illinois plan covers the full cost of preventive and wellness care services performed by an In-Network provider.

Preventive Care services that will not be subject to Deductible, Copayment, Coinsurance, or Out-of-pocket Maximum features of the plan include:

- Routine annual physicals
- Immunizations – for diphtheria, haemophilus influenza type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, COVID-19 and other immunization(s) as may be required by law for children
- Well child(ren) care
- Cancer screenings – including screenings for prostate cancer and colorectal cancer
- Mammograms
- Bone density tests
- Smoking cessation services
- Healthy diet counseling, and
- Obesity screenings and counseling.

Wellness care services that will not be subject to Deductible, Copayment, Coinsurance, or Out-of-pocket Maximum features of the plan include routine diagnostic medical procedures, EKG, x-ray, ovarian cancer screenings and colorectal cancer screening x-ray.

Physician Services

- Surgery.
- Anesthesia services – if administered at same time as covered surgical procedure.
- Assist at surgery – when performed by a physician, dentist or podiatrist
- Sterilization procedures – even if elective.
- Medical care visits – physician's office visit or if your physician comes to your home, or while an inpatient in a hospital, skilled nursing facility or abuse treatment facility or a patient in a partial hospitalization treatment program or coordinated home care program.
- Consultations – as requested by your doctor for another doctor's advice in the diagnosis or treatment of a condition that requires special skill or knowledge.

- Outpatient periodic health examinations – including:
 - Mammograms
 - Clinical breast examinations
 - Routine cervical smears or Pap smears
 - Routine prostate-specific antigen tests and digital rectal examinations
 - Colorectal cancer screening
 - Ovarian cancer screening.
- Routine pediatric care.
- Diagnostic services.
- Injected medicines.
- Amino acid-based elemental formulas.
- Electroconvulsive therapy.
- Radiation therapy.
- Chemotherapy.
- Outpatient rehabilitative therapy.
- Outpatient speech therapy – for pervasive developmental disorders.
- Outpatient respiratory therapy.
- Chiropractic and osteopathic manipulation.
- Hearing screening.
- Diabetes self-management training and education.
- Routine visual examination.
- Dental accident care.
- Family planning services.
- Bone mass measurement and osteoporosis.
- Investigational cancer treatment.
- Infertility treatment – see [Illinois Infertility Mandate](#).
- Mastectomy related services – see the [Women’s Health and Cancer Rights Act](#).
- Maternity services.
- Urgent Care – if you are traveling outside the plan’s service area.
- Follow-up care – if you will need follow-up care for an existing condition while traveling.

Hospital Services – Inpatient Care

- Bed, board, and general nursing care – provided in a semi-private or private room or in an intensive care unit.
- Ancillary services – including (but not limited to) operating rooms, drugs, surgical dressings, and lab work.
- Preadmission testing – preoperative tests performed on an outpatient basis.
- Partial hospitalization treatment – therapeutic treatment in a hospital for patients with mental illness.
- Coordinated home care.

Hospital Services – Outpatient Care

- Surgery and any related diagnostic services received on the same day as the surgery.
- Radiation therapy treatments.

- Chemotherapy.
- Electroconvulsive therapy.
- Renal dialysis treatments – if received in a hospital, a dialysis facility, or in your home under the supervision of a hospital or dialysis facility.

Hospital Services – Special Programs/Other Services

- Coordinated home care program.
- Pre-admission testing.
- Partial hospitalization treatment program – a therapeutic treatment program in a hospital for patients with mental illness.
- Surgical implants.
- Maternity services.
- Urgent Care – if you are traveling outside the plan’s service area.
- Follow-up care – if you will need follow-up care for an existing condition while traveling.

Supplemental Benefits

- Blood and blood components.
- Medical and surgical dressings, supplies, casts, and splints.
- Prosthetic devices.
- Durable medical equipment.

Emergency Care Benefits

- In-area treatment – if within 30 miles of your participating medical group.
- Out-of-area treatment – if more than 30 miles from your participating medical group.

Chemical Dependency Treatment Benefits

- In-patient services.
- Out-patient services.
- Detoxification.

Away from Home Care® Benefits

- Guest membership – if you will be living outside the plan’s service area for more than 90 days (but retaining your permanent residence within the service area).

Other Services

- Human organ transplant services.
- Hospice Care services:
 - Coordinated home care
 - Medical supplies and dressings
 - Medication
 - Nursing services – skilled and non-skilled
 - Occupational therapy
 - Pain management services
 - Physical therapy
 - Social and spiritual services
 - Respite care services.
- Vision care services – benefits for lenses, frames, and contact lenses.

Prescription Drugs

- Drugs that are self-administered that require – by federal law – a written prescription.
- Self-injectable insulin and insulin syringes.
- Diabetic supplies – including test strips, glucagon emergency kits, and lancets.

Services That Are Not Covered – Premier, Select, Value & ACA Value PPOs

In general, the PPO plans will pay no benefits for services that are deemed “medically unnecessary” by the Claims administrator.

Medically necessary means that a specific medical, health care, or hospital service is required – in the reasonable judgment of the Claims administrator – for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Other services that the Premier, Select, and Value PPO plans do not cover – and for which no benefits will be paid – include (but are not limited to):

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting – for example, in a doctor’s office or hospital outpatient department.
- Hospital admissions primarily for diagnostic studies (x-ray, laboratory, and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting – for example, in a doctor’s office or hospital outpatient department.
- Continued inpatient hospital care – when a patient’s medical symptoms and condition no longer require inpatient care.
- Hospitalization or admission to a skilled nursing facility, nursing home, or other facility for the primary purpose of providing custodial care service, convalescent care, rest cures, or domiciliary care to the patient.
- Hospitalization or admission to a skilled nursing facility for the convenience of the patient or doctor or because care in the home is not available or is unsuitable.
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care, or to provide services for the convenience of the patient and/or his family members.
- Services or supplies that are not specifically mentioned in the applicable plan’s Certificate of Coverage.
- Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers’ Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits.
- Services or supplies that are furnished to you by the local, state, or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state, or federal government – for example, Medicare – whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act, or as otherwise provided by law.
- Services and supplies for any illness or injury occurring on or after your coverage date as a result of war or an act of war.
- Services or supplies that do not meet accepted standards of medical and/or dental practice.

- Investigational services and supplies and all related services and supplies, except as may be provided under this handbook for the cost of routine patient care associated with investigational cancer treatment, if those services or supplies would otherwise be covered under this handbook if not provided in connection with an approved clinical trial program.
- Custodial care services.
- Long term care services.
- Respite care service, except as specifically mentioned under the Hospice Care program.
- Inpatient private duty nursing services.
- Services or supplies received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions, which are not specifically the result of mental illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- Cosmetic surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Charges for failure to keep a scheduled visit or charges for completion of a claim form.
- Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones.
- Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants – except as specifically mentioned in this handbook.
- Blood derivatives that are not classified as drugs in the official formularies.
- Eyeglasses, contact lenses, or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this handbook.
- Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.
- Routine foot care – except for persons diagnosed with diabetes.
- Maintenance occupational therapy, maintenance physical therapy, and maintenance speech therapy – except as specifically mentioned in this handbook.
- Maintenance care.
- Speech therapy – when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation.
- Hearing aids or examinations for the prescription or fitting of hearing aids – unless otherwise specified in this handbook.
- Services and supplies to the extent benefits are duplicated because the spouse, partner. And/or child are covered separately under a University-sponsored health plan.
- Diagnostic service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies, or tests which are investigational – unless otherwise specified in this handbook.

- Procurement or use of prosthetic devices, special appliances, and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
- Wigs (also referred to as cranial prostheses) – unless otherwise specified in this handbook.
- Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this handbook.
- Reversals of sterilization.
- Immunizations for foreign travel and employment requirements – unless otherwise specified in this handbook.
- Implants and any related services and supplies associated with the placement and care of implants.
- Endosteal implants and the associated surgical procedures.

Hospice Care

- Durable medical equipment.
- Home delivered meals.
- Homemaker services.
- Traditional medical services provided for the direct care of the terminal illness, disease, or condition.
- Transportation – including (but not limited to) ambulance transportation.

Prescription Drugs

- Drugs used for cosmetic purposes – including (but not limited to) Retin-A/Tretinoin and Minoxidil/Rogaine.
- Drugs for which there is an over-the-counter product available with the same active ingredient(s).
- Drugs that are not self-administered.
- Any devices or appliances – except as specifically mentioned above.
- Any charges that you may incur for the drugs being administered to you.
- Refills – if the prescription is more than one year old.

Services That Are Not Covered – HMO Illinois

Services that the HMO Illinois plan does not cover – and for which no benefits will be paid – include (but are not limited to):

- Services or supplies that are not specifically mentioned in the plan's Certificate of Coverage.
- Services or supplies that were not ordered by your PCP – except those received during an emergency or as identified in the Certificate of Coverage.
- Services or supplies that were received prior to the date your coverage began or after the date your coverage was terminated.
- Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits.
- Services or supplies that are furnished to you by the local, state, or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state, or federal government – for example, Medicare – whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act, or as otherwise provided by law.

- Services or supplies rendered to you as the result of an injury caused by another person.
- Services or supplies that do not meet accepted standards of medical and/or dental practice.
- Custodial care services.
- Long term care services.
- Respite care services – except as specifically mentioned under the Hospice Care program.
- Services or supplies rendered because of behavioral, social maladjustment, lack of discipline or other antisocial actions that are not specifically the result of mental illness.
- Special education therapy such as music therapy or recreational therapy.
- Cosmetic surgery and related services and supplies – except for the correction of congenital deformities or for conditions resulting from accidental injuries, tumors or disease.
- Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Charges for failure to keep a scheduled visit or charges for completion of a claim form or charges for the transfer of medical records.
- Personal hygiene, comfort or convenience items commonly used for other than medical purposes such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones.
- Special braces, splints, specialized equipment, appliances, ambulatory apparatus or, battery implants except as specifically mentioned in the Certificate of Coverage.
- Prosthetic devices, special appliances, or surgical implants which are for cosmetic purposes, the comfort or convenience of the patient, or unrelated to the treatment of a disease or injury.
- Nutritional items such as infant formula, weight-loss supplements, over-the-counter food substitutes, non-prescription vitamins, and herbal supplements.
- Blood derivatives that are not classified as drugs in the official formularies.
- Marriage counseling.
- Hypnotism.
- Inpatient and outpatient private duty nursing service.
- Routine foot care, except for persons diagnosed with diabetes.
- Maintenance occupational therapy, maintenance physical therapy, and maintenance speech therapy – except as specifically mentioned in the Certificate of Coverage.
- Maintenance care.
- Self-management training, education, and medical nutrition therapy – except as specifically mentioned in the Certificate of Coverage.
- Services or supplies rendered for the care, treatment, filling, removal, replacement, or artificial restoration of the teeth or structures directly supporting the teeth – except as specifically mentioned in the Certificate of Coverage.
- Treatment of temporomandibular joint syndrome with intraoral prosthetic devices or any other method which alters vertical dimension or treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.
- Services or supplies rendered for human organ or tissue transplants – except as specifically provided for in the Certificate of Coverage.

- Wigs – also referred to as cranial prostheses.
- Services or supplies rendered for infertility treatment except as specifically provided for in the Certificate of Coverage.
- Outpatient prescription drugs or medicines.
- Outpatient contraceptive devices and services.

Hospice Care

- Durable medical equipment.
- Home delivered meals.
- Homemaker services.
- Traditional medical services provided for the direct care of the terminal illness, disease, or condition.
- Transportation – including (but not limited to) ambulance transportation.

Prescription Drugs

- Drugs used for cosmetic purposes – including (but not limited to) Retin-A/Tretinoin and Minoxidil/Rogaine.
- Drugs for which there is an over-the-counter product available with the same active ingredient(s).
- Drugs that are not self-administered.
- Any devices or appliances – except as specifically mentioned above.
- Any charges that you may incur for the drugs being administered to you.
- Refills – if the prescription is more than one year old.

Coverage While On a Leave of Absence

If you are on a Leave of Absence you may continue to participate in health coverage. If you are on a(n):

- **Paid leave** – you may continue to pay your health plan Premiums through payroll deduction.
- **Unpaid leave** – you will be billed on a monthly basis for your health plan Premiums. Premiums can be paid via automatic withdrawal from your bank (if set-up) or by check made out to Inspira Financial and submitted to Inspira Financial directly.

Coverage While On Disability

If you are Disabled and receiving benefit payments from a University-sponsored disability plan you may continue your health coverage. If you are receiving:

- **Extended Sick Time benefits** – your health plan Premiums will be deducted on a pre-tax basis.
- **Long Term Disability benefits** – you will be billed on a monthly basis for your health plan Premiums. Premiums can be paid via automatic withdrawal from your bank (if set-up) or by check made out to Inspira Financial and submitted to Inspira Financial directly.

Note: Your medical plan coverage may continue for up to a maximum of two years while receiving Extended Sick Time and Long Term Disability benefits.

Coverage When You Retire

If you retire from University employment and meet specified age and service requirements (see table), you may continue to participate in University-sponsored medical coverage in either the Legacy Retiree PPO or Legacy Retiree HMO plans.

Retirement Age and Service Requirements for Medical Coverage in Retirement

Age at Retirement:	55	56	57	58	59	60	61	62	63	64	65
Service (in years):											
Full-Time	10	10	10	9	8	7	6	5	4	3	2
Part-Time	10	10	10	10	10	10	9	8	7	6	2

As an eligible retiree, your participation in a medical plan may continue as long as you submit the Premium payment to the University.

Should you die, your surviving spouse or partner and eligible children may continue University-sponsored medical coverage under the retiree plan. This eligibility ends for the spouse or partner upon remarriage, or for a child upon adoption or reaching age 26.

For details about your medical coverage options at retirement see [Benefit Program Information for Retirees](#).

Coverage Upon Termination of Employment

Your medical coverage will end at the end of the month in which termination of your University employment occurs. However, you may elect to temporarily continue medical coverage for yourself and your eligible family members, as provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA). For more information about COBRA coverage continuation and instructions for enrolling in this coverage, see [COBRA Benefits](#) and [Terminated Employees and COBRA](#).

Coverage Upon Your Death

Your surviving spouse or partner and eligible children may continue University-sponsored medical coverage under the retiree plan as long as they continue to submit the required Premium payment to Inspira Financial. This eligibility ends for the spouse or partner upon remarriage, or for a child upon adoption or reaching age 26.

Dental Plans

Dental PPO

The Dental PPO plan offers a type of coverage known as Preferred Provider Organization, or PPO. A PPO plan enables members to choose to receive care from any licensed dental provider, but will pay higher benefits for “In-Network” services (that is, services performed by members of a “preferred” provider Network) – in this case, the BlueCross/BlueShield of IL Dental Network. To see if a particular dentist is a member of the Network, call BlueCross/BlueShield of IL Customer Service at **(800) 573-9827** or search the online provider directory at www.bcbsil.com.

Note: When you choose to see an In-Network provider, your share of the cost and the benefits you receive will be based on the specified maximum allowance for these services and your share of these costs will generally be less than what you would pay for the same services performed by an Out-of-Network provider.

The Dental PPO is a self-insured plan administered by BlueCross/BlueShield of IL for dental services. As a self-insured plan, the Dental PPO:

- Is funded by both employee and employer contributions deposited to a Trust
- Pays claims and other expenses from the Trust, and
- Is exempt from covering services mandated by state law.

Dental HMO

This plan offers coverage through a “dental Health Maintenance Organization,” or Dental HMO. As a Dental HMO, this plan pays benefits only for dental care services received from a Network of dental providers – in this case, the Guardian HMO provider Network – and (except in the case of an emergency) only for services approved in advance by your primary dental care provider.

If you enroll in this coverage option, you – and each eligible family member you include under your coverage – must choose a dentist who is a member of the Guardian HMO provider Network as your primary dental care provider. To see if a particular dentist is a member of the Network, call Guardian Customer Service at **866-494-4542** or search the online provider directory at www.guardiananytime.com.

Note: Services received from a dental specialist must be based on a referral from – and authorized in advance by – the primary dental care provider. University employees located outside of Illinois should not enroll in this coverage.

Like most HMO plans, the Dental HMO is a fully insured plan. As a fully insured plan it:

- Is funded by both employee and employer contributions paid directly to it, and
- Must provide coverage mandated by state law.

For details about key plan features – including current-year Deductibles, Copayments, Coinsurance, out-of-pocket expense limits, and Premiums – see the individual [plan highlights](#). For a side-by-side comparison of these features for the PPO and HMO dental plans you can also refer to the materials you receive during annual Open Enrollment. Complete Dental PPO details are provided in the Certificate of Coverage at [Medical, Dental & Vision Plans](#), and a complete listing of Covered Services – and related Copayments – under the Dental HMO is provided in the [Schedule of Member Payment Responsibilities](#). For more information about Premiums and what they’re based on, see [Contributions](#) in this handbook.

How PPO and HMO Coverage Differ

While both plans provide benefits toward the cost of dental care services, they differ in three important ways:

- How much you pay in monthly Premiums toward the cost of your coverage
- How much flexibility you have in choosing the providers you go to for dental care services, and
- How much you pay out-of-pocket at the time you receive a dental care service or the amount you will owe once a claim is processed.

What You May Pay

Whichever dental plan you choose, you may pay a portion of the cost of any dental care services you receive – either at the time the service is received or after a dental care claim is processed by the sponsoring insurance company. The ways you may pay for dental care services differ based on the dental plan you choose.

If you choose coverage under the Dental PPO the amounts you will pay for dental care services are:

- **Deductible** – The flat-dollar amount you pay each year out-of-pocket for dental care services under the Dental PPO plan before the plan will begin paying benefits toward the cost of these services. **Note:** The Deductible does not apply to diagnostic and preventive services.
- **Coinsurance** – A percentage of the cost of a service that you pay (which varies from 0% to 50%). The charge on which this Coinsurance is based on whether you receive services from an In-Network or Out-of-Network provider; if you receive services:
 - **In-Network** – that is, from a dentist who is a member of the Blue Cross Blue Shield of Illinois Dental Network – your benefits will be based on the “maximum allowance” that applies to each service. The *maximum allowance* is the amount that Network providers have agreed to accept as payment in full for a particular service.
 - **Out-of-Network** – that is, from a dentist who is not a member of the Blue Cross Blue Shield of Illinois Dental Network – your benefits will be based on the *usual and customary fee* for the service in your area, as determined by Blue Cross Blue Shield of Illinois; you will pay any difference between your dentist’s charge and the usual and customary fee.

Coinsurance begins ONLY after you have met the annual Deductible.

If you choose coverage under the Dental HMO the amount you will pay for dental care services are the flat-dollar amounts you pay for specified services, as listed in the [Schedule of Member Payment Responsibilities](#), which is updated annually. Once you pay the Copayment, the Dental HMO plan pays the balance of the cost. You pay a Copayment – which is typically a small fraction of the total cost of the service to which it applies – at the time the service is received.

Note: No benefits will be paid for services received from a dentist who is not a member of the Guardian HMO provider Network.

Covered Services

The Dental PPO covers the following services unless otherwise noted. Additional information regarding Covered Services is available in the benefits booklets and certificates of coverage at [Medical, Dental & Vision Plans](#).

For a listing of services that are covered by the Dental HMO – and the Copayment that applies to each service – see the [Schedule of Member Payment Responsibilities](#).

Special Limitations

No benefits will be paid for:

- Dental services which are performed for cosmetic purposes.
- Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunctional and related disorders – except as specifically referenced in this section.
- Oral surgery for:
 - Surgical services related to a congenital malformation
 - Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth, and
 - Excision of exostoses of the jaws and hard palate (provided this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone, external incision and drainage of cellulitis, incision of accessory sinuses, salivary glands or ducts, reduction of dislocation or excision of the temporomandibular joints.
- Dental services which are performed due to an accidental injury when caused by external force (i.e., any outside strength producing damage to the dentition and/or oral structures).
- Hospital and ancillary charges.

Diagnostic and Preventive Dental Services

- Oral examinations (initial and period routine examinations) – up to two every benefit period (January 1-December 31).
- Dental x-rays – benefits for panoramic and routine full mouth x-rays are limited to one full mouth series every 36 months.
- Bitewings are limited to four horizontal films or eight vertical films twice per benefit period.
- Prophylaxis – the routine scaling and polishing of your teeth, limited to two cleanings each benefit period.
- Topical fluoride application – benefits are limited to two applications each benefit period.

Miscellaneous Dental Services

- Sealants – benefits for sealants are limited to permanent teeth for persons up to age 19.
- Space maintainers – benefits for space maintainers are only available to persons under age 19 and not when part of orthodontic treatment.
- Labs and tests – pulp vitality tests.
- Emergency oral examinations and palliative emergency treatment for the temporary relief of pain.

Restorative Dental Services

- Amalgams (fillings) – limited to once per surface per tooth in any benefit period.
- Pin retention.
- Composites.
- Simple extractions – except as specifically excluded under *Special Limitations* (see page 2.24).
- Denture reline – limited to once in any six-month period.
- Denture rebase – limited to once per tooth in any 60-month period.
- Addition of tooth or clasp.

General Dental Services

- General anesthesia/intravenous sedation – if medically necessary and administered with a covered dental procedure. **Note:** The anesthesia must be given by a person who is licensed to administer general anesthesia/intravenous sedation.
- Home visits – when medically required to render a covered dental service.
- Stainless steel crowns – limited to one per tooth in a 60-month period and not to be used as a temporary crown.
- Injection of antibiotic drugs.
- Occlusional guards for bruxism.

Endodontic Services

- Root canal therapy.
- Pulp cap.
- Apicoectomy.
- Apexification.
- Retrograde filling.
- Root amputation/hemisection.
- Therapeutic pulpotomy.
- Pulpal debridement.

Periodontic Services

- Periodontal scaling and root planning – limited to one full mouth treatment per benefit period.
- Full mouth debridement – limited to one time per benefit period.
- Gingivectomy/gingivoplasty – limited to one full mouth treatment per benefit period.
- Gingival flap procedure – limited to one full mouth treatment per benefit period.
- Osseous surgery – limited to one full mouth treatment per benefit period.
- Osseous grafts.
- Soft tissue grafts.
- Periodontal maintenance procedures – benefits for periodontal maintenance procedures are limited to two per benefit period. In addition, you must have received active periodontal therapy before benefits for these procedures will be provided.

Oral Surgery Services

- Surgical tooth extraction.
- Alveoloplasty.
- Vestibuloplasty.
- Other necessary dental surgical procedures.
- Impacted wisdom teeth.

Crowns, Inlays/Onlays Services

- Dental services resulting from extensive disease or fracture – limited to one per tooth in a 60-month period.
- Prefabricated post and cores.
- Cast post and cores.

- Crowns, inlays/onlays repairs.
- Recementation of crowns, inlays/onlays.

Prosthodontic Services

- Bridges.
- Dentures.
- Adjustments to bridges and dentures – during the first six months after obtaining dentures or having them relined, adjustments are covered only if done by someone other than the dentist or his in-office associates who provided or relined the dentures.
- Bridge and denture repairs – limited to once per tooth in any 60-month period.

Once you receive benefits for a crown, inlay, onlay, bridge or denture, replacements are not covered until five years have elapsed. Also, benefits are not available for replacement of a bridge or denture that could have been made serviceable.

Implants

Covered Services include the surgical placement, maintenance, and repair of an implant body, including services associated with preparation of the implant site (i.e., splinting, grafting).

Orthodontic Dental Services

If you elect Dental PPO coverage your dental benefits include coverage for orthodontic appliances and treatments when they are being provided to correct problems of growth and development. These benefits are subject to the lifetime maximum and limited as follows:

- Benefits are only available for dependent child(ren) under age 26 and will end at the end of the month in which they turn 26.
- Benefits for orthodontic treatment will be available over the course of treatment.
- Benefits will not be provided for the replacement or repair of any appliance used during orthodontic treatment.

Services That Are Not Covered

In general, the Dental PPO will not pay benefits for services that are deemed “medically unnecessary” by the Claims administrator.

Medically necessary means that a specific dental service is required – in the reasonable judgment of the Claims administrator – for the treatment or management of a dental symptom or condition and that the service or care provided is the most efficient and economical service that can safely be provided.

Other services that are not covered by the Dental PPO – and for which no benefits will be paid – include (but are not limited to):

- Services or supplies that are not specifically mentioned in this handbook.
- Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers’ Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers’ Compensation Act according to the provisions of the Act.

- Services or supplies that are furnished to you by the local, state, or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state, or federal government (for example, Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act, or as otherwise provided by law.
- Services and supplies for any illness or injury occurring on or after your coverage date as a result of war or an act of war.
- Services or supplies that do not meet accepted standards of medical and/or dental practice.
- Investigational services and supplies and all related services and supplies, except as may be provided under this benefit booklet for the cost of routine patient care associated with Investigational cancer treatment, if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with an approved clinical trial program.
- Charges for failure to keep a scheduled visit or charges for completion of a Claim form.
- Services and supplies to the extent benefits are duplicated because the spouse, partner, and/or child are covered separately under the plan.

Coverage While On a Leave of Absence

If you are on a Leave of Absence you may continue to participate in dental coverage. If you are on a(n):

- **Paid leave** – you may continue to pay your dental plan Premiums through payroll deduction.
- **Unpaid leave** – you will be billed on a monthly basis for your health plan Premiums. Premiums can be paid via automatic withdrawal from your bank (if set-up) or by check made out to Inspira Financial and submitted to Inspira Financial directly.

Coverage While On Disability

If you are Disabled and receiving benefit payments from a University-sponsored disability plan you may continue your dental coverage. If you are receiving:

- **Extended Sick Time benefits** – your dental plan Premiums will be deducted on a pre-tax basis.
- **Long Term Disability benefits** – you will be billed on a monthly basis for your health plan Premiums. Premiums can be paid via automatic withdrawal from your bank (if set-up) or by check made out to Inspira Financial and submitted to Inspira Financial directly.

Note: Your dental plan coverage may continue for up to a maximum of two years while receiving Extended Sick Time and Long Term Disability benefits.

Coverage When You Retire

If you retire from University employment and meet specified age and service requirements (see table), you may continue to participate in University-sponsored dental coverage through the Legacy Retiree Dental PPO or Legacy Retiree HMO plans.

Retirement Age and Service Requirements for Dental Coverage in Retirement

Age at Retirement:	55	56	57	58	59	60	61	62	63	64	65
Service (in years):											
Full-Time	10	10	10	9	8	7	6	5	4	3	2
Part-Time	10	10	10	10	10	10	9	8	7	6	2

As an eligible retiree, your participation in a dental plan may continue as long as you submit the Premium payment to the University.

Should you die, your surviving spouse or partner and eligible children may continue University-sponsored dental coverage under the retiree plan. This eligibility ends for the spouse or partner upon remarriage, or for a child upon adoption or reaching age 26.

For details about your dental coverage options at retirement, see [Benefit Program Information for Retirees](#).

Coverage Upon Termination of Employment

Your coverage will end at the end of the month in which termination of your University employment occurs. However, you may elect to temporarily continue dental coverage for yourself and your eligible family members, as provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA). For more information about COBRA coverage continuation and instructions for enrolling in this coverage, see [COBRA Benefits](#) and [Terminated Employees and COBRA](#).

Coverage Upon Your Death

Your surviving spouse or partner and eligible children may continue University-sponsored dental coverage under the retiree plan as long as they continue to submit the required Premium payment to the University. This eligibility ends for the spouse or partner upon remarriage, or for a child upon adoption or reaching age 26.

Vision Plan

BlueCross BlueShield of Illinois Vision Care

If you enroll in the BlueCross BlueShield of Illinois (BCBSIL) vision plan you will have the option of using an In-Network or an Out-of-Network provider each time you seek vision care. BCBSIL Vision Care's Network of providers includes private practitioners, as well as the nation's premier retailers, such as LensCrafters®, Target Optical, and most Pearle Vision locations.

To locate an BCBSIL Vision Care provider near you, visit www.eyemedvisioncare.com and choose the Insight Network. Or you can call BCBSIL's Customer Care Center at **855-362-5539** —.

Note: While BCBSIL Vision Care makes every attempt to keep its lists of In-Network providers current, changes to the provider Networks occur frequently. Before you schedule an appointment with a vision care provider you believe to be a member of the BCBSIL Vision Care Network, you should contact BCBSIL or the provider's office directly to confirm that the provider is a current member of the Network.

Using an BCBSIL Network Provider

Before going to a participating BCBSIL Vision Care provider for an eye exam, glasses or, contact lenses, it is recommended that you call ahead for an appointment. When you call:

- Identify yourself as an BCBSIL member
- Confirm the provider is an In-Network provider, and
- Provide your name and the name of your organization and employee ID number (located on the front of your Wildcard). Alternatively, you can provide your name and date of birth.

When you arrive for your appointment, show the receptionist or sales associate your BCBSIL Identification Card. If you forget to take your card, say that you are participating in an BCBSIL vision plan so that your

eligibility can be verified. **Note:** While your ID card is not necessary to receive services, it is helpful to present your BCBSIL Vision Care ID card to verify your eligibility.

The provider will file your claim. You will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable Copayments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

You may also want to add a reference in that now there are online options for In-Network providers for members to use via www.glasses.com, or www.contactsdirect.com.

Using an Out-of-Network Provider

If you choose to receive services from a vision care provider who is NOT a member of the BCBSIL Network, you will pay for the full cost of the service at the point of service. You will be reimbursed, as outlined in the [Summary of Covered Vision Care Services](#).

To receive a reimbursement for your out-of-pocket expenses, you will need to complete and submit a claim along with any associated itemized receipts from the transaction (see [Claim Filing](#)). **Note:** For your convenience, an BCBSIL Out-of-Network claim form is available at eyemedvisioncare.com/bcbsilvis or by calling BCBSIL's Customer Care Center at **855-362-5539**.

For details about key plan features – including current-year Copayments, discounts and allowances – see the [plan highlights](#). Additional information about key features of the Vision Plan is provided in the materials you receive during annual Open Enrollment. For more information about Premiums and what they're based on, see [Contributions](#) in this handbook. Note: If you are enrolled in one of the University's medical plans, you have vision discounts through the [Blue365 Discount Program](#) at no additional cost.

What You May Pay

To fully understand the benefits that are provided under the BCBSIL Vision Care Plan, you should know the meaning of the following terms.

Allowance

This is a specified amount the BCBSIL Vision Care Plan will pay toward the cost of certain vision care services and/or supplies. In some cases, a Copayment applies (see below). If the cost of a service or supply exceeds the applicable allowance, you pay the balance (but a discount typically applies to the excess). **Note:** Allowances are one-time use benefits; if you do not use the full allowance for a purchase, no remaining balance remains for use later in the same plan year. Lost or broken materials are not covered.

Copayment

A Copayment is a set dollar amount that you pay for specified vision services at the point of sale. Once you pay the Copayment, the BCBSIL Vision Care Plan pays 100% of the remaining cost of the service; in some cases, this 100% benefit is subject to a specified "allowance" amount (see above).

Covered Services

The BCBSIL Vision Care Plan covers the following services. Additional information regarding Covered Services is available in the Certificate of Coverage at [Medical, Dental & Vision Plans](#).

- Comprehensive eye exam – once per calendar year.
- Lenses for eyeglasses – once per calendar year:
 - One pair of standard single vision, lined bifocal, lined trifocal or standard lenticular lenses
 - Standard scratch-resistant coating and polycarbonate lenses.

Note: Lens options such as progressive lenses, tints, UV, and anti-reflective coating may be available at discount.

- Frames for eyeglasses – once per calendar year.
- Conventional contact lenses or disposable contact lenses – once per calendar year.
- Laser vision – discounted laser vision correction procedures through U.S. Laser Network (see [Laser Vision Correction Benefit](#) on page 2.31).

Services That Are Not Covered

The Vision Plan does not pay benefits for:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing.
- Aniseikonic lenses.
- Medical and/or surgical treatment of the eye, eyes, or supporting structures.
- Corrective eyewear required by an employer as a condition of employment and safety eyewear.
- Services provided as a result of any workers' compensation law.
- Plano non-prescription lenses and non-prescription sunglasses (except for 20% discount).
- Two pairs of glasses in lieu of bifocals.
- Services or materials provided by any other group benefit plan providing vision care or services rendered after the date you or a covered family member ceases to be covered under the policy (except when vision materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order).
- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when vision materials would next become available.
- Discounts on frames where the manufacturer prohibits discounts, including, but not limited to: Bulgari, Cartier, Chanel, Gold & Wood, Maui Jim, and Pro Design.
- Applicable taxes.
- Visual Display Terminal (VDT) Exam.

Laser Vision Correction Benefit

BCBSIL Vision Care, in partnership with U.S. Laser Network, offers discounts to members interested in Lasik and PRK. BCBSIL members receive a discount (15% off retail or 5% off promotional price) when using a Network provider in the U.S. Laser Network, owned and operated by LCA Vision. The U.S. Laser Network offers many locations nationwide.

For additional information or to locate a Network provider, visit www.eyemedlasik.com or call **877-5LASER6**.

Once you receive the name and number of a U.S. Laser Network provider:

- Contact the provider
- Identify yourself as an EyeMed vision plan member, and
- Schedule a consultation to determine if you are a good candidate for laser vision correction.

If it is determined that you are a good candidate for laser vision correction, you should schedule a treatment date with a U.S. Laser Network provider. To activate your benefit, you must call **877-5LASER6** again and provide your scheduled treatment date.

At the time your treatment is scheduled you will need to pay an initial deposit to U.S. Laser Network; this deposit will be applied toward the cost of your treatment. Should you decide against the treatment, the deposit

will be refunded. You will be issued an authorization number confirming your BCBSIL Vision Care discount; this number also will be sent to your U.S. Laser Network provider prior to treatment.

On your scheduled treatment date, you must pay (or arrange to pay) the balance of the fee. After the treatment, you will be responsible for following all post-operative instructions carefully and scheduling any required follow-up visits with a U.S. Laser Network provider.

Coverage While On a Leave of Absence

If you are on a Leave of Absence you may continue to participate in vision coverage. If you are on a(n):

- **Paid leave** – you may continue to pay your vision plan Premiums through payroll deduction.
- **Unpaid leave** – you will be billed on a monthly basis for your health plan Premiums. Premiums can be paid via automatic withdrawal from your bank (if set-up) or by check made out to Inspira Financial and submitted to Inspira Financial directly.

Coverage While On Disability

If you are Disabled and receiving benefit payments from a University-sponsored disability plan you may continue your vision coverage. If you are receiving:

- **Extended Sick Time benefits** – your vision plan Premiums will be deducted on a pre-tax basis.
- **Long Term Disability benefits** – you will be billed on a monthly basis for your health plan Premiums. Premiums can be paid via automatic withdrawal from your bank (if set-up) or by check made out to Inspira Financial and submitted to Inspira Financial directly.

Note: Your vision plan coverage may continue for up to a maximum of two years while receiving Extended Sick Time and Long Term Disability benefits.

Coverage When You Retire

If you retire from University employment and meet specified age and service requirements (see table), you may continue to participate in University-sponsored vision coverage through the Legacy Retiree Vision PPO plan.

Retirement Age and Service Requirements for Vision Coverage in Retirement

Age at Retirement:	55	56	57	58	59	60	61	62	63	64	65
Service (in years):											
Full-Time	10	10	10	9	8	7	6	5	4	3	2
Part-Time	10	10	10	10	10	10	9	8	7	6	2

As an eligible retiree, your participation in a vision plan may continue as long as you submit the Premium payment to the University.

Should you die, your surviving spouse or partner and eligible children may continue University-sponsored vision coverage under the retiree plan. This eligibility ends for the spouse or partner upon remarriage, or for a child upon adoption or reaching age 26.

For details about your vision coverage options at retirement, see [Benefit Program Information for Retirees](#).

Coverage Upon Termination of Employment

Your coverage will end at the end of the month in which termination of your University employment occurs. However, you may elect to temporarily continue vision coverage for yourself and your eligible family members, as provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA). More information about COBRA coverage continuation and instructions for enrolling in this coverage is provided in [COBRA Benefits](#) and [Terminated Employees and COBRA](#).

Coverage Upon Your Death

Your surviving spouse or partner and eligible children may continue University-sponsored vision coverage under the retiree plan as long as they continue to submit the required Premium payment to the University. This eligibility ends for the spouse or partner upon remarriage, or for a child upon adoption or reaching age 26.

State & Federal Notices

This section includes important information about state and federal notices that may affect your coverage – and the benefits you receive – under your medical, dental, and/or vision coverage.

Consolidated Omnibus Budget Reconciliation Act/COBRA Continuation Coverage

A federal law called COBRA – the Consolidated Omnibus Budget Reconciliation Act – allows you, your spouse or partner, and/or dependent children to continue your enrollment in certain University-sponsored benefit plans – at your own expense – if your enrollment terminates due to a Qualifying Event.

A Qualifying Event includes termination of employment or transfer to a non-benefits-eligible position. The type of coverage offered under COBRA is the same as that provided to active employees. However, you are responsible for the total cost of your COBRA coverage (and, if elected, the enrollment costs for your dependents) plus an additional 2% administrative fee.

Under COBRA, you and your currently enrolled family members may continue:

- To be enrolled in medical, dental, and/or vision coverage for:
 - **18 months** – if you lose coverage because employment ends or hours are reduced.
 - **36 months** – if an enrolled family member loses coverage because of your divorce, your children no longer qualify as eligible family members, your death, or you become eligible for Medicare.
 - **29 months** – if you or an enrolled family member becomes totally Disabled within the first 60 days of COBRA coverage.
- **Note:** Additional continuation rules may apply if enrolled in HMO Illinois.
- To participate in a Health Care Flexible Spending Account (FSA) for the remaining part of the plan year – as long as you continue to remit your deposits.

To continue your current medical, dental, and/or vision enrollment – and/or your participation in a Health Care FSA – you must elect COBRA coverage within 60 days of the date you are notified of your COBRA rights. If you elect COBRA coverage, you will be required to remit your COBRA payments to the University's COBRA administrator within 45 days.

For more information about your right to continuing coverage under COBRA, see [COBRA Benefits](#).

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) expands the genetic information protections included under HIPAA. HIPAA prevents the University's health plans from imposing a preexisting condition exclusion provision based solely on genetic information and prohibits discrimination in individual eligibility, benefits, or Premiums based on any health factor (including genetic information).

GINA provides that group health plans cannot base Premiums for a group of similarly situated individuals on genetic information. (However, Premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan.)

GINA also generally prohibits group health plans from requesting or requiring you to undergo a genetic test. However, your health care provider is permitted to request a genetic test. Additionally, genetic testing information may be requested to determine payment of a claim for benefits, although GINA limits the scope of the request to only the minimum amount of information necessary in order to determine payment. There is also a research exception that permits a plan or issuer to request (but not require) that you undergo a genetic test. GINA also prohibits group health plans from collecting genetic information (including family medical history) prior to or in connection with enrollment.

Under GINA, group health plans are generally prohibited from offering rewards in return for collection of genetic information, including family medical history information collected as part of a Health Risk Assessment. An exception is included for incidental collection, provided the information is not used prior to or in connection with enrollment. However, this exception is not available if it is reasonable for group health plans to anticipate that health information will be received in response to a collection unless the collection explicitly states that genetic information should not be provided.

Health Insurance Portability and Accountability Act/HIPAA Protected Health Information

Effective April 14, 2003, health plans became subject to new federal privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These regulations describe certain limitations on the disclosure of protected health information as well as the measures that organizations must take to safeguard this information.

For more information, see [Protection of Personal Health Information](#).

Illinois Infertility Mandate

Illinois law requires insurance companies and fully insured plans to provide coverage for infertility to employee groups of more than 25 members. The law does not apply to self-insured plans or to Trusts or insurance policies written outside of Illinois.

For details, see [Illinois Infertility Mandate](#).

Newborns' and Mothers' Health Protection Act

Federal law generally prohibits group health plans from restricting benefits for hospital lengths of stay in connection with childbirth for the mother or newborn child to:

- Less than 48 hours following a vaginal delivery, and
- Less than 96 hours following a caesarean section.

However, federal law does not generally prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the University's health plans may not, under federal law, require that a provider obtain

authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Patient Protection and Affordable Care Act

The PPO and HMO medical plans are not “grandfathered health plans” under the Affordable Care Act. Therefore, these University-sponsored medical plans must include all consumer protections of the Affordable Care Act.

The employer shared responsibility (ESR) portion of the Affordable Care Act went into effect January 1, 2015. ESR requires that employers with 50 or more employees must offer minimum essential health coverage (MEC) to all employees who work an average of 130+ hours per month (30+ hours per week). “Employee” is defined as anyone on the payroll. All temporary employees, employees scheduled to work less than 18.75 hours per week (less than half time), employees on special pay, and adjunct faculty will be subject to look-back periods where their hours are examined to determine whether or not they meet qualifications to be offered the University’s ACA health plan. The University ACA coverage is health and prescription insurance only through BCBS and Express Scripts.

The employee’s hours will be monitored during the initial measurement period – the first year of employment – to determine eligibility for coverage after that if employment with Northwestern University continues. If an employee accepts the coverage that is offered, the employee will remain on the plan for the one year stability period as long as their employment relationship with the University continues. The employee’s hours worked will continue to be monitored to determine continued eligibility in the plan beyond the stability period. Employees enrolled in the coverage will be offered COBRA upon termination.

For more information on COBRA coverage, click [here](#). For more information on the Affordable Care Act and the medical plan the University offers to this group, visit our website at <http://www.northwestern.edu/hr/benefits/health-plans/employee-plans/aca-value-ppo.html>.

Questions regarding the Affordable Care Act and how it applies to University-sponsored medical plans can be directed to Benefits at **847-491-4700** or askHR@northwestern.edu. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at www.dol.gov/ebsa/healthreform or **866-444-3272**.

Patient Protection/Designation of Primary Care Provider Disclosure

The HMO Illinois plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the HMO Illinois Network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact BCBS HMO Illinois at **800-892-2803**.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from BCBSIL or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our Network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact BCBSIL at **800-892-2803**.

Protection from Loss of Health Coverage

If you are an active employee and you decline enrollment for yourself or your eligible family members (including your spouse or partner) under University-sponsored medical, dental, and/or vision coverage because of other health insurance coverage, you may in the future be able to enroll yourself or your eligible family members provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new eligible family member as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your eligible family members, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

For more about your enrollment rights in these situations, see [Benefit Changes](#).

Qualified Medical Child Support Order

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, he or she will be eligible for enrollment in the coverage as required by the order. You must notify Benefits and enroll that child (and yourself if you are not enrolled) in a University-sponsored medical plan within 31 days of the date the Qualified Medical Child Support Order is issued.

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for medical benefit coverage to such child and relates to benefits under a group medical plan, and satisfies all of the following:

- The order recognizes or creates a child's right to receive group medical benefits for which you are eligible
- The order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address
- The order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined
- The order states the period to which it applies, and
- If the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the above requirements.

The Qualified Medical Child Support Order may not require a University-sponsored medical plan to provide coverage for any type or form of benefit or option not otherwise provided under the medical plan except an order may require that the medical plan comply with state laws regarding child medical care coverage.

Any payment of benefits in reimbursement for covered expenses paid by the child, the child's custodial parent or legal guardian shall be made to the child, the child's custodial parent or legal guardian, or state official whose name and address have been substituted for the name and address of the child.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which a mastectomy has been performed

- Surgery and reconstruction of the other breast to create a symmetrical appearance
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call BlueCross BlueShield at **800-327-8497**.

3 Spending & Savings Accounts

The University offers you, as an eligible participant, two types of tax-favored accounts in which you may choose to participate – Flexible Spending Accounts (FSAs) and a Health Savings Account (HSA).

When you participate in – and make contributions to one of these types of accounts – you can use the money in the account to pay eligible health care or dependent care expenses (depending on the account). Because you make your contributions on a pre-tax basis through automatic payroll deductions – and pay no taxes on these contributions when you use them to pay eligible expenses – participating in these types of accounts is an easy, convenient way to get more out of your paycheck.

Flexible Spending Accounts

You may elect to participate in one or both of the following Flexible Spending Accounts:

- [Health Care FSA](#) (or [Limited Use FSA](#) if enrolled in the Value PPO health plan), and/or
- [Dependent Care FSA](#).

If you elect to participate in the Dependent Care FSA – and you meet certain eligibility guidelines – the University may make a tax-free [matching contribution](#) to your account.

While Northwestern University administers these Flexible Spending Accounts, the Claims administrator is Inspira Financial.

Health Savings Account

If you elect coverage with the Value PPO health plan, you may choose to open – and make Pre-tax Contributions to – a [Health Savings Account](#). **Note:** You cannot participate in an HSA if you elect coverage under the University-sponsored Premier PPO, Select PPO, or HMO Illinois medical plans or if you are eligible for Medicare.

If you elect coverage under the Value PPO and open a Health Savings Account, the University will make a tax-free matching contribution to your HSA. This contribution is a dollar-for-dollar match made each year. This contribution will not apply to any “catch-up” contributions you may be eligible to make to the account for that year.

While Northwestern University administers this account, the Claims administrator is Inspira Financial.

For details about key account features – including current-year contribution limits – see the individual [account highlights](#).

Flexible Spending Accounts

You may choose to participate in a:

- **Health Care FSA** – You can make Pre-tax Contributions to this account and use this money to pay the cost of eligible health care expenses that you incur anytime during the calendar year during which the contributions are made (January 1-December 31), or during the two-and-a-half month grace period that runs from January 1-March 15 of the following calendar year. **Note:** If you elect coverage under the Value PPO medical plan, you cannot participate in a Health Care FSA because you are eligible to open a pre-tax [Health Savings Account](#); however, you can participate in a [Limited Use FSA](#).
- **Dependent Care FSA** – You can make Pre-tax Contributions to this account and use this money to pay the cost of eligible dependent care expenses that you incur anytime during the calendar year during which the contributions are made (January 1-December 31).

Note: If you are newly eligible and your enrollment in an FSA takes effect sometime after January 1, you cannot use your contributions to the FSA for expenses incurred prior to the date your enrollment took effect.

Enrollment in a Health Care FSA (or Limited Use FSA) or in a Dependent Care FSA is not automatic; it is optional and requires active enrollment each year during Open Enrollment.

Use It or Lose It Rule

When enrolling in an FSA you should carefully estimate your anticipated eligible expenses for the year, as you will forfeit any excess (unused) contributions left in your account(s) after filing claims for all of your eligible expenses for the year. This “use it or lose it” rule is imposed under federal tax laws.

Note: You cannot transfer unused contributions from your Health Care FSA (or Limited Use FSA) to your Dependent Care FSA, and vice versa.

Health Care FSA

If you elect to participate in a Health Care FSA, you choose how much you want to contribute to your account through pre-tax payroll deductions each year.

- The minimum you can choose to contribute in a year is \$240.
- The maximum you can choose to contribute in a year is \$3,050.

Your contributions will be taken from your pay through automatic payroll deductions. The amount deducted each pay period will be based on the total amount you elect to contribute for the year and the number of pay periods to which the deduction will apply.

You may use your tax-free contributions to a Health Care FSA to reimburse yourself for eligible health care expenses that:

- Are not covered by your medical, dental, or vision coverage, nor by your spouse’s plans
- Are included in the IRS list of eligible health care expenses, and
- Are for services received by you or your eligible family members whom you claim as a tax exemption on your federal income tax return.

Note: It is up to you whether you use tax-free dollars from a Health Care FSA to reimburse yourself these expenses or take them as a tax-deduction on your annual federal income tax return (IRS Form 1040). You may

choose one or the other; you may not take a tax-deduction for an eligible expense that has been reimbursed from a Health Care FSA, and vice versa.

You must renew your participation in a Health Care FSA each year during Open Enrollment.

Eligible Health Care Expenses

If you elect coverage under the Premier PPO, Select PPO, or HMO Illinois medical plan, you may use a Health Care FSA to reimburse the Copayments, Coinsurance, and Deductibles you pay under that coverage with tax-free dollars.

Specific health care services and products for which the cost may be reimbursed through a Health Care FSA include (but are not limited to):

- Acupuncture.
- Ambulance services.
- Birth control prescriptions.
- Blood pressure monitoring devices.
- Breast pumps and supplies that assist lactation.
- Childbirth preparation classes.
- Chiropractic professional fees.
- Contact lenses and cleaning solutions.
- Crutches.
- Dental services.
- Diabetic supplies.
- Diagnostic services and tests.
- Drugs – prescription.
- Eyeglasses.
- Eye examinations.
- Genetic testing.
- Guide animals.
- Hearing aids and batteries.
- Home health care.
- Hospital services.
- Immunizations.
- Laboratory fees.
- Lamaze classes.
- Laser eye surgery.
- Nursing services.
- Obstetrical expenses.
- Optometrist fees.
- Orthodontia.
- Orthopedic shoes.
- Over-the-counter drugs/medicines – with a prescription.

- Physicians' fees.
- Prostheses.
- Psychiatrists' fees.
- Psychologists' fees.
- Radial keratotomy/ortho keratology.
- Reading glasses.
- Schools and education – special (for mentally impaired or physically disabled person).
- Smoking cessation programs.
- Sterilization procedures – vasectomy or tubal ligation.
- Surgical fees.
- Vitamins – only if necessary to treat a specific medical condition and accompanied with a letter of medical necessity.
- Walkers.
- Weight-loss programs.
- Wheelchair.
- Wigs – if purchased on advice of physician for mental health of patient.
- X-ray fees.

Ineligible Health Care Services and Products

You cannot use a Health Care FSA to reimburse yourself costs for services that:

- Are not eligible for a federal income tax deduction – for example, generally not directed or prescribed by a physician or directly related to illness or injury.
- Are taken as a federal income tax deduction.
- Are Premiums you pay for group coverage, such as another employer plan or your spouse's employer plan.
- Are incurred before your enrollment in a Health Care FSA begins, after the end of the applicable plan year, or after your enrollment in a Health Care FSA ends.
- Are otherwise paid or reimbursed by insurance, a third party, another employer, Medicare, or any other federal or state program.
- Are for cosmetic purposes, or services aimed at only general physical or mental improvement.

A more complete list of eligible and ineligible health care expenses is available at the Inspira Financial – <https://www.inspirafinancial.com> – or you can obtain a copy of IRS Publication 502: Medical and Dental Expenses from the IRS website: www.irs.gov.

Limited Use FSA

This type of account is offered as an alternative to a Health Care FSA if you elect coverage under the Value PPO health plan; if you are enrolled in that plan you cannot participate in a Health Care FSA. You may elect to participate in this type of account only if you elect coverage under the Value PPO health plan.

Like a Health Care FSA, this type of account is designed to help you set aside tax-free dollars you can use to pay your share of eligible expenses. Until you meet the Value PPO health plan's annual Deductible each year, you may use the account to reimburse only eligible dental and vision care expenses; once you meet the plan's annual Deductible, however, you may use contributions in your Limited Use FSA to reimburse eligible health care expenses, too.

The amount you can contribute to a Limited Use FSA each year is subject to the same guidelines as the Health Care FSA: the minimum is \$240, the maximum is \$3,050.

Dependent Care FSA

You may elect to participate in a Dependent Care FSA if you have at least one eligible dependent and you are:

- A single parent, or
- Married and your spouse:
 - Works, or
 - Is a full-time student, or
 - Is disabled and unable to provide for his or her own care, or
- A divorced or legally separated parent who has custody of the child(ren) most of the time, even if the other parent may claim the child(ren) as dependent(s) for tax purposes.

When you elect to participate in a Dependent Care FSA, you choose how much you will contribute to your account through pre-tax payroll deductions for the year.

- The minimum you can choose to contribute in a year is \$240.
- The maximum you can choose to contribute in a year is:
 - \$5,000 – if you are married and file a joint tax return or if you are single and file taxes as head of household, or
 - \$2,500 – if you are married and you and your spouse file separate tax returns.

You must renew your participation in a Dependent Care FSA each year during Open Enrollment.

Eligible Dependent Care Services

You may use tax-free dollars from a Dependent Care FSA to reimburse the cost of dependent care services to the extent that they:

- Are necessary to permit you and, if you are married, your spouse to work. **Note:** If you are married and contributing to a Dependent Care FSA, and your spouse quits working, you must terminate your enrollment unless your spouse is a full-time student or incapable of self-care.
- Cover care provided in a private home (including yours) or in a day care center. **Note:** If the latter – and the day care center cares for more than six children – it must be a licensed day care facility.
- Are provided for the wellbeing and protection of an eligible dependent, which includes:
 - Any child through age 12 whom you claim as a dependent for federal income tax purposes, and
 - Any other dependent that normally spends at least eight hours a day in your home and is unable to care for himself or herself because of a physical or mental disability.

Dependent Care University Match

If you are a full-time employee the University may provide a matching contribution to your Dependent Care FSA of up to \$4,000 a year to assist in meeting a portion of your annual dependent care expenses. This matching contribution is considered taxable income and must be reported as such on your income tax filing for the year.

To qualify for this matching contribution:

- Your total family Adjusted Gross Income (AGI) must not exceed \$130,000 a year – as reported on your latest federal income tax return (IRS Form 1040) – or, if married and you and your spouse file income taxes separately, on your spouse's latest federal income tax return.
- You must be actively at work and, if married, your spouse must also work full-time or be a full-time student.

Note: Only full-time Faculty and Staff expenses related to the care of dependent children through age 12 and disabled children through age 15 qualify for this matching contribution.

The amount of the match you can receive will be based on your total family income (see table).

The University match will equal...		
If your AGI is...	This percent of your own contributions	This dollar amount...
\$60,000 or less	80%	\$4,000
\$60,001-\$75,000	60%	\$3,000
\$75,001-\$100,000	40%	\$2,000
\$100,001-\$130,000	20%	\$1,000

Note: The dollar amount of the Dependent Care University match shown in this table is based on the assumption that you are contributing the maximum allowed to your Dependent Care FSA under federal guidelines – \$5,000. The amount you receive will also be prorated during any calendar year for which you are not eligible to participate in a Dependent Care FSA for the entire year.

For example, if your AGI is \$70,000 and you contribute \$5,000 to your account for the year, the University match will equal 60% of your contributions, or \$3,000. In this case, the amount deducted on a pre-tax basis from your paycheck each month is \$416.67 ($\$5,000 \div 12$) and the amount the University adds to your Dependent Care FSA each month in taxable income is \$250 ($\$3,000 \div 12$).

Ineligible Dependent Care Services

You cannot use tax-free dollars from a Dependent Care FSA to reimburse yourself the cost of:

- Care provided by someone you claim as a dependent for federal income tax purposes
- Care not necessary for you and your spouse to be employed, such as “evening out” or weekend baby-sitting expenses
- 24-hour-a-day convalescent nursing home expenses for a parent or a disabled spouse
- Educational expenses
- Kindergarten or school tuition for a child in a higher grade
- Overnight camp expenses
- Expenses for child care that allow your spouse to do volunteer work, or
- Expenses that are incurred before your enrollment in a Dependent Care FSA begins, after the end of the plan year, or after your enrollment in the Dependent Care FSA terminates.

Dependent Care FSA vs. Federal Tax Credit

You can use a Dependent Care FSA to reimburse yourself for eligible dependent care expenses **or** you can pay these expenses after tax and take a federal income tax credit when filing your taxes for the year. You cannot use a Dependent Care FSA **and** take the tax credit for the same expense. Depending on your tax situation, one approach may produce more tax savings than the other.

You should always consult a tax professional if you are unsure as to which approach is better for you. For more information about the federal tax credit, you can obtain a copy of *IRS Publication 596: Earned Income Credit* from the IRS website: www.irs.gov.

A more complete list of eligible and ineligible dependent care expenses is available at the Inspira Financial website – <https://www.inspirafinancial.com> – or you can obtain a copy of IRS Publication 503: Child and Dependent Care Expenses from the IRS website: www.irs.gov.

Participation While On a Leave of Absence

If you are on a(n):

- **Paid leave** – you may continue to make your contributions to a Health Care FSA (or Limited Use FSA) through automatic payroll deductions. **Note:** You cannot make contributions to a Dependent Care FSA while on a leave of absence.
- **Unpaid leave** – you must make your contributions to a Health Care FSA (or Limited Use FSA) by check made out to Inspira Financial and submitted to Inspira Financial directly. The contribution amount must be the same amount you were making to a Health Care FSA or Limited Use FSA prior to the leave. **Note:** You cannot make contributions to a Dependent Care FSA while on a leave.

Participation While On Disability

If you are Disabled and receiving:

- **Extended Sick Time benefits** – your contributions to a Health Care FSA will be deducted on a pre-tax basis.
- **Long Term Disability benefits** – you cannot participate in a Health Care FSA.

Participation When You Retire

If you retire from University employment, you may continue to submit claims for reimbursement of eligible health care and/or dependent care expenses for services received prior to your retirement date. You will not be able to make any further contributions to an FSA.

Participation Upon Termination of Employment

Your enrollment in a Health Care FSA, Limited Use FSA and/or Dependent Care FSA will end at the end of the month in which your University employment terminates. However, you may elect to temporarily participate in a Health Care FSA for yourself and your eligible family members, as provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

For more information about COBRA coverage continuation and instructions for enrolling in this coverage, see [COBRA Benefits](#) and [Terminated Employees and COBRA](#).

Participation Upon Your Death

Your surviving eligible family members may elect to temporarily continue participation in a Health Care FSA for themselves, as provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

For more information about COBRA coverage continuation and instructions for enrolling in this coverage, see [COBRA Benefits](#) and [Terminated Employees and COBRA](#).

Health Savings Account

If enrolled for coverage under the University's Value PPO medical plan, you can set up a Health Savings Account (HSA) and use Pre-tax Contributions to the account to pay the cost of qualified health care expenses – as defined by the Internal Revenue Service (IRS) – as they occur, or save and invest this money to pay your share of these expenses in the future. You may not participate in the Northwestern Sponsored HSA if you are not enrolled in the University's Value PPO, even if you are enrolled in a High Deductible Health Plan (HDHP) outside of the University.

The Value PPO medical plan and a Health Savings Account are designed to work together to help you and your family plan, save, and pay for health care. Enrollment in a Health Savings Account is not automatic; it is optional and requires active enrollment each year during Open Enrollment.

The University makes dollar-for-dollar matching contributions to your account of up to:

- **\$1,000**– if you choose You coverage (coverage for you only).
- **\$2,000** – if you choose You + Spouse/Partner, You + Child(ren), or You + Spouse/Partner + Child(ren) coverage.

This contribution will provide funds in your HSA to pay any eligible health care costs that you may incur before your own contributions to the account begin.

Each year, you can make your own Pre-tax Contributions to your account of:

- **\$240 to \$3,150*** – if you choose You coverage (coverage for you only).
- **\$240 to \$6,300*** – if you choose You + Spouse/Partner, You + Child(ren), or You + Spouse/Partner + Child(ren) coverage.

* The maximum contribution excludes the amount Northwestern University will match. When Northwestern's match is included, the actual maximum contribution is up to the IRS limit (\$4,150 for single coverage and \$8,300 for family coverage)..

If age 55 or older, you can make a separate "catch-up" contribution to your HSA of up to an additional **\$1,000** a year. **Note:** If your spouse is age 55 or older and wants to make catch-up contributions, those contributions must be made to your spouse's own HSA. The catch-up amount is not matched with Northwestern University funds.

You can invest your HSA balance and pay no taxes on investment earnings as long as you leave this money in your account or use it to pay for qualified health care expenses.

When you become eligible for Medicare, your contributions to an HSA must stop, but you can continue to use your accumulated HSA balance to pay qualified health care expenses, including your Medicare Part B Premiums.

Important! If you use the money in your HSA to pay for things other than qualified health care expenses, you will pay taxes on this money *plus* an additional 20% penalty tax. If you are age 65 or older or Disabled, the 20% penalty tax will not apply.

You Can Take Your HSA With You

Unlike a Health Care FSA (or Limited Use FSA) you can roll over any remaining balance in your HSA at the end of the year for use in future years. In other words, you don't lose what you don't use. This way, the balance in your HSA can grow over time – through automatic rollover of the unused portion of your account from year-to-year, new contributions you make to the account each year and interest and investment earnings on your account.

What's more, your HSA is completely portable; if you leave University employment you can take your HSA balance with you, or if you switch coverage from the Value PPO medical plan to another University-sponsored medical plan any balance remaining in your account is yours to keep.

You are responsible for saving receipts for all expenses paid from your HSA. If audited by the IRS, you may need to provide proof that all distributions from your HSA were used to pay qualified health care expenses. Any distributions for which you're unable to provide receipts will be subject to income tax plus an additional 20% tax penalty.

Qualified Health Care Expenses

You can use tax-free dollars from your HSA to pay qualified health care expenses only. Qualified health care expenses include:

- Deductible, Coinsurance, and Copayment amount you pay under your medical coverage
- Prescription drugs (including over-the-counter drugs for which you have a prescription)
- Acupuncture and chiropractic services
- Dental care – including orthodontia
- Vision care – including contact lenses, prescription sunglasses, and LASIK surgery
- Hearing aids – including batteries
- Premiums for medical coverage while receiving federal or state unemployment benefits
- COBRA continuation coverage after leaving University employment
- Premiums for eligible long-term care, and
- Medicare Premiums and out-of-pocket expenses – including Deductibles, Copayments, and Coinsurance.

You can use your HSA to pay qualified health care expenses for your spouse and children.

Important! Only qualified health care expenses incurred on or after the date your account is opened may be reimbursed through your HSA; your account opening date is noted on your online HSA summary.

For more information about qualified health care expenses, visit the IRS Web site at www.irs.gov.

Ineligible Health Care Services

You cannot use a Health Savings Account to pay:

- Expenses incurred before your enrollment in a Health Savings Account begins
- Expenses otherwise paid or reimbursed by insurance, a third party, another employer, Medicare or any other federal or state program
- Expenses not eligible for a federal income tax deduction – for example, generally not directed or prescribed by a physician or directly related to illness or injury

- Expenses taken as a federal income tax deduction, and
- Premiums for group coverage, such as another employer plan or your spouse's employer plan.

Federal Tax Reporting

When you participate in an HSA, you are responsible for reporting activity related to your account to the IRS and your state revenue department when filing your federal and state income tax returns. There are three IRS tax-reporting forms you will need – **IRS Form 5498-SA**, **IRS Form 1099-SA**, and **IRS Form 8899**.

The first two forms report the HSA contributions you made (IRS Form 5498-SA) and the distributions you received (IRS Form 1099-SA) during the preceding calendar year. Typically, you will receive these forms by the end of January of the next calendar year; you also can print out these forms at any time from the HSA administrator's web site. **Note:** Contributions made after the end of a calendar year – but before April 15 of the next year – will be reported on an updated IRS Form 5498-SA issued in May.

Using this information and the additional account information available to you online, you will need to complete IRS Form 8899 and attach it to your IRS Form 1040 when filing your annual federal income tax return.

Note: To print a copy of IRS Form 8899, go to www.irs.gov.

For details about federal HSA tax reporting requirements, visit the IRS Web site at www.irs.gov or see a professional tax advisor. Be sure to remind your tax preparer that you are participating in an HSA.

A more complete list of qualified and ineligible health care expenses is available at the Inspira Financial website – <https://www.inspirafinancial.com> – or you can obtain a copy of IRS Publication 502: Medical and Dental Expenses from the IRS website: www.irs.gov.

Participation While On a Leave of Absence

If you are on a(n):

- **Paid leave** – you may continue to make contributions to your Health Savings Account through automatic payroll deductions.
- **Unpaid leave** – you may make post tax contributions to your Health Savings Account directly with Inspira Financial. These contributions will not be matched by Northwestern. You may be assessed a fee to maintain your account with Inspira Financial while on leave.

You may continue to pay qualified health care expenses from your Health Savings Account.

Participation While On Disability

If you are Disabled and receiving:

- **Extended Sick Time benefits** – your contributions to your Health Savings Account will be deducted on a pre-tax basis.
- **Long Term Disability benefits** – you may make post tax contributions to your Health Savings Account directly with Inspira Financial. These contributions will not be matched by Northwestern. You may be assessed a fee to maintain your account with Inspira Financial while on leave.

Note: Your participation in your Health Savings Account may continue for up to a maximum of two years while receiving Extended Sick Time and Long Term Disability benefits.

Participation When You Retire

If you retire from University employment, you will not be able to make any further contributions to your Health Savings Account.

You may continue to pay qualified health care expenses from your Health Savings Account.

Participation Upon Termination of Employment

If your University employment terminates and you don't enroll in another consumer-driven health plan (like the Value PPO medical plan), you may:

- **Keep your HSA open with the current HSA administrator.** Although you will no longer be able to make contributions to the HSA, your account will continue to earn interest and you can withdraw funds to pay for qualified health care expenses. **Note:** A monthly account maintenance fee will apply if no longer making contributions through University payroll deductions.
- **Transfer your HSA balance to a new HSA administrator.** No taxes or tax penalties will apply to this transfer.
- **Close your HSA.** You will receive a distribution of your Health Savings Account balance and may be subject to income tax and tax penalties.

Participation Upon Your Death

Your Health Savings Account balance will be available to your surviving spouse (or to your estate, if you have no surviving spouse at the time of your death).

4 Disability Benefits

If you are an eligible Northwestern University employee and you have a medically disabling condition lasting longer than 180 days, you may be approved to receive continuing income benefits from the University's Long Term Disability Plan.

The plan offers two levels of benefit coverage:

- **50% Core Benefit** – continuing income equal to 50% of your regular base wages/salary, up to a maximum Monthly Benefit of \$11,500.
- **10% Buy-Up Benefit** – continuing income equal to an additional 10% of your regular base wages/salary (for a total of 60%), up to a maximum Monthly Benefit (core and buy-up coverage combined) of \$13,800.

Core benefit coverage is automatic and fully paid by the University; this is your default coverage. You may elect to enroll in the optional buy-up benefit coverage; you will pay the cost of this additional coverage. **Note:** If you elect the buy-up benefit coverage, you may receive additional benefits from other sources – including Social Security Disability Income (SSDI) – providing you continuing income equal to as much as 70% of your regular base wages/salary.

Note: To receive LTD benefits, you must be under the regular care of a physician.

Important! Some states require contact information and certain notices be provided to participants in this plan. This information is contained in the [Certificate of Coverage](#) for the plan.

This plan is administered by MetLife.

For details about key plan features – including Premiums for buy-up benefit coverage – see the individual [plan highlights](#), the Certificate of Coverage and other information available at [Disability Plans](#). For more information about Premiums and what they're based on, see [Contributions](#) in this handbook.

Long Term Disability

As a Benefits-eligible Employee, you have automatic 50% Core Benefit LTD coverage provided by Northwestern University. You may purchase additional coverage for yourself through the 10% Buy-Up Benefit.

Any benefit you may be entitled to receive under this plan is subject to reduction if you are eligible to receive income from other sources (see [Other Income Benefits](#)).

The University pays the full cost of your 50% core benefit coverage. You pay the cost of additional 10% buy-up benefit coverage, based on low group insurance rates.

50% Core Benefit

This part of the plan provides a continuing income benefit equal to 50% of your Pre-Disability Earnings, up to a maximum Monthly Benefit of \$11,500.

Your Pre-Disability Earnings is your contracted annual rate of pay from Northwestern University divided by the number of pay periods occurring in the pay cycle established by you and the University prior to your date of Disability. So, Pre-Disability Earnings for:

- **Faculty** – means your contracted annual rate of pay from the University in effect prior to your date of Disability divided by 12. This does not include summer salary, honoraria or consulting fees.
- **Hourly employees** – means your bi-weekly scheduled hours multiplied by your hourly rate of pay from the University in effect prior to your date of Disability and then multiplied by 26.1 (there are 26.1 bi-weekly pay periods in a year) divided by 12. This does not include overtime.
- **All other employees** – means your contracted annual rate of pay from the University in effect prior to your date of Disability divided by 12. This does not include overtime, summer salary, or bonus payments.

10% Buy-Up Benefit

This part of the plan provides an additional continuing income benefit equal to 10% of your regular base wages/salary (total of 60%), up to a maximum Monthly Benefit of \$13,800 from your core and buy-up benefit coverage combined.

Important! If you opt-out of buy-up benefit coverage when first eligible – and you subsequently elect this coverage – you will be required to provide Evidence of Insurability (EOI) that is satisfactory to MetLife before your buy-up benefit coverage will take effect. EOI may include a completed and signed application, a medical examination, a statement from your attending physician and any additional information MetLife may require.

The University requires faculty and staff who apply for the LTD benefit to also apply for Social Security Disability Income (SSDI). MetLife will coordinate the University's LTD benefit payments with SSDI benefit payments.

You must apply within 45 days from the date of MetLife's request. If the Social Security Administration denies your eligibility for benefits:

- You will be required to follow the process established by the Social Security Administration to reconsider the denial.
- If denied again, you will be required to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

How Long LTD Benefits Will Be Paid

Once monthly LTD benefit payments begin, you will continue to receive these Monthly Benefit payments as long as you remain Disabled, up to your Social Security Normal Retirement Age or for a specified number of months depending upon your age at the time your Disability begins (see table).

Maximum Duration of Benefits

If your Disability begins...	LTD benefit payments will continue to...
Before age 63	Your Social Security Normal Retirement Age or for up to 42 months, if greater
At age 63	Your Social Security Normal Retirement Age or for up to 36 months, if greater
At age 64	30 months
At age 65	24 months
At age 66	21 months
At age 67	18 months
At age 68	15 months
At age 69 or older	12 months

Your Social Security Normal Retirement Age...

Normal Retirement Age means the Social Security Normal Retirement Age as stated in the 1983 revision of the United States Social Security Act, as determined by your date of birth:

If you were born in...	Your Social Security Normal Retirement Age is...
1937 or before	65
1938	65 + 2 months
1939	65 + 4 months
1940	65 + 6 months
1941	65 + 8 months
1942	65 + 10 months
1943 through 1954	66
1955	66 + 2 months
1956	66 + 4 months
1957	66 + 6 months
1958	66 + 8 months
1959	66 + 10 months
1960 or after	67

When LTD Benefit Payments Will End

LTD benefit payments will stop on the earliest of the:

- Date you are no longer Disabled
- Date you fail to provide required proof of continuing Disability.
- Date you are no longer under the Regular Care of a Physician
- Date you refuse our request that you submit to an examination by a physician or other qualified medical professional
- Date of your death
- Last day benefits are payable according to the maximum duration of benefits table;
- Date you refuse to participate in a rehabilitation program, or refuse to cooperate with or try.

What It Means to Have a Disability

Having a Disability (or being Disabled) means that, due to Sickness or as a direct result of an accidental injury:

- You are receiving Appropriate Care and Treatment and complying with the requirements of such treatment; and
- You are, during the Elimination Period and for the next 24 months:
 - unable to earn more than 80% of your pre-disability earnings at your own occupation for any employer in the National Economy; and
 - unable to perform each of the material duties of your own occupation for any employer in the National Economy; and
- You are, after such period:
 - unable to earn more than 60% of your pre-disability earnings at any gainful occupation for any employer in the National Economy; and
 - unable to perform the duties of any gainful occupation for any employer in the National Economy for which you are reasonably qualified taking into account your training, education and experience.

Appropriate Care and Treatment means medical care and treatment that is:

- Given by a Physician whose medical training and clinical specialty are appropriate for treating your Disability;
- Consistent in type, frequency, and duration of treatment with relevant guidelines of national medical research, health care coverage organizations and governmental agencies;
- Consistent with a Physician's diagnosis of your Disability; and
- Intended to maximize your medical and functional improvement.

Minimum Benefit

The minimum Monthly Benefit payable under this plan is the greater of \$100 or 10% of the benefit based on monthly income loss before the deduction of Other Income Benefits (the difference between your Pre-Disability Earnings and your Current Monthly Earnings) before the deduction of Other Income Benefits, whichever is greater.

Income Tax Liability

Because the University pays the full cost your core LTD coverage, benefit payments from this portion of the plan are subject to federal and – if any – state and local taxes. **Note:** To request federal income tax withholding, you will need to submit a W-4S Form.

Because you pay the full cost of your buy-up LTD coverage with After-tax Contributions, this portion of your monthly LTD benefit may not be subject to income tax. For information on any taxes that may be associated with this benefit, please contact MetLife's Customer Service at (800) 396-8876.

Recurrent Disability

Periods of Recovery during the Elimination Period will not interrupt the Elimination Period, if the number of days you return to work as an Active Employee are less than 60 days.

Any day within such period of Recovery, will not count toward the Elimination Period.

After the Elimination Period, if you return to work as an Active Employee and then become Disabled again, the Period of Disability prior to your return to work and the recurrent Disability will be considered one Period of Disability provided the policy remains in force and such Disability is:

- Due to the same cause, or
- Due to a related cause, and
- Within six months of the return to work.

If you return to work as an Active Employee for six month(s) or more, any recurrence of a Disability will be treated as a new Disability. The new Disability is subject to a new Elimination Period and a new Maximum Duration of Benefits.

Other Income Benefits

Other Income Benefits means the amount of any benefit for loss of income, provided to you or your family, as a result of the period of Disability for which you are claiming benefits under the policy.

Other Income Benefits include any such benefits for which you or your family are eligible or that are paid to you, or your family or to a third party on your behalf, pursuant to any:

- Temporary, permanent Disability, or impairment benefits under a Workers' Compensation Law, the Jones Act, Occupational disease law, similar law or substitutes or exchanges for such benefits;
- Governmental law or program that provides disability or unemployment benefits as a result of your job with your Employer;
- Plan or arrangement of coverage, whether insured or not, which is received from your employer as a result of employment by or association with your employer or which is the result of membership in or association with any group, association, union or other organization;
- Mandatory "no fault" automobile insurance plan for loss of income, excluding supplemental disability benefits;
- Disability benefits under:
 - The United States Social Security Act or alternative plan offered by a state or municipal government
 - The Railroad Retirement Act
 - The Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan, or
 - Similar plan or act; that you, your spouse and/or children, are eligible to receive because of your Disability, or

Other Income Benefits also includes any payments that are made to you or to your family, or to a third party on your behalf, pursuant to any:

- Disability benefit under Your Employer's Retirement plan;
- Temporary, permanent Disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;

- Portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for your loss of earnings;
- Retirement benefit from a Retirement Plan that is wholly or partially funded by employer contributions, unless:
 - You were receiving it prior to becoming Disabled, or
 - You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement. (Other Income Benefits will not include the portion, if any, of such retirement benefit that was funded by your After-tax Contributions.); or
- Retirement benefits under:
 - The United States Social Security Act or alternative plan offered by a state or municipal government;
 - The Railroad Retirement Act;
 - The Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan;
 - Similar plan or act;

...that you, your spouse and/or children receive because of your retirement, unless you were receiving them prior to becoming Disabled.

If you are paid Other Income Benefits in a lump sum or settlement, you must provide proof satisfactory to MetLife within 10 days after receipt of such payment of the following:

- The amount of the lump sum settlement account; and
- The amount attributed to loss of income; and
- The period of time for which the lump sum or settlement applies.

MetLife will pro rate the lump sum or settlement over this period of time and adjust the amount of your Disability benefit accordingly. If you do not provide this information, MetLife will assume the entire sum to be for loss of income and will reduce your Disability benefit by an amount equal to such benefit not less than the minimum benefit amount until the lump sum has been exhausted. MetLife may make a retroactive allocation of any retroactive Other Income Benefit. A retroactive allocation may result in an overpayment of your claim.

The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:

- Takes effect after the date benefits become payable under the policy, and
- Is a general increase that applies to all persons who are entitled to such benefits.

Rehabilitation Program Incentive Benefit

If you participate in a Rehabilitation program, MetLife will increase your Monthly Benefit by an amount equal to 10% of the Monthly Benefit before it is reduced by any other sources of income as defined by the policy.

Moving Expense Incentive Benefit

If you participate in a Rehabilitation Program while you are Disabled, MetLife may reimburse you for expenses you incur to move to a new residence recommended as part of such Rehabilitation Program. Such expenses must be approved by MetLife in advance. You must send proof that you have incurred such expenses for moving.

MetLife will not reimburse you for such expenses if they were incurred for services provided by a member of your immediate family or someone who is living in your residence.

Family Care Credit

If you work or participate in a program of Rehabilitation while you are Disabled, MetLife will reimburse you for up to \$400 of monthly expenses you incur for each family member to provide:

- Care for your or your spouse's child, legally adopted child or child for whom you or your spouse are legal guardian and who is:
 - Under the age of 13;
 - Living with you as part of your household; and
 - Dependent on you for support.

The childcare must be provided by a licensed childcare provider who may not be a member of your immediate family or living in your residence.

- Care for your family member who is:
 - Living with you as part of your household;
 - Dependent on you for support; and
 - Incapable of independent living, regardless of age, due to mental or physical handicap as defined by applicable law.

Care to your family member may not be provided by a member of your immediate family.

MetLife will make reimbursement payments to you monthly starting with the first monthly benefit payment until you have received 12 monthly benefit payments. Payments will not be made beyond the maximum benefit period. MetLife will not reimburse you for any expenses for which you are eligible for payment from any other source. You must provide proof that you have incurred such expenses.

Work Incentive Benefit

While you are Disabled, MetLife encourages you to work. If you work while you are Disabled and receiving Monthly Benefits, your Monthly Benefit will be adjusted as follows:

- Your Monthly Benefit will be increased by your Rehabilitation Program Incentive (10%), if any; and
- Reduced by other sources of income as defined by the policy.

Your Monthly Benefit as adjusted above will not be reduced by the amount you earn from working, except to the extent that such adjusted Monthly Benefit plus the amount you earn from working and the income you receive from other sources of income as defined by the policy exceeds 100% of your Pre-disability Earnings as calculated in the definition of Disability. After the first 12 months following your return to work, MetLife will reduce your Monthly Benefit by 50% of the amount you earn from working while Disabled.

In addition, the Minimum Monthly Benefit will not apply.

When LTD Benefits Will Not Be Paid

The policy does not cover (and MetLife will not pay a benefit for) any Disability unless you are under the Regular Care of a Physician. In addition, the policy does not cover (and MetLife will not pay a benefit for) any Disability that is caused by:

- War or act of war (declared or not), insurrection, rebellion, or terrorist act
- Your active participation in a riot
- Your commission of or attempt to commit a felony
- By an intentionally self-inflicted injury
- Attempted suicide

No benefits will be payable for a Disability under this policy if you are receiving or are eligible for benefits for that Disability under a prior disability plan that was:

- Sponsored by Northwestern; and
- Terminated before the Effective Date of the policy.

Pre-Existing Conditions Limitation

MetLife will not pay any benefit, or any increase in benefit amount due to an elected increase in the amount of insurance, or an amendment to the plan for a Disability that results from a Pre-existing Condition, if you have been actively at work for less than 12 consecutive months after the date your Disability insurance or elected increase in the amount of such insurance takes effect unless, at the time you become Disabled:

- You have not received medical treatment, consultation, care or services, or took prescription medication or had medications prescribed in the 6 months before your insurance or any increase in the amount of insurance under the plan takes effect.

Termination of Coverage

Unless your coverage is continued in accordance with any of the Continuation Provisions, your coverage will end on the earliest of the following:

- The date the plan terminates
- The date the plan no longer insures your class
- The date the Premium payment is due but not paid
- The last day of the period for which you make any required Premium contribution
- The end of the month in which Northwestern terminates your employment, or
- The end of the month in which you cease to be a Full-time or Part-time Active Employee in an eligible class for any reason.

In any event, your benefit level, or the amount of earnings upon which your benefits may be based, will be that in effect on the day before your coverage was continued.

Coverage may be continued in accordance with the above restrictions and as described below:

- **Leave of Absence:** If you are on a documented personal, academic, repatriation or administrative Leave of Absence, your coverage may be continued for up to 12 month(s). If the leave terminates prior to the agreed upon date, this continuation will cease immediately.
- **Family Medical Leave:** If you are granted a Leave of Absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, your coverage may be continued for up

to 12 weeks, or 26 weeks if you qualify for Family Military Leave, or longer if required by other applicable law, following the date your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

- **Military Leave of Absence:** If you enter active military service and are granted a military Leave of Absence in writing, your coverage may be continued for up to 12 months. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

5 Life Insurance & Other Financial Protection Plans

The benefits described in this section provide valuable financial protection through two types of insurance – life and business travel.

Life Insurance

You have four types of life insurance available to you:

- [Basic Term Life Insurance](#) – automatic term life insurance coverage for you.
- [Supplemental Term Life Insurance](#) – optional term life insurance coverage for you.
- [Spouse Term Life Insurance](#) – optional term life insurance coverage for your spouse or partner.
- [Child Term Life Insurance](#) – optional term life insurance coverage for your eligible child(ren).

These plans include an [Accidental Death and Dismemberment \(AD&D\) Insurance](#) feature that will pay benefits in the event a covered individual experiences loss of life, limb, sight, or hearing, becomes paralyzed or suffers certain other losses as the result of an accident.

The University pays the full cost of your Basic Term Life Insurance coverage. You pay the cost of any Supplemental, Spouse, and Child Term Life Insurance coverage you may choose based on group insurance rates.

While Northwestern University administers these insurance plans, the insurance coverage is provided through MetLife.

Business Travel Insurance

[Business Travel Insurance](#) is designed to provide eligible faculty and staff with Accidental Death and Dismemberment (AD&D) coverage in the event of an accident while traveling on University business.

The University pays the full cost of this coverage.

While Northwestern University administers this insurance plan, the insurance coverage is provided through Reliance Standard Life Insurance Company.

For details about key plan features – including Premiums – see the individual [plan highlights](#) and the Certificate of Coverage at [Life Insurance & Other Financial Protection Plans](#). For more information about Premiums and what they're based on, see [Contributions](#) in this handbook.

Life Insurance

As a Benefits-eligible Employee, you have automatic [Basic Term Life Insurance](#) coverage and you may choose optional coverage for yourself through [Supplemental Term Life Insurance](#). You also may choose optional coverage for your spouse and your eligible child(ren) through [Spouse Term Life Insurance](#) and [Child Term Life Insurance](#), respectively.

The University pays the full cost of your automatic Basic Term Life Insurance coverage. You pay the cost of any optional Supplemental Term Life Insurance, Spouse Term Life Insurance and/or Child Term Life Insurance you elect, based on low group insurance rates.

Guaranteed Coverage/Evidence of Insurability

If you enroll yourself or your eligible family members in life insurance coverage within 31 days of your initial eligibility date, you will be entitled to Guaranteed Coverage – without Evidence of Insurability – of up to:

- \$250,000 in automatic Basic Term Life Insurance for yourself
- 3 times your Annual Base Salary up to \$1 million in optional Supplemental Term Life Insurance for yourself
- \$50,000 in optional Spouse Term Life Insurance for your spouse or partner, and
- \$25,000 in optional Child Term Life Insurance for each eligible child.

If you elect optional coverage in excess of these limits – or increase coverage during a subsequent annual enrollment by more than one level increment – the additional coverage will be subject to Evidence of Insurability. Evidence of Insurability also will apply if:

- You voluntarily cancel your optional insurance and choose to reapply at a later date, or
- You enroll for additional coverage that is greater than:
 - One increment level above your current Supplemental and/or Spouse Term Life Insurance coverage or the applicable Guaranteed Coverage amounts during an annual Open Enrollment
 - One increment level above your current Supplemental Term Life Insurance or the applicable Guaranteed Coverage amount due to a change in family status.
 - The applicable Guaranteed Coverage amount for Spouse Term Life Insurance (\$50,000) due to a change in family status.

Evidence of Insurability means a statement of your medical history provided on an [Evidence of Insurability](#) form. Any increase in coverage beyond the Guaranteed Coverage limits will not take effect until MetLife approves your Evidence of Insurability.

Basic Term Life Insurance

You choose the amount of Basic Term Life Insurance you want – two-and-a-half times your Annual Base Salary up to a maximum coverage amount of:

- \$250,000, or
- \$50,000.

Note: Coverage amounts over \$50,000 are subject to Imputed Income; the Premium cost that applies to these coverage amounts will be included as taxable income on your annual Form W-2 for tax reporting purposes.

The minimum annual salary required for Basic Term Life Insurance is \$1,000; if your annual salary is less than \$1,000, you are not eligible for this coverage. Based on this requirement, the minimum Basic Term Life Insurance coverage amount is \$2,500.

This automatic coverage will pay your Beneficiary(ies) a life insurance benefit upon your death equal to the amount of coverage you choose.

For purposes of determining your life insurance coverage, Annual Base Salary is the University salary you are receiving on an annual basis as of September 1 of the preceding year (or, if newly hired, your new hire salary). Your Annual Base Salary does not include any bonus payments, honoraria, summer salary or overtime pay you may receive. **Note:** If you are paid on a bi-weekly basis, the benefits base amount is your bi-weekly scheduled hours multiplied by your hourly rate and multiplied by 26.1 (because there are 26.1 bi-weekly pay periods in a calendar year).

The University pays the full cost of your Basic Term Life Insurance coverage.

Adjustments in Coverage

Your Basic Term Life Insurance coverage amount will increase or decrease each year – effective January 1 – based on your Annual Base Salary as of September 1 in the prior year and your age as of December 31 of the current year. Also, if your employee classification changes from full-time to part-time – or vice versa – your Basic Term Life Insurance coverage amount will change based on your new salary.

Your Basic Term Life Insurance coverage will be reduced when you reach age 65 and again when you reach age 70 to:

- 65% of the coverage amount in effect on January 1 of the year in which you reach age 65.
- 50% of the coverage amount in effect on January 1 of the year in which you reach age 70.

These reductions – which will also apply to your Basic AD&D Insurance coverage – will take effect on January 1 of the years in which you reach ages 65 and 70, respectively.

Supplemental Term Life Insurance

You choose the amount of coverage you want from one to eight times your annual salary (up to maximum of \$2,000,000). You pay the full cost of the coverage you elect; Premiums vary based on your age (see [Contributions](#)). **Note:** Coverage amounts may be subject to approval by MetLife, which may require Evidence of Insurability, lab tests, copies of medical records and/or a physician's statement.

This voluntary coverage will pay your Beneficiary(ies) a life insurance benefit upon your death – in addition to your Basic Term Life Insurance – equal to the amount of coverage you choose. **Note:** In general, this benefit will not be payable if you die as the result of suicide or attempted suicide within two years from the original effective date of this coverage (or the effective date of any subsequent increase in coverage). For more details, refer to the [Certificate of Coverage](#).

Adjustments in Coverage

Your Supplemental Term Life Insurance coverage amount will increase or decrease each year – effective January 1 – based on your Annual Base Salary as of September 1 in the prior year and your age as of December 31 of the current year. Also, if your employee classification changes from full-time to part-time – or vice versa – your Supplemental Term Life Insurance coverage amount will change based on your new salary; this change will take effect the same date as your new salary.

Spouse Term Life Insurance

You choose the amount of Spouse Term Life Insurance you want in \$10,000 increments, up to a maximum of \$500,000 (but not more than the sum of your total Basic and Supplemental Term Life Insurance coverage combined). Coverage amounts greater than \$50,000 are subject to approval by MetLife, which may require Evidence of Insurability, lab tests, copies of medical records and/or a physician's statement.

Child Term Life Insurance

You choose the amount of Child Term Life Insurance you want in \$5,000 increments, up to a maximum of \$25,000 per child. Evidence of Insurability is not applicable to Child Term Life Insurance coverage amounts you elect. The voluntary coverage will pay you a life insurance benefit upon the death of a covered child equal to the amount of coverage you choose. You pay the full cost of the Child Term Life Insurance coverage you elect. The Premiums you pay will be based on the amount of coverage you choose. For more information, see Contributions.

Naming Your Beneficiary(ies)

A Beneficiary is the person (or persons) who will receive your Basic and Supplemental Term Life Insurance benefits if you die.

You can name anyone you want as your Beneficiary(ies) – and designate as many people as Beneficiary(ies) as you wish – for your Basic and Supplemental Term Life Insurance. (**Note:** You may not name Northwestern University as a Beneficiary.) You must specify the percentage of the benefit to be paid to each Beneficiary (up to a maximum of 100% for all allocations).

You are automatically the Beneficiary for payment of any Spouse Term Life Insurance or Child Term Life Insurance coverage you elect.

A Primary Beneficiary is someone you designate as the first to receive the proceeds of your life insurance policy; a Contingent Beneficiary is someone you designate to receive the benefit if a Primary Beneficiary dies before you do. If you don't want to name a person or entity as your Beneficiary, you can name your own estate. The proceeds will then be distributed with your other assets as specified in your will. Before naming your estate as Beneficiary, however, you should discuss your decision with a legal or tax advisor. **Note:** A change of Beneficiary in your will does not override the Beneficiary Designation(s) you make on your life insurance policy.

Important! If you do not name a Beneficiary – or if your Beneficiary dies before you – any benefits from Basic and Supplemental Term Life Insurance in effect at the time of your death will be paid to the first surviving class of the classes listed below:

- Your spouse or partner
- Your natural or adopted child(ren)
- Your parents
- Your brothers and sisters
- Your estate.

If you name a minor as a Beneficiary, you should also appoint a guardian in your will or use a Trust. If you don't, the probate court will appoint a guardian for the minor child.

You may change your Beneficiary Designation(s) at any time using the myHR Self Service Portal at <https://myhr.northwestern.edu>.

Note: For purposes of Spouse Term Life Insurance coverage, the term “spouse” also includes a domestic partner and/or civil union partner.

The voluntary coverage will pay you a life insurance benefit upon the death of your covered spouse or partner equal to the amount of coverage you choose.

You pay the full cost of the Spouse Term Life Insurance coverage you elect. The Premiums you pay will be based on the amount of coverage you choose and your spouse's age. For more information, see Contributions.

Accelerated Death Benefit

If you are diagnosed with a terminal illness with a life expectancy of 24 months or less, you may request an Accelerated Death Benefit payment. This payment can equal up to 80% of your Basic Term Life Insurance benefit and, if you have elected this optional coverage, your Supplemental Term Life Insurance benefit combined. This benefit cannot be more than \$250,000 if you have only Basic Term Life Insurance or \$1,000,000 if you have both Basic and Supplemental Term Life Insurance.

Note: This payment option will not be payable if your terminal condition is the result of attempted suicide or an intentionally self-inflicted injury; and is not available if your term life insurance is less than the minimum payment allowed under this plan (\$10,000), your life insurance benefit has been assigned or your life insurance benefit is payable to an irrevocable Beneficiary. If you elect to port your life insurance coverage – as described in [Portability of Coverage](#) – this payment option will no longer be available to you.

For more information – including instructions for how to apply for this form of benefit payment – call Benefits at **847-491-4700**.

Accidental Death and Dismemberment (AD&D) Insurance

All four types of term life insurance – Basic, Supplemental, Spouse, and Child – include AD&D Insurance coverage. This coverage will provide a benefit in an amount up to the applicable life insurance if you, your covered spouse, partner, or child experiences a loss of life, limb, sight, or hearing, becomes paralyzed, or suffers certain other losses as the result of an accident. In the event of your death due to the accident, any Basic and Supplemental AD&D Insurance benefit will be paid – in addition to any Basic and Supplemental Term Life Insurance benefit in effect at that time – to your designated Beneficiary(ies).

Loss of Use Benefit

If you or a covered spouse or child experience permanent, total and irreversible paralysis of a limb – or irrecoverable loss of speech or hearing in both ears – as the result of an accidental injury you may be eligible to receive a Loss of Use Benefit. To qualify for this benefit, the loss must:

- Occur within one year of the accident, and
- Be the direct result of the accident.

The Loss of Use Benefit will be based on the injured party's coverage amount and the nature of the loss, as outlined below:

For loss of use of...	Benefit will be...
Both arms and both legs (quadriplegia)	150% of coverage amount
Both legs (paraplegia)	75% of coverage amount
Both leg and arm on same side of body (hemiplegia)	75% of coverage amount
One arm or one leg (uniplegia)	50% of coverage amount
Speech and hearing in both ears	100% of coverage amount
Speech	50% of coverage amount
Hearing in both ears	50% of coverage amount

For a complete list of covered losses or a list of circumstances under which this AD&D benefit will not be paid, see [Accidental Death and Dismemberment \(AD&D\) Insurance Benefits](#).

This coverage will pay a benefit equal to all or part of the corresponding life insurance coverage amount – based on the nature of the loss – as outlined below:

For loss¹ of...	Benefit will be...
Life	100% of coverage amount
Both hands or both feet	100% of coverage amount
Entire sight in both eyes	100% of coverage amount
One hand and one foot	100% of coverage amount
One hand	50% of coverage amount
One foot	50% of coverage amount
Entire sight in one eye	50% of coverage amount
Thumb and index finger of same hand	25% of coverage amount

¹ Loss means actual and permanent severance of hand or foot through or above the wrist or ankle joint, entire and irrevocable loss of sight or complete severance of both thumb and index finger at or above the joints.

AD&D benefits – and “loss of use” benefits – will not be paid for any loss caused or contributed to by:

- Physical or mental illness or the diagnosis or treatment of such illness;
- Infection, other than infection occurring in an external accidental wound or from food poisoning;
- Suicide or attempted suicide;
- Any intentionally self-inflicted injury;
- Service in the armed forces of any country or international authority. However, service in reserve forces does not constitute service in the armed forces, unless in connection with such reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training. For purposes of this provision, reserve forces are defined as reserve forces of any branch of the military of the United States or of any other country or international authority, including but not limited to the National Guard of the United States or the national guard of any other country;
- Any incident related to:
 - travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger.
 - travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
 - parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;
 - travel in an aircraft or device used;
 - for testing or experimental purposes;
 - by or for any military authority; or
 - for travel or designed for travel beyond the earth’s atmosphere
- Committing or attempting to commit a felony;
- The voluntary intake or use by any means of:
 - any drug, medication, or sedative, unless it is:

- taken or used as prescribed by a Physician; or
- an “over the counter” drug, medication, or sedative taken as directed;
- alcohol in combination with any drug, medication, or sedative; or
- poison, gas, or fumes; or
- War, whether declared or undeclared; or act of war, insurrection, rebellion or active participation in a riot.

The plan will not pay AD&D benefits for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident. Intoxicated means that the injured person’s blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

For details regarding circumstances under which AD&D and “loss of use” benefits will not be paid – as well as additional details about AD&D coverage – see the [Certificate of Coverage](#).

Condolence Check

In the event of a staff member’s death, Northwestern remits a condolence check as an expression of sympathy and concern to the staff member’s surviving beneficiary. The Condolence check is calculated using the deceased employee’s benefits base pay at a rate of two times their monthly pay and is paid by MetLife directly to the surviving spouse or partner (registered with the University) of the deceased staff member. If the staff member is not married at the time of death, the condolence check is paid by MetLife directly to the beneficiary(ies) of the staff member’s basic life insurance benefits. If there is no surviving life insurance beneficiary on record, the condolence check is paid by MetLife to the staff member’s estate.

When Coverage Ends

Your coverage will end on the earliest to occur of the following dates:

- The date on which the policy is terminated, or
- The effective date of any amendment to the policy which terminates coverage for your employee classification, or
- End of the period for which the last premium has been paid for coverage, or
- The end of the month in which you:
 - Are no longer in an eligible employee classification, or
 - Request termination of your coverage, or
 - Retire.

You may continue your coverage if you are no longer actively at work due to:

- **Disability** – until the end of the 24th month following the month in which the Disability began.
- **Layoff** – until the end of 365 days after the layoff began.
- **Leave of absence** – until the end of the 12th month following the month in which the Leave of Absence began or the period of time in accordance with FMLA requirements. **Note:** If you qualify for a leave under the Family and Medical Leave Act of 1993 (FMLA) – or any state family and medical leave law – your coverage will remain in effect for a period of up to the leave period permitted under FMLA or, if longer, up to the leave period permitted under any applicable state law. For more information about FMLA leave, see the [Certificate of Coverage](#).

- **Sabbatical** – until the end of the 24th month following the month in which the sabbatical began.
- **Military leave** – until the end of the 12th month following the month in which the military leave began.

This continuation of coverage will apply as long as any required Premiums are paid when due, the policy remains in force and your coverage is not replaced with group life insurance provided by a new carrier.

You may be eligible to convert all or a portion of your Basic and Supplemental Term Life Insurance coverage – and any Spouse and/or Child Term Life Insurance then in effect – to an individual policy; for details, see [Conversion of Coverage](#).

Additional Benefits

Under certain circumstances – as noted below – your Basic and Supplemental AD&D will pay a(an):

- **Air Bag Benefit** – a benefit equal to 5% of your AD&D coverage amount (up to a maximum of \$15,000) if you die as the result of an automobile accident and – at the time of the accident – you were sitting in a seat that was equipped with an air bag.
- **Common Disaster Benefit** – a benefit payable if you and your covered spouse die as a result of injury in the same accident (or separate accidents that occur within a 24-hour period) and death occurs within 90 days of the accident. This feature will increase the benefit payable under your spouse's AD&D coverage to the amount payable under your Basic and Supplemental AD&D coverage combined (up to a maximum increase of \$150,000).
- **Day Care Benefit** – a benefit to help pay the cost of day care for a dependent child through age 12 at a legally licensed day care center after your death or the death of your covered spouse. This benefit will equal 3% of your Basic AD&D Insurance benefit (up to a maximum of \$2,000 a year), payable for up to six years, plus 5% of your Supplemental AD&D Insurance benefit (up to a maximum of \$10,000 a year), payable for up to six years.
- **Coma Benefit** – a benefit equal to 1% of your AD&D coverage amount paid monthly beginning on the 5th day of a coma resulting from an accidental injury for a maximum duration of up to 60 months. The coma must have begun within 30 days of the accident.
- **Child Education Benefit** – a benefit to help pay the cost of education for your dependent child at a school of higher education after your death or the death of your covered spouse. This benefit will equal 5% of your Basic AD&D Insurance benefit (up to a maximum of \$3,000 a year), payable for up to four years, plus 5% of your Supplemental AD&D Insurance benefit (up to a maximum of \$10,000 a year), payable for up to four years.
- **Workplace Felonious Assault Benefit** – a benefit payable to your Beneficiary(ies) if you die as the result of a felonious assault (including robbery, holdup or kidnapping) while on University business or while commuting to or from work. This benefit will equal your coverage amount up to a maximum of \$25,000.
- **Common Carrier Benefit** – a benefit payable to your Beneficiary(ies) if you die or payable to you if your dependent dies as the result of an accident while traveling as a fare-paying passenger in a public, government-regulated entity that is in the business of transporting fare paying passengers. This benefit will equal to 100% of your Basic and Supplemental AD&D coverage.
- **Seat Belt Benefit** – a benefit equal to 10% of your AD&D coverage amount (up to a maximum of \$25,000) if you die as the result of an automobile accident and – at the time of the accident – you were wearing a seat belt.
- **Spouse Education Benefit** – a benefit payable after your accidental death to your surviving spouse who enrolls in a school of higher education for training, retraining or refreshing skills needed for employment. This benefit will equal \$5,000 a year, payable for up to three years.

For details – including any limitations that may apply – refer to the [Certificate of Coverage](#).

Conversion of Coverage

You may apply to convert your life insurance coverage under Basic and Supplemental Term Life Insurance to an individual policy if this coverage – or any portion of it – ends because:

- Your University employment terminates
- You move into an ineligible employee classification
- Your life insurance benefits under this plan cease or are reduced, or
- The Group Policy ends or is amended making you ineligible for coverage, provided you have been insured for Life insurance for at least 5 continuous years.

Your covered family members also may apply to convert their life insurance coverage under Spouse or Child Term Life Insurance to an individual policy if their coverage ends because:

- Your University employment terminates
- You move into an ineligible employee classification
- You die
- A spouse is no longer eligible as the result of a divorce or dissolution of marriage
- A dependent child reaches the limited age under the plan, or
- A spouse or dependent child is no longer eligible, as defined by the plan.

In general, you may convert to an individual policy all or any portion of the coverage that was in effect on the date your coverage (or your dependent's coverage) ended. If, however, your coverage ends because life insurance benefits under this plan cease or the plan is amended making you ineligible for coverage, the amount you may apply to convert to an individual policy will be limited to the life insurance in effect on the date your coverage ended *minus* any amount for which you became eligible under this or any other group policy within 31 days after the date your life insurance ended up to \$10,000. In this case, your coverage will be eligible for conversion to an individual policy only if it had been in effect for at least five years. **Note:** This provision limiting the amount of coverage that may be converted also applies to a spouse or child who applies for conversion of their coverage to an individual policy.

An application to convert coverage to an individual policy must be submitted within 31 days after the date coverage under this plan ends. If the application is approved, the individual policy will take effect on the day following the 31-day period during which the application for conversion could be made. The individual policy will be a whole life policy; it will not include certain ancillary benefits (e.g., Accelerated Death Benefit, AD&D benefits) that may be included under Basic, Supplemental, Spouse and/or Child Term Life Insurance. **Note:** If you or a covered family member dies before your individual coverage takes effect, the benefit payable is limited to the maximum coverage amount that could have been converted.

The minimum coverage that may be converted to an individual policy is \$2,000. The Premiums for this coverage will be set by MetLife based on the amount of coverage converted and the rates in effect based on the insured's age and class of risk.

For details regarding Conversion of Coverage, see the [Certificate of Coverage](#).

Portability of Coverage

If your Basic, Supplemental Term Life, and Accidental Death & Dismemberment Insurance coverage – or any portion of it – terminates, you may elect to “port” this coverage and have it continue by paying the required premiums directly to MetLife. The same opportunity applies to any Term Life and Accidental Death & Dismemberment Insurance coverage you elect for your Dependents.

To qualify for the portability benefit:

- You must have been insured under your coverage prior to electing the portability benefit
- Your life and AD&D insurance – or a portion of it – must have been terminated for reasons other than sickness, injury or termination of the master policy
- You must not have previously exercised your right to convert to an individual policy the coverage you wish to port. **Note:** You may subsequently convert any portion of your life insurance that you do not port.

You must submit an application to port your terminated coverage within 31 days after the date of termination.

The maximum coverage you can port is the amount of life and AD&D coverage in effect at the time you elect this portability benefit – but may not exceed \$2,000,000 (Employee); \$250,000 (Spouse) and \$25,000 (Child); these maximums apply separately to life and AD&D coverage.

The Premiums for this coverage will be set by MetLife based on the amount of coverage you port and the rates then in effect based on your age and class of risk. Evidence of Insurability is not required to port coverage. However, to qualify for lower portability premium rates, you may provide MetLife with Evidence of Insurability. MetLife will notify you if you are approved and qualify for lower portability premium rates.

For details regarding Portability of Coverage, see the [Certificate of Coverage](#).

Business Travel Insurance

This automatic coverage will pay:

- A **life insurance benefit** in the event you die (or your covered spouse or dependent child dies) in an accident while traveling on Northwestern University business. This life insurance benefit will equal:
 - **Three times your Basic Annual Earnings, up to a maximum benefit of \$500,000** in the event of your death. This benefit will be paid to your Beneficiary(ies).
 - **\$50,000** – in the event your covered spouse’s death. This benefit will be paid to you.
 - **\$25,000** – in the event of a covered dependent child’s death. This benefit applies separately to each covered dependent child and will be paid to you.

The benefit amounts specified are also referred to as “principal sum” benefits. This life insurance benefit will be paid in addition to any other University-sponsored life and AD&D insurance benefit.

- An **Accidental Death and Dismemberment (AD&D) Insurance benefit** in the event you (or a covered spouse or dependent child) suffer a loss of limb (including loss of ability to function because of incurable paralysis or stiffening), loss of sight, or loss of hearing as the result of an accident while traveling on Northwestern University business. This benefit will be equal to 25% to 100% of the applicable Business Travel Insurance principal sum amount, based on the nature of the loss, will be paid in addition to any other University-sponsored AD&D life insurance benefit.

Northwestern pays the full cost of Business Travel Insurance coverage for you, your spouse, and your dependent children, as defined by this plan.

This coverage will apply to “any trip for University business” that requires you to travel away from your regular place of employment. The trip will:

- Begin when you leave your home or, if later, when you leave your place of regular employment, and
- End when you return to your home or, if sooner, when you return to your place of regular employment.

Any trip for University business means any travel authorized by or at the direction of Northwestern University to further the University’s business. It does not include everyday travel to and from work. However, personal deviations while on a trip for University business will be covered if coinciding 14 days before or after business travel.

When flying in an aircraft, this coverage will apply only while riding as a passenger in:

- Any civilian aircraft that has a valid airworthiness certificate, and
- Is piloted by a person holding a valid license to operate the aircraft.

Business Travel Insurance Coverage

This plan will pay the benefits shown above if you, your spouse, or a covered dependent child suffers a covered loss that occurs while traveling:

- On Northwestern University business
- In the course of the business of Northwestern
- On a trip authorized in advance by Northwestern, or
- Away from the premises of Northwestern.

Covered travel activities include commuting directly between your home and Northwestern's premises where you normally work when using an alternative means of transportation due to discontinuance of service, strike, or major breakdown of one or more public transportation systems that you normally use, subject to certain limitations.

In addition to the standard exclusions that apply (see *When Business Travel Insurance Benefits Will Not Be Paid* on page 5.13), this coverage does not apply to:

- Travel to another location where you are expected to be assigned for more than 365 days
- Normal commuting between your home and place of work
- Any activity not authorized or organized, or not reimbursable, by Northwestern
- Your participation in any race or speed contest, or
- Your driving any vehicle or private passenger automobile for pay or hire.

AD&D Benefits

This coverage will pay an AD&D insurance benefit equal to all or part of the applicable principal sum based on the nature of the loss, as outlined below:

For ...	The AD&D benefit payable will be this percentage of the applicable principal sum ...
Loss of life	100%
Loss of two or more hands or feet	100%
Loss or use of two or more hands or feet	100%
Loss of sight of both eyes	100%
Loss of speech and hearing in both ears	100%
Loss of one hand or foot and sight in one eye	100%
Loss of one hand or foot	50%
Loss or use of one hand or foot	50%
Loss of sight in one eye	50%
Loss of speech	50%
Loss of hearing in both ears	50%
Loss of thumb and index finger of same hand	25%
Loss of all four fingers of same hand	25%
Loss of all toes of same foot	25%

The maximum Business Travel Insurance benefit that will be paid for all losses due to one accident is \$5,000,000.

Felonious Assault and Violent Crime Coverage

This plan will pay the benefits shown on page 5.11 if you, your spouse, or a covered dependent child suffers a covered loss that occurs during a:

- **Felonious assault** – any willful and unlawful use of force by an individual against you (or your covered spouse or a dependent child) in connection with a robbery, theft, kidnapping, hostage taking, hijacking, assault, murder, manslaughter, riot, or insurrection. Such use of force must be a felony or equivalent of a felony under any country, state, territory, or local statutory or common law applicable in the jurisdiction where the covered loss occurs.
- **Violent crime** – a crime that involves force or threat of force and is composed of murder and non-negligent manslaughter, forcible rape, robbery, and/or aggravated assault.

War Risk Coverage

This plan will pay the benefits shown on page 5.11 if you, your spouse, or a covered dependent child suffers a covered loss that occurs during war or an act of war in which the insured person is not an active participant and that occur:

- Worldwide, excluding the United States and its territories and possessions, the insured person's country of permanent residence, Afghanistan, and Iraq, and
- While traveling on Northwestern business.

When Business Travel Insurance Benefits Will Not Be Paid

In addition to any benefit or coverage specific exclusion, Business Travel Insurance benefits will not be paid for any loss which is caused by or results from any of the following unless coverage is specifically provided for by name in the Plan certificate:

- Intentionally self-inflicted injury, suicide, or any attempt while sane or insane.
- Commission or attempt to commit a felony or an assault.
- Commission of or active participation in a riot or insurrection.
- Declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by this Policy.
- Covered accident or emergency sickness that occurs while on active duty service in the military, naval, or air force of any country or international organization. Upon Our receipt of proof of service, the Company will refund any Premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days.
- Flight in, boarding, or alighting from an aircraft, except as:
 - Passenger on a regularly scheduled commercial airline
 - Passenger in a non-scheduled, private aircraft used for pleasure purposes with no commercial intent during the flight, or
 - Passenger in a military aircraft flown by the air mobility command or its foreign equivalent.
- Travel in any aircraft owned, leased operated or controlled by Northwestern, or any of its subsidiaries or affiliates. An aircraft will be deemed to be “controlled” by Northwestern if the aircraft may be used as Northwestern wishes for more than 10 straight days, or more than 15 days in any year.
- Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, (including exposure, whether or not Accidental, to viral, bacterial or chemical agents) whether the loss results directly or indirectly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food.
- Medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice.
- Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a physician and taken in accordance with the prescribed dosage.
- An accident if the Insured person is the operator of a motor vehicle and does not possess a valid motor vehicle operator’s license, unless:
 - The insured person holds a valid learners permit, and
 - The Insured Person is receiving instruction from a driver’s education instructor.
- Operating any type of vehicle or conveyance while under the influence of alcohol or any drug, narcotic, or other intoxicant including any prescribed drug for which the insured person has been provided a written warning against operating a vehicle or conveyance while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the motor vehicle laws of the state in which the covered loss occurred.

Additional Benefits

Under certain circumstances – as noted below – your Business Travel Insurance will pay a(an):

- **Bereavement and Trauma Counseling Benefit** – up to \$150 per session (for up to a maximum of 10 sessions) for counseling sessions following an accidental death or covered loss.
- **Carjacking Benefit** – 10% of the benefit amount applicable to a covered loss (up to a maximum of \$25,000 for a covered loss that occurs during a carjacking of a private automobile.
- **Child Care Center Benefit** – a benefit equal to 10% of the applicable principal sum (up to a maximum of \$10,000 a year) for the care of each surviving dependent child for up to four years (or until the child reaches age 13, if sooner).
- **Coma Benefit** – a benefit equal to 1% of the applicable principal sum for each of the first 11 months the coma lasts, and 100% of the applicable principal sum if the coma lasts at least 12 months. This benefit will be paid for you, or your covered spouse, or a dependent child suffers a covered injury that results in a coma.
- **Education Benefit** – a benefit to help pay the cost of education for your dependent child(ren) and surviving spouse after your death in a covered accident. This benefit will equal 10% of your principal sum (up to a maximum of \$10,000) for each surviving dependent child and for your surviving spouse.
- **Emergency Reunion Benefit** – a benefit of up to \$2,000 to cover expense to have an immediate family member accompany you or your covered spouse or dependent child to the injured person's home country or hospital following a covered accident.
- **Home Alteration and Vehicle Modification Benefit** – a benefit equal to 10% of the benefit amount applicable to a covered loss (up to a maximum of \$50,000) to help pay cost of alterations to your home or modifications to your vehicle.
- **Medical Evacuation Benefit** – a benefit equal to 100% of the usual and customary expenses for emergency evacuation while outside a 100 mile radius from your primary residence.
- **Paralysis Benefit** – a specified percentage of the applicable principal sum (from 25% to 100%) if a covered person suffers paralysis as a result of a covered injury.
- **Psychological Treatment Benefit** – a benefit equal to 10% of the applicable principal sum (up to a maximum of \$25,000) toward cost of mental health counseling to help you or a covered spouse or dependent child deal with a covered loss.
- **Rehabilitation Benefit** – a benefit equal to 10% of the benefit amount applicable to a covered loss (up to a maximum of \$25,000) for rehabilitation services following a covered loss.
- **Repatriation Benefit** – a benefit equal to 100% of the usual and customary expenses for preparation and transportation of your body (or the body of your spouse or dependent child) to your primary residence following death in a covered accident while more than 100 miles from home.
- **Seatbelt and Airbag Benefit** – a benefit equal to a specified percentage of the applicable principal sum if a covered person dies while operating or riding as a passenger in a private passenger automobile – 25% of the applicable principal sum (up to a maximum of \$50,000) if the insured person was wearing a seatbelt plus 10% of the applicable principal sum (up to a maximum of \$25,000) if the insured person was in a seat protected by an airbag.
- **Security Evacuation Benefit** – a benefit equal to 100% of the usual and customary expenses for a security evacuation while traveling outside your home country.

For details – including any limitations that may apply – refer to the [Certificate of Coverage](#).

In addition, benefits will not be paid for services or treatment rendered by any person who is:

- Employed or retained by Northwestern
- Living in the insured person's household
- An Immediate family member of either the insured person or the insured person's spouse, or
- The insured person.

Coverage While On a Leave of Absence

This coverage will not be in effect while you are on a Leave of Absence (and, therefore, not actively at work).

Coverage While On Disability

This coverage will not be in effect while you are receiving University-sponsored Long Term Disability benefits (and, therefore, not actively at work).

Coverage Upon Termination of Employment

Upon termination of your University employment, your coverage under this plan ends.

Coverage When You Retire

Upon your retirement from University employment, your coverage under this plan ends.

Coverage Upon Your Death

Upon your death, your coverage under this plan ends.

6 Tuition Benefits

The University's tuition benefit plans provide valuable financial assistance to you if you are a full-time, benefits-eligible University employee and you have higher education expenses for yourself, your spouse/partner and/or your dependent child(ren).

For Employees:

- [Employee Reduced Tuition Plan](#) – pays benefits toward the cost of undergraduate or graduate courses eligible employees take at Northwestern University.
- [Enhanced Employee Reduced Tuition Plan](#) – pays benefits toward the cost of undergraduate or graduate courses eligible employees take at Northwestern University.
- [Employee Northwestern Certificate Tuition Plan](#) – pays benefits toward the cost of certificate courses taken by eligible employees at Northwestern University (SPS post baccalaureate programs are covered under the Employee Reduced Tuition Plan).
- [Employee Portable Tuition Plan](#) – pays benefits toward the cost of tuition for undergraduate or graduate job-related courses eligible employees take at an accredited, FAFSA-approved college or university other than Northwestern University.

For Dependents:

- [Dependent Reduced Tuition Plan](#) – pays benefits toward the cost of tuition for eligible spouse/partner, and eligible dependent child(ren) enrolled in a Northwestern University undergraduate degree program or in the University's School of Professional Studies undergraduate level classes.
- [Dependent Portable Tuition Plan](#) – pays benefits toward the cost of tuition for eligible dependent child(ren) enrolled in an undergraduate degree program at an accredited, FAFSA-approved college or university other than Northwestern University.

For Employees & Dependents:

- [Music Lessons Reduced Tuition Plan](#) – pays benefits toward the cost of non-degree music lessons eligible employees, eligible spouse/partner, and eligible dependent child(ren) take at Northwestern University's Music Academy.

Note: Certain eligibility guidelines, service requirements and benefit limits may apply, as described in this summary.

These plans are administered by Northwestern University, which pays the full cost of the benefits these plans provide.

Eligibility for any of the University-sponsored tuition benefit plans does not imply Northwestern University admission, nor does it guarantee acceptance into any University program.

Waiver of Service

For faculty and staff hired on or after September 1, 2014: you may qualify to waive part or all of the Northwestern service period for the tuition benefit plans. You must have worked in a full-time, benefits-eligible position at a FAFSA-qualified college or university offering a comparable tuition benefit immediately prior to joining Northwestern University as a faculty or staff member.

To apply, please complete the top portion of the waiver form and have your previous employer complete the bottom portion. Return the form to Benefits at AskHR@northwestern.edu.

Tuition Benefit Plans – By Years of Service

Upon Hire as a Full-Time, Benefits-Eligible Employee:

Tuition Benefit Plan	Plan ID
Employee Reduced*	ER
Music Lessons	N/A

After 6 Months of Continuous, Full-Time, Benefits-Eligible Service:

Tuition Benefit Plan	Plan ID
Employee Reduced*	ER
Dependent Reduced – 6 Months	DRU1
Music Lessons	N/A

After 1 Year of Continuous, Full-Time, Benefits-Eligible Employee:

Tuition Benefit Plan	Plan ID
Employee Reduced*	ER
Employee Northwestern Certificate*	EC
Employee Portable* (employees hired on or after 1/1/2020 not eligible)	EP
Dependent Reduced – 6 Months	DRU1
Music Lessons	N/A

After 3 Years of Continuous, Full-Time, Benefits-Eligible Service:

Tuition Benefit Plan	Plan ID
Employee Reduced*	ER
Enhanced Employee Reduced (if less than \$100K gross salary)*	EER
Employee Northwestern Certificate*	EC
Employee Portable* (employees hired on or after 1/1/2020 not eligible)	EP
Dependent Reduced – 6 Months	DRU1
Music Lessons	N/A

After 5 Years of Continuous, Full-Time, Benefits-Eligible Service:

Tuition Benefit Plan	Plan ID
Employee Reduced*	ER
Enhanced Employee Reduced (if less than \$100K gross salary)*	EER
Employee Northwestern Certificate*	EC
Employee Portable* (employees hired on or after 1/1/2020 not eligible)	EP
Dependent Reduced – 6 Months	DRU1
Dependent Reduced – 5 Year	DRU2
Dependent Portable – 5 Year	DP1
Music Lessons	N/A

* Tuition benefit plans denoted with an asterisk are taxable under IRS regulations. Employees receiving these benefits above \$5,250 per calendar year will be taxed accordingly.

**If Hired Prior to 1/1/2000 and Having Continuous Years of,
Full-Time, Benefits-Eligible Service:**

Tuition Benefit Plan	Plan ID
Employee Reduced*	ER
Enhanced Employee Reduced (if less than \$100K gross salary)*	EER
Employee Northwestern Certificate*	EC
Employee Portable* (employees hired on or after 1/1/2020 not eligible)	EP
Dependent Reduced – 6 Months	DRU1
Dependent Reduced – 5 Year	DRU2
Dependent Reduced – Hired Prior to 1/1/2000	DRU0
Dependent Portable – 5 Year	DP1
Dependent Portable – Hired Prior to 1/1/2000	DPO
Music Lessons	N/A

Full List of Tuition Benefit Plans:

Tuition Benefit Plan	Plan ID	Benefit	Maximum
Employee Reduced*	ER	90%	\$12,000
Enhanced Employee Reduced (if less than \$100K gross salary) *	EER	90%	No limit
Employee Northwestern Certificate*	EC	100%	\$12,000
Employee Portable*	EP	100%	\$5,250
Dependent Reduced – 6 Months	DRU1	85%	12 quarters
Dependent Reduced – 5 Year	DRU2	50%	12 quarters
Dependent Reduced – Hired Prior to 1/1/2000	DRU0	90%	12 quarters
Dependent Portable – 5 Year	DP1	50%	8 semesters or 12 quarters
Dependent Portable – Hired Prior to 1/1/2000	DPO	100% up to \$2,808 per semester or \$1,872 per quarter	8 semesters or 12 quarters
Music Lessons	N/A	25%	None

* Tuition benefit plans denoted with an asterisk are taxable under IRS regulations. Employees receiving these benefits above \$5,250 per calendar year will be taxed accordingly.

Employee Reduced Tuition Plan

This plan is designed to provide financial assistance to you – if you are a full-time, benefits- eligible Northwestern University employee – toward the cost of undergraduate or graduate courses taken at the University, as well as non-credit, on-campus Professional Development Programs through the School of Professional Studies.

To be eligible to receive benefits from this plan, you must be a full-time, benefits-eligible employee of Northwestern University as of the first day of the term.

The Employee Reduced Tuition Plan benefit of 90% reduced tuition will be applied to the full amount of the applicable tuition. Student Finance will post billing statements on CAESAR showing total tuition charges, tuition benefit amounts and the balance due. You are responsible for the balance due.

Note: You will be subject to the rules and prerequisites of your school of attendance.

The maximum amount you can receive each calendar year in benefits from the Employee Reduced Tuition Plan is \$12,000. Amounts above \$5,250 each year are taxable.

Maximum Benefit Amounts

The maximum amount you may receive in tuition benefits from this plan each calendar year is \$12,000.

Applying for Benefits

To apply for tuition benefits from this plan, you must complete an Employee Reduced Tuition Benefit Application online. Review the [application process](#) on the Benefits website.

You need to submit only one Employee Reduced application for each calendar year of study. Application should be submitted within 90 days of 1st course it applies to or no later than December 15th of the current calendar year course is taken. However, if you reach your three-year anniversary mid-year and wish to use the Enhanced Employee Reduced Tuition Plan for terms beginning after your anniversary date, you will need to submit an Enhanced Employee Reduced application at that time.

Note: You must have full-time, benefits-eligible employment status as of the first day of the term for which you are requesting tuition benefits. If you lose eligibility to participate in this plan and you are currently enrolled in a course for which benefits from this plan have been approved, you may receive benefits through the end of the term of study in which your loss of eligibility occurs.

To receive Employee Reduced Tuition Plan benefits you MUST submit a completed application no later than December 15th in the calendar year for which the benefit is being requested.

Coverage While On a Leave of Absence

If you are on a paid full-time leave you may continue to receive benefits from the Employee Reduced Tuition Plan as long as you continue to be eligible for University insurance benefits. Your benefits will be based on your accumulated years of full-time, benefits-eligible service.

If you are on an unpaid leave of absence, the time you are on your leave will not count toward your years of accumulated continuous University service and you are not eligible to use the benefit.

Coverage While On Disability

You may continue to receive benefits from the Employee Reduced Tuition Plan as long as you continue to be eligible for University insurance benefits.

Taking Courses During Work Hours

It is your responsibility to arrange a class schedule that does not conflict with your regular work hours. If a course is available only during regular work hours, your supervisor will decide if your department or laboratory operational requirements permit your absence from work. Any work time missed for class and travel time must be made up.

Alternatively, you may use available unused vacation time. If you are a non-exempt employee (paid biweekly), you must arrange "make-up time" with your supervisor to ensure that no legal or contractual obligation for overtime premium pay is incurred.

In some situations, scheduled workhours may be reduced, with a corresponding reduction in pay. If your scheduled work hours are reduced to fewer than 37.5 hours per week (the minimum required to maintain full-time status), you will no longer be eligible to receive tuition benefits through this plan.

Coverage When You Retire

You may continue to receive Employee Reduced Tuition Plan benefits through the end of the term of study in which you retire from the University.

Coverage Upon Termination of Employment

You may continue to receive Employee Reduced Tuition Plan benefits through the end of the term of study in which the termination of your University employment occurs.

Coverage Upon Your Death

No benefits from the Employee Reduced Tuition Plan will be paid following your death unless your death occurs after you have completed a course of study but before you have received benefits toward the cost of that course.

Tax Considerations

This plan is subject to two sections of the Internal Revenue Code – Section 117 for undergraduate courses and Section 127 for graduate level courses. You can receive up to \$5,250 a year in benefits from this plan each year tax free; any benefits you receive from this plan in excess of \$5,250 a year will be treated as non-cash compensation and will be considered as taxable income for that year.

The benefits you receive from this plan must be added to your taxable gross income for purposes of computing and withholding federal income tax, state income tax, and Medicare and Social Security taxes under the Federal Insurance Contribution Act (FICA). While the first \$5,250 you receive each year will not be subject to income tax withholding, any amount in excess of \$5,250 will be. Additional tax withholding – based on the amount in excess of \$5,250 – will be deducted from your pay over a three-month period (and will be itemized on your paystub).

The full amount of the benefits you receive from this plan will be included on your annual W-2 wage and salary statement under the section “Wages, Tips and Other Compensation.”

Legislation passed by Congress in 1997 created the opportunity for certain students or their parents to obtain a tax credit for tuition paid to attend a college or university. As a result, Northwestern University is required to file Form 1098-T by January 31 each year with the Internal Revenue Service. This form reports certain enrollment and identifying information for U.S. Resident Students for which the University has received payments for “Qualified Tuition and Related Expenses” in a tax year. The University is not required to file Form 1098-T for students who are Nonresident Aliens for U.S. income tax purposes.

Information about Form 1098-T is needed to determine eligibility for the Hope Scholarship Credit and Lifetime Learning Credit provided in Internal Revenue Code Section 25A.

When Employee Reduced Tuition Plan Benefits Will Not Be Paid

Benefits from this plan will not be paid for:

- Non-credit enrollment – except for SPS Professional Development Programs billed through CAESAR by Student Finance and courses audited through the School of Professional Studies. Note: If you are auditing a course through the School of Professional Studies, you will be charged the regular School of Professional Studies per-course rate and will receive the corresponding benefit.
- Extensions of registration – beyond those normally required in each school or program
- Graduate school registration for PhD students who are post-candidacy, with completed coursework and are focusing on research - for example, TGS 500.
- Courses taken during a prior calendar year.
- Courses taken during working hours – see [Taking Courses During Working Hours](#).

Enhanced Employee Reduced Tuition Plan

This plan is designed to provide financial assistance to you – if you are a full-time, benefits- eligible Northwestern University employee – toward the cost of undergraduate or graduate courses taken at the University, as well as non-credit, on-campus Professional Development Programs through the School of Professional Studies.

To be eligible to receive benefits from this plan, you must:

- Be a full-time, benefits-eligible employee of Northwestern University
- Have completed three years of continuous, full-time, benefits-eligible service prior to the beginning of the term

- Be earning less than \$100,000 gross annually, and
- Be an actively working employee, currently on University payroll.

The Enhanced Employee Reduced Tuition Plan benefit of 90% reduced tuition will be applied to the full amount of the applicable tuition. Student Finance will post billing statements on CAESAR showing total tuition charges, tuition benefit amounts and the balance due. You are responsible for the balance due.

Note: You will be subject to the rules and prerequisites of your school of attendance.

The amount you may receive each calendar year in benefits from the Enhanced Employee Reduced Tuition Plan is unlimited; however, any benefit received above \$5,250 per calendar year is taxable.

Maximum Benefit Amounts

The amount you may receive in tuition benefits from this plan each calendar year is unlimited and subject to taxation.

Applying for Benefits

To apply for tuition benefits from this plan, you must complete an Enhanced Employee Reduced Tuition Benefit Application online. Review the [application process](#) on the Benefits website.

You need to submit only one Enhanced Employee Reduced application for each calendar year of study. Application should be submitted within 90 days of 1st course it applies to or no later than December 15th of the current calendar year course is taken.

Note: You must have eligible employment status as of the first day of the term for which you are requesting a tuition benefit. If you lose eligibility to participate in this plan and you are currently enrolled in a course for which benefits from this plan have been approved, you may receive benefits through the end of the term of study in which your loss of eligibility occurs.

To receive Enhanced Employee Reduced Tuition benefits you MUST submit a completed application no later than December 15th in the calendar year for which the benefit is being requested.

Tax Considerations

All Employee Tuition Benefits above \$5,250 received per calendar year will be taxed as non-cash compensation. The benefits you receive from this plan are subject to the same taxation rules outlined for the Employee Reduced Tuition Plan, and can be used in conjunction with benefits from that plan.

When Enhanced Employee Reduced Tuition Plan Benefits Will Not Be Paid

Benefits from this plan will not be paid for:

- Non-credit enrollment – except for SPS Professional Development Programs billed through CAESAR by Student Finance and courses audited through the School of Professional Studies. Note: If you are auditing a course through the School of Professional Studies, you will be charged the regular School of Professional Studies per-course rate and will receive the corresponding benefit.
- Extensions of registration – beyond those normally required in each school or program.

- Graduate school registration for PhD students who are post-candidacy, with completed coursework and are focusing on research - for example, TGS 500.
- Courses taken during a prior calendar year.
- Courses taken during working hours – see [Taking Courses During Work Hours](#).

Coverage While On a Leave of Absence

If you are on a paid full-time leave you may continue to receive benefits from the Enhanced Employee Reduced Tuition Plan as long as you continue to be eligible for University insurance benefits. Your benefits will be based on your accumulated years of full-time, benefits-eligible service.

If you are on an unpaid leave of absence, you will not be eligible to receive benefits from the Enhanced Employee Reduced Tuition Plan.

Coverage While On Disability

You will not be eligible to receive benefits from the Enhanced Employee Reduced Tuition Plan.

Coverage When You Retire

You may continue to receive Employee Reduced Tuition Plan benefits through the end of the term of study in which you retire from the University.

Coverage Upon Termination of Employment

You may continue to receive Enhanced Employee Reduced Tuition Plan benefits through the end of the term of study in which the termination of your University employment occurs.

Coverage Upon Your Death

No benefits from the Enhanced Employee Reduced Tuition Plan will be paid following your death unless your death occurs after you have completed a course of study but before you have received benefits toward the cost of that course.

Employee Northwestern Certificate Tuition Plan

This plan is designed to provide financial assistance to you – as a full-time, benefits-eligible Northwestern University employee – toward the cost of short duration certificate programs at Northwestern University (SPS post baccalaureate certificate programs are covered under the Employee Reduced Tuition Plan and Enhanced Employee Reduced Tuition Plan).

To be eligible to receive benefits from this plan, you must:

- Be a full-time, benefits-eligible employee
- Have completed one year of full-time, benefits-eligible service prior to the beginning of the term, and
- Be on the University payroll at the beginning and completion of a course.

The Employee Northwestern Certificate Tuition Plan benefit of up to 100% of tuition may be used to reimburse tuition only for certificate courses you complete that are:

- Job-related
- Non-credit
- Short duration

- Certificate programs
- Offered by Northwestern University, and
- Billed outside of CAESAR.

Maximum Benefit Amounts

The maximum amount you may receive in tuition benefits from this plan each calendar year is \$12,000.

Applying for Benefits

You should review policies and procedures to ensure eligibility prior to the start of the certificate program. If you have questions about a program's eligibility, email a request for the program's review to AskHR@northwestern.edu including your name, employee ID, and a link to the program's website. You must obtain your supervisor's approval and signature indicating that the program is job-related. Upon completion of the program, you must submit an Employee Northwestern Certificate Tuition Benefit Application online. Review the [application process](#) on the Benefits website.

Note: You must indicate the amount of financial assistance received from other sources on the form. These are subtracted from your out-of-pocket tuition and fee expenses. You will be reimbursed via Payroll.

To receive benefits from the Employee Northwestern Certificate Tuition Plan you MUST submit a completed application within 90 days after course completion, or by December 15th of the current calendar year of course completion.

Tax Considerations

All Employee Tuition Benefits above \$5,250 received per calendar year will be taxed as non-cash compensation. The benefits you receive from this plan are subject to the same taxation rules outlined for the Employee Reduced Tuition Plan, and can be used in conjunction with benefits from that plan. The benefits you receive from this plan will count toward the \$12,000 annual maximum that applies under the Employee Reduced Tuition Plan and Employee Portable Tuition Plan.

When Employee Northwestern Certificate Tuition Benefits Will Not Be Paid

Benefits from this plan will not be paid for:

- Programs offered by institutions outside of Northwestern.
- School of Professional Studies Post-baccalaureate Certificate programs.
- Programs taken during a prior calendar year.
- Programs taken during working hours – see [Taking Courses During Work Hours](#).

Coverage While On a Leave of Absence

If you are on a paid full-time leave you may continue to receive benefits from the Employee Northwestern Certificate Tuition Plan as long as you continue to be eligible for University insurance benefits. Your benefits will be based on your accumulated years of full-time, benefits-eligible service.

If you are on an unpaid Leave of Absence, the time you are on your leave will not count toward your years of accumulated continuous University service and you will not be able to use the benefit.

Coverage While On Disability

You may continue to receive benefits from the Employee Northwestern Certificate Tuition Plan as long as you continue to be eligible for University insurance benefits.

Coverage When You Retire

You may continue to receive Employee Reduced Tuition Plan benefits through the end of the term of study in which you retire from the University.

Coverage Upon Termination of Employment

You may not receive Employee Northwestern Certificate Tuition Plan benefits if you are terminated from the University during the course term.

Coverage Upon Your Death

No benefits from the Employee Northwestern Certificate Tuition Plan will be paid following your death unless your death occurs after you have completed an eligible certificate program but before you have received benefits toward the cost of that course.

Employee Portable Tuition Plan

This plan is designed to provide financial assistance to you— as a full-time, benefits-eligible Northwestern University employee – toward the cost of undergraduate and graduate job-related courses you take at any accredited, FAFSA-approved college or university other than Northwestern University.

To be eligible to receive benefits from this plan, you must:

- Be a full-time, benefits-eligible employee of Northwestern University
- Have completed one year of full-time, benefits-eligible service prior to the beginning of the term, and
- Be on the University payroll at the beginning and completion of a course.
- Employees hired on or after 1/1/2020 are not eligible for the Employee Portable Tuition Plan

The Employee Portable Tuition Plan benefit of up to 100% of tuition may be used to reimburse tuition only for undergraduate or graduate courses you complete:

- That are job related
- At any accredited, FAFSA-approved college or university other than Northwestern University, and
- For which you receive a letter grade of “C” or higher – OR “P” (“Pass”) OR “S” (“Satisfactory”) – and for which you earn credit hours.

Maximum Benefit Amounts

The maximum amount you may receive in tuition benefits from this plan each calendar year is \$5,250.

Applying for Benefits

Before starting a degree program or enrolling in a job-related course, you should review University policy and procedures to confirm you are eligible to receive benefits from this plan. If you have questions about a program’s eligibility, email a request for the program’s review to AskHR@northwestern.edu. You should also obtain your supervisor’s approval to enroll in course(s); this will confirm the coursework is degree- or job-related.

Once you complete a course – with a letter grade of “C” or higher (or a letter grade of “P” for “Pass” or “S” for “Satisfactory”), you must complete an Employee Portable Tuition Benefit Application online. Review the [application process](#) on the Benefits website.

Note: Scholarships and grants are subtracted from your out-of-pocket tuition. You will be reimbursed via Payroll.

To receive benefits from the Employee Portable Tuition Plan you MUST submit a completed application within 90 days after course completion.

Tax Considerations

All Employee Tuition Benefits above \$5,250 received per calendar year will be taxed as non-cash compensation. The benefits you receive from this plan are subject to the same taxation rules outlined for the [Employee Reduced Tuition Plan](#), and can be used in conjunction with benefits from that plan. The benefits you receive from this plan will count toward the \$12,000 annual maximum that applies under the Employee Reduced Tuition Plan and Employee Northwestern Certificate Tuition Plan.

When Employee Portable Tuition Benefits Will Not Be Paid

Benefits from this plan will not be paid for:

- Non-credit enrollment.
- Extensions of registration – beyond those normally required in each school or program.
- Courses taken during a prior calendar year.
- Courses taken during working hours – see [Taking Courses During Work Hours](#).

Coverage While On a Leave of Absence

If you are on a paid full-time leave you may continue to receive benefits from the Employee Portable Tuition Plan as long as you continue to be eligible for University insurance benefits. Your benefits will be based on your accumulated years of full-time, benefits-eligible service.

If you are on an unpaid Leave of Absence, the time you are on your leave will not count toward your years of accumulated continuous University service and you will not be able to use the benefit.

Coverage While On Disability

You may continue to receive benefits from the Employee Portable Tuition Plan as long as you continue to be eligible for University insurance benefits.

Coverage When You Retire

You may continue to receive Employee Reduced Tuition Plan benefits through the end of the term of study in which you retire from the University.

Coverage Upon Termination of Employment

You may not receive Employee Portable Tuition Plan benefits if you are terminated from the University during the course term.

Coverage Upon Your Death

No benefits from the Employee Portable Tuition Plan will be paid following your death unless your death occurs after you have completed a course of study but before you have received benefits toward the cost of that course.

Taking Courses During Work Hours

It is your responsibility to arrange a class schedule that does not conflict with your regular work hours. If a course is available only during regular work hours, your supervisor will decide if your department or laboratory operational requirements permit your absence from work. Any worktime missed for class and travel time must be made up.

Alternatively, you may use available unused vacation time. If you are a non-exempt employee (paid biweekly), you must arrange “make-up time” with your supervisor to ensure that no legal or contractual obligation for overtime premium pay is incurred.

In some situations, scheduled work hours may be reduced, with a corresponding reduction in pay. If your scheduled work hours are reduced to fewer than 37.5 hours per week (the minimum required to maintain full-time status), you will no longer be eligible to receive tuition benefits through this plan.

Tax Considerations

This plan is subject to two sections of the Internal Revenue Code – Section 117 for undergraduate courses and Section 127 for graduate level courses. You can receive up to \$5,250 a year in benefits from this plan each year tax free; any benefits you receive from this plan in excess of \$5,250 a year will be treated as non-cash compensation and will be considered as taxable income for that year.

The benefits you receive from this plan must be added to your taxable gross income for purposes of computing and withholding federal income tax, state income tax, and Medicare and Social Security taxes under the Federal Insurance Contribution Act (FICA). While the first \$5,250 you receive each year will not be subject to income tax withholding, any amount in excess of \$5,250 will be.

Additional tax withholding – based on the amount in excess of \$5,250 – will be deducted from your pay.

Dependent Reduced Tuition Plan

This plan is designed to provide financial assistance to you – as a full-time, benefits-eligible Northwestern University employee – toward the cost of undergraduate courses taken by your spouse/partner and/or dependent child(ren) at the University.

The reduced tuition benefits provided under this plan are based on:

- Your continuous full-time, benefits-eligible University employment – as of the first day of class for the term for which the benefit is requested, and/or
- The course of study – courses taken through the School of Professional Studies vs. regular daytime courses (see table).

If you are enrolled in...	And you have continuous full-time University employment of at least...	The reduced tuition benefit you can receive is...	Plan ID
School of Professional Studies			
• Courses taken in Fall/Winter/Spring Term or during Summer Session	6 Months	85%	DRU
Regular Day Time Undergraduate Degree Programs			
• Faculty and Staff hired <u>before</u> January 1, 2000	22+ years	90%	DRU0
• Faculty and Staff hired <u>on or after</u> January 1, 2000	5 years	50%	DRU2

The reduced tuition benefit percentage will be applied to the Northwestern billed tuition. Student Finance will post billing statements on CAESAR showing total tuition charges, the reduced tuition benefit and the balance due. You are responsible for the balance due.

Benefits under this plan will be paid only for courses taken by individuals pursuing an undergraduate degree at Northwestern. This benefit is available to continuing and returning students.

To receive reduced tuition benefits under this plan you MUST submit a completed application no later than December 15 of the calendar year for which the benefit is being requested.

Maximum Benefit Amounts

The maximum benefit for which the reduced tuition benefit will be paid for an eligible spouse/partner or dependent child is 12 full-time academic quarters. They may pursue a portion of their undergraduate program at Northwestern University. In this case, the regular reduced tuition benefit for Northwestern University study may be applied. However, terms for which this benefit is received will coordinate with the Dependent Portable Tuition Plan benefit (for eligible dependent children only) such that benefits will be received for no more than 8 full-time academic semesters or 12 full-time academic quarters.

The term limit provisions under this plan apply separately to each eligible family member.

Terms for which this benefit is received will coordinate with Dependent Portable Tuition Plan benefits to ensure that benefits are received for no more than 8 full-time academic semesters or 12 full-time academic quarters.

Applying for Benefits

To apply for reduced tuition benefits from this plan, you must complete a Dependent Reduced Tuition Benefit Application online. Review the [application process](#) on the Benefits website.

Note: You must be a full-time, benefits-eligible employee as of the first day of the term for which you request the reduced tuition benefit. If you lose eligibility to participate in this plan and an eligible family member is currently enrolled in a course for which benefits from this plan have been approved, those benefits will be paid through the end of the term of study in which your loss of eligibility occurs.

This benefit is provided for the eligible dependent student and their tuition expenses. If a student has more than one parent eligible for this benefit, only one parent may apply.

To receive Dependent Reduced Tuition Plan benefits, an eligible spouse/partner or dependent child MUST be enrolled in an undergraduate degree program. The maximum number of quarters for which the reduced tuition benefit will be paid for an eligible spouse/partner or child is 12 full-time academic quarters.

When Dependent Reduced Tuition Benefits Will Not Be Paid

Benefits from this plan will not be paid for:

- Students who are either not enrolled in a degree program or not working toward the requirements of a teaching certificate at Northwestern.
- Non-credit courses, seminars or programs in the summer session.
- School of Professional Studies Professional Development Programs.
- Extensions of registration – beyond those normally required in each school or program.
- Graduate or professional study.
- High school students enrolled in University courses as a supplement to their high school curriculum – either as part of their college preparation or as part of the National High School Institute (“Cherub”) program. However, a high school student who has been admitted to a degree program in the University and is otherwise eligible for the benefit may receive the tuition reduction for courses taken the summer prior to his or her freshman year.
- Overage dependent child(ren) – a child who reaches age 24 before the first day of the term for which the benefit is requested.

Coverage While On a Leave of Absence

If you are on a paid full-time leave you may continue to receive benefits from the Dependent Reduced Tuition Plan as long as you continue to be eligible for University insurance benefits. Your benefits will be based on your accumulated years of full-time, benefits-eligible service.

If you are on an unpaid leave, the time you are on your leave will not count toward your years of accumulated continuous University service and you will not be able to use the benefit.

Tax Considerations

The benefits your spouse and dependent child(ren) receive are exempt from taxation and will not be included in the calculation of your taxable income for the year. On the other hand, the benefits your partner and/or your partner's child(ren) receives will be considered income. However, if you have legally adopted your partner's child(ren), the benefits they receive will be exempt from taxation.

The full amount of the benefits you receive from this plan will be included on your annual W-2 wage and salary statement under the section “Wages, Tips and Other Compensation.”

Legislation passed by Congress in 1997 created the opportunity for certain students or their parents to obtain a tax credit for tuition paid to attend a college or university. As a result, Northwestern University is required to file IRS Form 1098-T by January 31 each year with the Internal Revenue Service (IRS). This form reports certain enrollment and identifying information for U.S. Resident Students for which the University has received payments for “Qualified Tuition and Related Expenses” in a tax year. The University is not required to file IRS Form 1098-T for students who are Nonresident Aliens for U.S. income tax purposes.

Information about IRS Form 1098-T is needed to determine eligibility for the Hope Scholarship Credit and Lifetime Learning Credit provided in Internal Revenue Code Section 25A.

Coverage While On Disability

You may continue to receive benefits from the Dependent Reduced Tuition Plan as long as you continue to be eligible for University insurance benefits.

Coverage When You Retire

If you retire from University employment and meet specified age and service requirements (see table), you may continue to receive benefits from the Dependent Reduced Tuition Plan.

For faculty members, retirement is at the point at which one ceases to work full-time, not merely ends his/her employment at Northwestern University.

Retirement Age and Service Requirements for Dependent Reduced Tuition Plan Coverage in Retirement

Age at Retirement:	55	56	57	58	59	60	61	62	63	64	65
Service (in years):											
Full-Time	10	10	10	9	8	7	6	5	4	3	2

For more information about your continuing participation in the Dependent Reduced Tuition Plan after you retire, see Benefit Program Information for Retirees.

Coverage Upon Termination of Employment

You may continue to receive Dependent Reduced Tuition Plan benefits through the end of the term of study in which the termination of your University employment occurs.

Coverage Upon Your Death

Your spouse/partner and child(ren) will continue to be eligible to receive Dependent Reduced benefits from this plan based on your years of continuous full-time, benefits-eligible University employment at the time of your death. This eligibility ends for the spouse or partner upon remarriage, or for a child upon adoption or when the child reaches age 24.

Dependent Portable Tuition Plan

This plan is designed to provide financial assistance to you – as a full-time, benefits-eligible Northwestern University employee – toward the cost of undergraduate courses taken by your dependent child(ren) at a U.S. accredited, FAFSA-approved college or university other than Northwestern University.

The portable tuition benefits provided under this plan are based on:

- Your most recent University hire date – whether your hire date was before January 1, 2000 or on or after that date, and
- Your continuous full-time, benefits-eligible University employment – as of the first day of classes for the term for which the benefit is requested.

If your employment with the University began...	And you have continuous full-time University employment of at least...	The portable tuition benefit you can receive for each eligible dependent child is...	Plan ID
--	---	---	----------------

On or after January 1, 2000	5 years	Up to 50% of billed tuition ²	DP1
Before January 1, 2000 ¹	24+ years	100% of billed tuition up to \$5,616 per calendar year ³	DPO

1 Based on your years of continuous, full-time, benefits-eligible University employment, you may be able to choose between these portable tuition benefit plans for your dependent child. Once you choose the 50% plan, it cannot be changed for that child. You may, however, choose one portable tuition plan for one dependent child and a different plan for another dependent child.

2 The portable tuition benefit will be based on tuition (not to exceed 100% when financial aid, such as scholarships, is considered).

3 The calendar year portable tuition benefit will be made available in term segments based on whether the college or university in question maintains a semester or quarter academic year; the \$5,616 calendar year maximum breaks down to \$2,808 per semester or \$1,872 per quarter.

Note: The benefit amount received may not exceed the total amount due in tuition.

Terms for which this benefit is received will coordinate with Dependent Reduced Tuition Plan benefits to ensure that benefits are received for no more than 8 full-time academic semesters or 12 full-time academic quarters.

Maximum Benefit Amounts

The maximum number of terms for which the Dependent Portable Tuition Plan benefit will be paid for a dependent child is 8 full-time academic semesters or 12 full-time academic quarters.

An eligible dependent child may pursue a portion of his or her undergraduate degree program at the University. In this case, the regular Dependent Reduced Tuition Plan benefit for Northwestern University study may be applied, and the benefits earned will be coordinated with the limits that apply under this plan.

The term limit provisions under this plan apply separately to each eligible family member.

Applying for Benefits

To apply for portable tuition benefits for an eligible dependent child, you must complete a Dependent Portable Tuition Benefit Application online. Review the [application process](#) on the Benefits website.

Note: Scholarships and grants are subtracted from your out-of-pocket tuition. You will be reimbursed via Payroll, or a University check will be issued from Accounts Payable.

If you are applying for benefits for more than one eligible dependent child, you must submit a separate application for each child. Your application(s) should be submitted at least four weeks prior to the date you will need the benefit payment and no later than one year from the start date of the term for which the benefit is requested. For more information, see the instructions provided in Application Process.

The proof of a dependent child's eligibility is certified by you at the time application is submitted.

To receive Dependent Portable Tuition benefits you MUST submit a completed application within one year from the start date of the term for which the benefit is requested.

Note: You must be a full-time, benefits-eligible employee as of the first day of the term for which you request the dependent portable tuition benefit. If you lose eligibility to participate in this plan and an eligible dependent child is currently enrolled in a term for which benefits from this plan have been approved, you may receive benefits through the end of the term of study in which your loss of eligibility occurs.

This benefit is provided for the eligible dependent student and their tuition expenses. If a student has more than one parent eligible for this benefit, only one parent may apply.

How Benefit is Paid

Once your application is approved, a Northwestern University payment for the portable tuition benefit will be made payable to:

- The university or college – if you have not already paid the tuition in full, or
- To you (via Payroll) – if you have already paid the tuition in full (and include proof of payment with your application).

Checks will NOT be mailed directly to another university or college. Northwestern is not responsible for late fees/penalties you incur. Your application will not be expedited due to payment deadlines at another university or college.

Expenses which qualify for the portable tuition benefit are tuition. Room, board, fees, and student health insurance expenses are ineligible expenses.

Tuition and Fees	Eligible Expenses
• Tuition	Yes
• Room	No
• Board	No
• Computer Lab Fees	No
• Books	No
• Student Health Insurance Premium	No

Eligible dependent children receiving portable tuition benefits are subject to the rules and prerequisites of their school of attendance. The maximum number of terms for which the portable tuition benefit will be paid for an eligible dependent child is 8 full-time academic semesters or 12 full-time academic quarters.

How the Benefit Is Calculated

If scholarships and grants equal less than 50% of the tuition, then the benefit is 50% of the total tuition. If scholarships and grants equal more than 50% of tuition, then the benefit is equal to the tuition minus the scholarships and grants (the tuition benefit plus scholarships and grants can never be more than the tuition).

Example

Tuition: \$12,000.00	
<i>times</i> Benefit Percentage:	<u>x 50%</u>
<i>equals</i> 50% of Tuition:	\$6,000.00
<hr/>	
Scenario 1: Scholarship = \$2,000.00	Scenario 2: Scholarship = \$8,000.00
\$2,000.00 is less than 50% of \$12,000.00	\$8,000.00 is more than 50% of \$12,000.00
Tuition = Benefit	Tuition <i>minus</i> Scholarship = Benefit
 \$12,000.00 x 50% = \$6,000.00	 \$12,000.00 - \$8,000.00 = \$4,000.00

Scenario 3: Scholarship = \$15000.00

\$15,000 is more than 50% of \$12,000.00
of Tuition = Benefit

\$12,000.00 - \$15,000 = **-\$3000.00 Which would
result in denied benefit.**

When Dependent Portable Tuition Benefits Will Not Be Paid

Benefits from this plan will not be paid for:

- Non-credit enrollment – the dependent child must be enrolled in an undergraduate degree program.
- Part-time enrollment – if a dependent child's course load drops below full-time during a term (either 12 credit hours per semester or nine credit hours per quarter), you are responsible for repaying Northwestern the amount of benefit granted to that child for that term.
- Extensions of registration – any extension beyond those normally required.
- Graduate or professional study.
- Incidental expenses – books, parking and room and board.
- High school students enrolled in college courses as a supplement to their high school curriculum – even as part of their college preparation. However, a high school student who has been admitted to a degree program in an institution and is otherwise eligible for the benefit may receive the tuition benefit for courses taken the summer prior to his or her freshman year.
- Overage dependent child(ren) – a child who reaches age 24 before the first day of the term for which the benefit is requested.
- Dependent children of Contributed Service Faculty in the Medical School.
- If Scholarships, awards, or grants are more than 50% of tuition.

Coverage While on a Leave of Absence

If you are on a paid full-time leave you may continue to receive benefits from the Dependent Portable Tuition Plan as long as you continue to be eligible for university insurance benefits. Your benefits will be based on your accumulated years of full-time, benefits-eligible service.

If you are on an unpaid Leave of Absence, the time you are on your leave will not count toward your years of accumulated continuous University service and you will not be able to use the benefit.

Coverage While on Disability

You may continue to receive benefits from the Dependent Portable Tuition Plan as long as you continue to be eligible for university insurance benefits. Your eligible dependent child(ren) must have qualified for this benefit at the time you became Disabled and continue to qualify for the duration of the time for which the benefit is requested.

Coverage When You Retire

If you retire from University employment and meet specified age and service requirements (see table), you may continue to receive benefits from the Dependent Portable Tuition Plan. Retired ACAD & CNT are not eligible for any tuition benefits after retirement as they generally do not meet the university retirement service requirements.

For faculty members, retirement is the point at which one ceases to work full-time, not merely ends his/her employment at Northwestern University.

Retirement Age and Service Requirements for Dependent Portable Tuition Plan Coverage in Retirement

Age at Retirement:	55	56	57	58	59	60	61	62	63	64	65
Service (in years):											
Full-Time	10	10	10	9	8	7	6	5	4	3	2

For more information about your continuing participation in the Dependent Portable Tuition Plan after you retire, see [Benefit Program Information for Retirees](#).

Coverage Upon Termination of Employment

You may continue to receive Dependent Portable Tuition benefits through the end of the term of study in which the termination of your University employment occurs.

Coverage Upon Your Death

Your dependent child(ren) will continue to be eligible to receive Dependent Portable Tuition benefits from this plan based on your years of continuous full-time, benefits-eligible University employment at the time of your death. A dependent child's eligibility ends upon adoption or upon reaching age 24.

Music Lessons Reduced Tuition Plan

This plan is designed to provide financial assistance to you— as a full-time, benefits-eligible Northwestern University employee – toward the cost of non-degree lessons taken in the Music Academy in the School of Music at the University by yourself, your spouse/partner and/or your dependent child(ren).

To be eligible to receive benefits from this plan, you must be a full-time, benefits-eligible employee of Northwestern University as of the first day of class.

The Music Lessons Tuition Plan benefit of 25% reduced tuition will be applied to the full amount of the eligible lesson tuition. The Music Academy will post billing statements showing total tuition charges, tuition benefit amounts and the balance due. You are responsible for the balance due.

Note: You will be subject to the rules of your school of attendance.

Applying for Benefits

To apply for tuition benefits for this plan, you must complete a questionnaire with the Music Academy at <https://hr.northwestern.edu/benefits/tuition/employee/music-academy-reduced-tuition-benefits.html> or email the Music Academy at musicacademy@northwestern.edu.

Note: You must have full-time, benefits-eligible employment status as of the first day of the term for which you are requesting the tuition benefit. If you lose eligibility to participate in this plan and you are currently enrolled in a course for which benefits from this plan have been approved, you may receive benefits through the end of the term of study in which your loss of eligibility occurs.

To receive Music Lesson Tuition Plan benefits you MUST submit a completed application no later than December 15th in the calendar year for which the benefit is being requested.

When Music Lessons Tuition Plan Benefits Will Not Be Paid

Benefits from this plan will not be paid for:

- Degree-related lessons in the School of Music's Music Academy, or
- Courses taken during a prior calendar year.

Coverage While On a Leave of Absence

If you are on a paid full-time leave you may continue to receive benefits from the Music Lesson Tuition Plan as long as you continue to be eligible for University insurance benefits. Your benefits will be based on your accumulated years of full-time, benefits-eligible service.

If you are on an unpaid leave of absence, the time you are on your leave will not count toward your years of accumulated continuous University service and you will not be able to use the benefit.

Coverage While On Disability

You may continue to receive benefits from the Music Lesson Tuition Plan as long as you continue to be eligible for University insurance benefits.

Coverage When You Retire

You may continue to receive Employee Reduced Tuition Plan benefits through the end of the term of study in which you retire from the University.

Coverage Upon Termination of Employment

You may continue to receive Music Lesson Tuition Plan benefits through the end of the quarter in which the termination of your University employment occurs.

Coverage Upon Your Death

Your dependent spouse/partner and child(ren) will continue to be eligible to receive Music Lesson Tuition benefits from this plan based on your full-time, benefits-eligible University employment at the time of your death. This eligibility ends for the spouse or partner upon remarriage, or for a child upon adoption or when the child reaches age 24.

7 Employee Assistance Program (“EAP”)

This plan is designed to provide eligible employees and their family, including spouses and dependents (“Participants”). The EAP provides Participants with access to a network of mental health support services, including free and confidential short-term counseling, to help cope with everyday life issues such as anxiety and stress, relationship/marital concerns, workplace concerns, family issues, loss of a loved one, coping with a serious illness, depression, etc. The benefit is administered by SupportLinc.

To be eligible to receive benefits from this plan, you must be a full- or part-time, benefits-eligible employee of Northwestern University as of the first day you use the service. This plan is extended to eligible employee’s immediate family members, including spouses and dependents (up to age 26), even if the dependent is not living in the household, as well as others in the household including roommates.

The University assumes all costs for all Participants to use the Employee Assistance Program. If you need additional assistance, referrals by SupportLinc will consider your preferences, medical plan, and financial circumstances.

Accessing the Benefits

To access the plan, contact SupportLinc at 888-881-5462 or online at Online at supportlinc.com. All services are confidential in accordance with applicable laws. The University receives program usage data in aggregate. No identifying information is provided.

When Coverage Ends

Your coverage will end on the earliest to occur of the following dates:

- The date on which the policy is terminated
- The effective date of any amendment to the policy which terminates coverage for your employee classification, or
- The end of the month in which you:
 - Are no longer in an eligible employee classification
 - Request termination of your coverage, or
 - Retire.

You may continue your coverage if you are no longer actively at work due to:

- **Disability** – until the end of the 24th month following the month in which the Disability began.
- **Layoff** – until the end of 365 days after the layoff began.
- **Leave of absence** – until the end of the 12th month following the month in which the Leave of Absence began or the period of time in accordance with FMLA requirements. **Note:** If you qualify for a leave under the Family and Medical Leave Act of 1993 (FMLA) – or any state family and medical leave law – your coverage will remain in effect for a period of up to the leave period permitted under FMLA or, if longer, up to the leave period permitted under any applicable state law.
- **Sabbatical** – until the end of the 24th month following the month in which the sabbatical began.
- **Military leave** – until the end of the 12th month following the month in which the military leave began.

8 Filing Claims

This section provides instructions and information you will need to file claims and appeals under the various health & welfare and educational assistance benefit plans described in this handbook, as well as guidelines regarding coordination of benefits and subrogation guidelines that will apply if you or your covered family members are eligible to receive benefits from another plan or party, or as a result of a settlement, judgment or arbitration award from another insurance program or similar coverage.

To access and print a copy of a claim form, simply click on the appropriate links incorporated in the following pages. Most claim forms contain detailed instructions for completing the form, where to submit the form for processing and any additional information (e.g., receipts) you may need to include when submitting a claim. If you have any questions regarding claim filing procedures, contact the appropriate Claims administrator (as listed in [Administrative Information](#)).

Medical Plans

The following guidelines apply to filing claims – or an appeal of a claim denial – under a University-sponsored medical plan.

Plan	How to File a Claim	Filing Deadline
Premier PPO Select PPO	<p>For physician and hospital services:</p> <ul style="list-style-type: none">• In-Network – present your BCBSIL coverage ID card at time of service; Network providers will file the claim for you automatically• Out-of-Network – file a claim using the BCBSIL Health Insurance Claim Form <p>For prescription drugs:</p> <ul style="list-style-type: none">• In-Network – present your BCBSIL coverage ID card, which contains Express Scripts information in the lower-right corner, at time of service and pay the Copayment; you do not need to file a claim• Out-of-Network – file a claim using the Express Scripts Prescription Drug Claim Form	<ul style="list-style-type: none">• No later than one year after the date on which the service is received
Value PPO	<p>For physician and hospital services:</p> <ul style="list-style-type: none">• In-Network – present your BCBSIL coverage ID card at time of service; Network providers will file the claim for you automatically• Out-of-Network – file your own claim using the BCBSIL Health Insurance Claim Form <p>For prescription drugs:</p> <ul style="list-style-type: none">• In-Network – present your BCBSIL coverage ID card, which contains Express Scripts information in the lower-right corner, at time of service and pay full cost of drug up to annual Deductible, then pay Coinsurance; if you have an HSA and a Inspira Financial debit card you may pay your share of these costs using your debit card; alternatively, you can use the checkbook provided by Inspira Financial for reimbursement of eligible expenses• Out-of-Network – file a claim using the ExpressScripts Prescription Drug Claim Form	<ul style="list-style-type: none">• No later than one year after the date on which the service is received

Plan	How to File a Claim	Filing Deadline
HMO Illinois	<ul style="list-style-type: none"> You do not need to file a claim for physician and hospital services and/or prescription drugs; present your BCBSIL coverage ID card, which contains Express Scripts information in the lower-right corner, Copayment(s) may apply at time of service 	NA

Important! Whether a claim is filed automatically on your behalf or by you personally, it is your responsibility to ensure that the necessary claim information is provided to the Claims administrator. If you are filing a claim yourself, you will need to submit itemized receipts from the provider detailing the services provided along with your completed claim form.

If you are covered under the University-sponsored PPO health plan and need to submit a claim for services received from a non-participating provider, your claim form must include:

- Your name, address and Social Security number
- The patient's name and date of birth
- The member and group number, if applicable, as shown on your coverage ID card
- The date the injury or sickness began
- The provider's name and address
- The diagnosis and a description of the service
- The date of service
- Copies of the bills to be considered for benefits or payment, and
- A statement indicating that you either are or are not covered under any other health insurance plan. If you do have other coverage, you must provide the name of the other carrier.

You may designate a representative to act on your behalf in pursuing a claim or appeal, but this designation must be explicitly stated in writing and must authorize disclosure of protected health information with respect to the claim. If you would like to designate a representative, you will need to contact the Claims administrator.

Note: You must follow the procedures described in this section to "exhaust" your administrative remedies under your coverage before you can pursue an external review and/or other legal action relating to a claim for coverage or benefits under that coverage.

Payment of Claims

Generally, payments will be made to the hospital, clinic or physician's office that provided your care or services, except that in some instances (e.g., for care or services received by a non-participating provider), you may be required to pay the provider and then submit a claim to the Claims administrator. The Claims administrator may request any information required to determine benefits or to process a claim. You or the provider of the services will be contacted if additional information is needed to process your claim.

When your child is subject to a Qualified Medical Child Support Order (QMCSO), the Claims administrator will make reimbursement of eligible expenses paid by you, the child, the child's non-employee custodial parent, or legal guardian, to that person as provided in the QMCSO.

Payment of benefits will be made in accordance with an assignment of rights for you and your dependents as required under state Medicaid law.

Claims Decisions

After submission of a claim by you, your Beneficiary or your authorized representative acting on behalf of you (each a “claimant”), the Claims administrator will notify the claimant of the Claims administrator’s decision in writing or by acceptable electronic means, in a culturally and linguistically appropriate manner, and within a reasonable time, as follows:

- **Pre-Service Claims** – The Claims administrator will notify the claimant of a favorable or adverse determination of a claim for medical care for which the Plan requires advance approval (including pre-certification or utilization review) within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the pre-service claim.

However, this period may be extended by an additional 15 days if the claims administrator determines that an extension is necessary due to matters beyond the administrator’s control. The Claims administrator will notify the claimant of the extension before the end of the initial 15-day period, the reason(s) the extension is necessary, and the date by which the Claims administrator expects to make a decision. If the reason for the extension is because the claimant failed to submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will have at least 45 days from the date of the notice to provide the specified information. If the claimant’s pre-service claim does not follow the procedures for filing a pre-service claim, the claimant will receive notice from the Claims administrator within 5 days following the failure.

- **Urgent Care Claims** – The Claims administrator will determine whether a claim is an Urgent Care Claim, with deference to the determination of the attending provider. The Claims administrator may require the claimant to clarify the medical urgency and circumstances that support the Urgent Care Claim for expedited decision-making.

The Claims administrator will notify the claimant of a favorable or adverse determination as soon as possible (taking into account the medical urgency particular to the participant’s situation) but not later than 72 hours after receipt of the Urgent Care Claim.

However, if a claim is submitted that does not provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan, the Claims administrator will notify the claimant as soon as possible, but not more than 24 hours after receipt of the Urgent Care Claim. The notice will describe the specific information necessary to complete the claim.

The claimant will then have a reasonable amount of time (up to 48 hours) to provide the necessary information. The Claims administrator will notify the claimant of the Urgent Care Claim determination as soon as possible, but in no event more than 48 hours after the earlier of:

- The receipt of the specified information; or
- The end of the 48-hour period given to the claimant to provide the specified additional information.

The claimant may be notified of this determination orally, but if so, the Claims administrator will also send a written or electronic notice of the determination within three days of the oral notice. If the claimant’s Urgent Care Claim does not follow the procedures for filing an Urgent Care Claim, the claimant will receive a notice from the Claims administrator within 24 hours following the failure.

- **Concurrent Care Decisions** – The Claims administrator will notify the claimant of a concurrent care decision that involves a reduction in or termination of the care that the participant is receiving (a participant’s current course of treatment). The Claims administrator will provide the notice sufficiently in

advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of the adverse determination before the benefit is reduced or terminated.

A claimant's request to extend a course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care will be decided by the Claims administrator as soon as possible, taking into account the medical urgency particular to the participant's situation. The Claims administrator will notify the claimant of the benefit determination, whether favorable or adverse, within 24 hours after receipt of the claim, but the claimant must have submitted the claim for extension at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

- **Post-service Claims** – The Claims administrator will notify the claimant of a determination, whether favorable or adverse, of a claim that is filed after the participant received the medical care within a reasonable time, but not later than 30 days after receipt of the claim.

However, this period may be extended by an additional 15 days if the Claims administrator determines that the extension is necessary due to matters beyond the control of the administrator.

The Claims administrator will notify the claimant of the extension before the end of the initial 30-day period, the reason(s) the extension is necessary, and the date by which the plan expects to make a decision. If the reason for the extension is because of the claimant's failure to submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will have at least 45 days from the date of the notice to provide the specified information.

Initial Denial Notices

A claim denial notice from the Claims administrator will include:

- Information sufficient to identify the claim involved including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability of the diagnosis and treatment codes and their corresponding meanings (if you request the diagnosis and treatment codes, this information will be provided to you as soon as possible following your request)
- The specific reason or reasons for the denial
- The code assigned to the reason for the denial (along with the meaning of the code)
- A description of the plan's standard, if any, that was used in denying the claim
- The specific plan provisions on which the determination is based
- A description of the internal appeals procedures and external review processes for the plan (including information about how to appeal a denial and the time limits applicable to such procedures)
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary
- Contact information for any office of health insurance consumer assistance or Ombudsman available to assist the claimant with the internal claims and appeals and external review processes, and
- A description of any internal rule, protocol or similar criterion that the Claims administrator relied on to deny the claim and a statement that a copy of this rule, protocol or similar criterion will be provided to the claimant free of charge upon request.

If the denial is based on medical necessity, experimental treatment, or a similar exclusion or limit under the plan, the notice will provide either an explanation of the scientific or clinical judgment for the determination (applying the terms of the plan to the participant's medical circumstances) or a statement that such explanation will be provided free of charge upon request.

In the case of a denial of an Urgent Care Claim, the notice will provide a description of the plan's expedited review procedures applicable to such claims.

Appeals of Adverse Determinations

A claimant must appeal a claim denial within 180 days after receiving written notice of the denial (or partial denial). A claimant must make an appeal of the initial claim denial by means of written application, in person, or by mail (postage prepaid), addressed to:

Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, IL 60690

However, in the case of an appeal of a claim denial involving Urgent Care, the claimant may make a request for an expedited appeal of a claim denial orally or in writing and all necessary information will be transmitted between the Plan and the claimant by telephone, fax or other available similarly expedited method.

A claimant may submit written comments, documents, records, and other information and, upon request and free of charge, will be given reasonable access to (and copies of) all documents, records and other information relevant to the claim. Appeals of denied claims will be conducted promptly, will not defer to the initial determination and will not be made by the person who made the initial adverse claim determination or a subordinate of that person.

The determination on appeal will also take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, regardless of whether such information or documentation was submitted or considered in the initial benefit determination.

Coverage will continue pending the outcome of the appeal, to the extent required by applicable law.

If the denial was based (in whole or in part) on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the medical field involved in the medical judgment.

The consulting health care professional will not be the same person who was consulted in connection with the initial denial or a subordinate of that person. The Claims administrator reviewing the appeal will identify any medical or vocational experts whose advice was obtained in connection with the denial being appealed, regardless of whether the advice was relied upon in denying the claim.

If any new or additional evidence is considered, relied upon or generated by the plan as part of the appeal review or if the determination is based on any new or additional rationale, this evidence and rationale will be provided (free of charge) to the claimant as soon as possible and sufficiently in advance of the date on which any notice of a denial of an appeal is required to give the claimant a reasonable opportunity to respond prior to that date.

Time Periods for Decisions on Appeal

Appeals of claim denials will be decided and notice of the decision will be provided as follows:

- **Urgent Care Claims** – As soon as possible, but not later than 72 hours after the claimant filed the appeal request

- **Pre-service Claims** – Within a reasonable period, but not later than 15 days after the claimant filed the appeal request
- **Post-service Claims** – Within a reasonable period, but not later than 30 days after the claimant filed the appeal request.
- **Concurrent Care Decisions** – Within the time periods specified above, depending on the type of claim involved.

Appeal Denial Notices

A notice of a denial on appeal will include:

- The specific reason or reasons for the denial of an appealed claim
- A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination
- The identification of the claim, date of service, health care provider, claim amount (if applicable) and information about how to obtain diagnosis, treatment and denial codes and their meanings – subject to privacy laws and other restrictions
- An explanation of the Claims administrator's external review processes (including how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal
- A statement in non-English language(s) that future notices of claim denials and certain other benefit information may be available in such non-English language(s) – in certain situations
- Notification of the claimant's right to request – free of charge – reasonable access to and copies of all documents, records and other information relevant to the claim for benefits
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge upon request, and
- An explanation of the scientific or clinical judgment that was relied on in the determination, or a statement that such explanation will be provided free of charge upon request, and
- A description of the plan's standard, if any, that was used in denying the claim.

Second Appeal of a Claim Denial

A claimant may request a standard or expedited external review of a benefit denial by an Independent Review Organization (IRO). To request an external review of a denial by an IRO, a claimant must contact:

Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, IL 60690

Within five business days of receiving the claimant's external review request, the Claims administrator will complete a preliminary review of this request and will provide the claimant with written notice within one business day after completing its preliminary review.

The preliminary review determines whether:

- The claimant is or was covered under the Plan at the time the health care item or service was requested or provided
- The denial relates to the claimant's failure to meet the requirements for eligibility under the Plan
- The claimant has exhausted (or is not required to exhaust) the Plan's internal appeal process, and

- The claimant has provided all of the information and forms required to process an external review.

If the claimant's request is complete but the denial is not eligible for external review, the notice will include the reason(s) for ineligibility and the contact information for the Employee Benefits Security Administration at **866-444-3272**.

If the request is not complete, the notice will describe the information or materials needed to complete the request.

The claimant will have until the later of the initial four-month filing period or the 48-hour period after the receipt of the notice to provide such information or materials. If the claimant's request is eligible for external review, an IRO will be assigned to conduct the external review and the IRO will provide timely notification to the claimant that the request is eligible for and has been accepted for external review. Within 10 business days after the receipt of the notice, the claimant may submit to the IRO any additional information that the IRO will consider when conducting the external review.

The IRO will provide the Claims administrator with any information submitted by the claimant within one business day after it receives the information, and the Claims administrator may reconsider its denial. If the Claims administrator decides to reverse its denial, it will provide written notice of its decision to the claimant and the IRO within 1 business day of completing its reconsideration and the IRO will terminate the external review upon receiving this notice.

The IRO will review all of the information and documentation that it timely receives and will provide written notice of its final decision within 45 days after the IRO receives the claimant's request for an external review. This notice to the claimant will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (such as the date of service, the health care provider, the claim amount, and the diagnosis code, the treatment code and the meanings of these codes)
- The date the IRO received the assignment to conduct the external review and the date the IRO made its decision
- References to the evidence or documentation (including the specific coverage provisions and evidence-based standards) the IRO considered in making its decision
- A discussion of the principal reason(s) for the IRO's decision (including the rationale for its decision and any evidence-based standards that were relied on in making its decision)
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to the claimant
- A statement that judicial review may be available to the claimant, and
- Current contact information (including the phone number) for any applicable office of health insurance consumer assistance or Ombudsman that may be available to assist the claimant.

Upon receipt of a notice that the IRO has reversed the claim or appeal denial, the Plan will immediately provide coverage or payment for the denied claim.

Expedited External Review Process

The external review process described above may be conducted on an expedited basis if:

- The claim denial involves a medical condition for which the timeframe for completing an Urgent Care Claim internal appeal (provided the claimant has filed an internal appeal for an Urgent Care Claim denial) would

seriously jeopardize the life or health of the participant or would jeopardize the participant's ability to regain maximum function

- The denial of the internal appeal involves a medical condition for which the timeframe for completing a standard external appeal would seriously jeopardize the life or health of the participant or would jeopardize the participant's ability to regain maximum function, or
- The denial of the internal appeal concerned an admission, availability of care, continued stay or health care item or service for which the participant received emergency services but has not been discharged from a facility.

Under an expedited external review process, the Claims administrator will complete its preliminary review and immediately thereafter send a notice to the claimant of the request's eligibility for an expedited external review. The Claims administrator will then assign an IRO to such request if it is eligible for an expedited external review and will provide or transmit all necessary documentation and information considered in denying the claim or appeal by any available expeditious method (such as electronically or by telephone or fax). The IRO will consider the information or documentation under the procedures for a standard external review but will complete the expedited review and provide notification to the claimant as expeditiously as the participant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If this notice is not in writing, the IRO will provide written confirmation of the decision to the claimant within 48 hours after providing that notice.

Assistance

If you need assistance with the internal claims and appeals or the external review processes that are described in this section, you may contact the Illinois Ombudsman Program at **877-527-9431**, or call the number on the back of your coverage ID card for further information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at **866-444-3272**.

Exhaustion

Upon completion of the claims and appeals and external review process under this section, the claimant will have exhausted his or her administrative remedies under the plan. If the Claims administrator fails to complete a claim determination or an appeal according to the requirements set forth above*, the claimant may be treated as if he or she has exhausted the internal claims and appeals process and he or she may request an external review or pursue any available remedies under applicable law. No action at law or in equity may be brought with respect to plan benefits until all rights under the plan have been exhausted and any such action must be brought no later than two years from the date of the Claims administrator's final decision upon review of a second level appeal or the expiration of the applicable limitations period under applicable law (whichever is earlier).

* Other than a failure that is de minimis, non-prejudicial, due to good cause or matters beyond the Claims administrator's control, in the context of an ongoing, good-faith exchange of information, and not reflective of a pattern or practice of non-compliance.

Dental Plans

The following guidelines apply to filing claims – or an appeal of a claim denial – under the University-sponsored Blue Cross Blue Shield of Illinois dental benefit plan.

Plan	How to File a Claim	Filing Deadline
Dental PPO	<ul style="list-style-type: none">• Prior to visiting a dentist, complete the Patient's Information section on an Attending Dentist's Statement• Following treatment, have the dentist complete the Dentist's Information section	<ul style="list-style-type: none">• No later than one year after the date on which the service is received.
Dental HMO	<ul style="list-style-type: none">• You do not need to file a claim; Copayment(s) may apply at time of service	<ul style="list-style-type: none">• NA

Important! It is your responsibility to ensure that the necessary claim information is provided to the Claims administrator. If you are filing a claim yourself, you will need to submit itemized receipts from the provider detailing the services provided along with your completed claim form.

The Claims administrator will pay all claims within 30 days of receipt of all information required to process a claim. The Claims administrator will provide written notice when all information required to process and pay the claim has been received.

In the event that the Claims administrator does not process a claim within this 30-day period, you or your valid assignee will be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all claim information until the date payment is actually made.

Note: You may designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.

After submission of a claim by you, your Beneficiary or your authorized representative acting on behalf of you (each a “claimant”), the Claims administrator will notify the claimant of its decision regarding the claim.

Filing an Appeal

If a claim is denied in whole or in part, the notice the claimant receives from the Claims administrator will include:

- The reason(s) for the denial
- A reference to the plan provisions on which the denial is based
- A description of additional information which may be necessary to perfect the appeal, and
- An explanation of how the claimant may have the claim reviewed by the Claims administrator if the claimant does not agree with the denial.

If the claimant would like the claim to be reviewed, the claimant must submit a written request to the Claims administrator within 180 days after receipt of the notice of the denial, which should include the reason(s) why the claimant does not agree with the denial. The claimant should send the request to:

While the Claims administrator will honor telephone requests for information, such inquiries will not constitute a request for review.

The claimant may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after he receives notice of a denial or partial denial. The Claims administrator will give the claimant a written decision within 60 days after it receives the request for review.

If you have any questions about the claims procedures or the review procedure, write or call the Claims administrator (see [Administrative Information](#)).

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.

BlueCross BlueShield of Illinois Vision Care Plan

The following guidelines apply to filing claims – or an appeal of a claim denial – under the University-sponsored BCBSIL Vision Care benefit plan.

Plan	How to File a Claim	Filing Deadline
BCBSIL Vision Care Plan	<ul style="list-style-type: none"> In-Network – contact provider for an appointment and indicate that you have BCBSIL Vision Care coverage; you do not need to file a claim Out-of-Network – pay the bill in full and mail in any itemized receipts along with the Out of Network Vision Services Claim Form. Mail to: EyeMed Vision Care Attn: OON Claims PO Box 8504 Mason, OH 45040-7111 	<ul style="list-style-type: none"> 1 Year

For Out-of-Network services (that is, services received from a vision care provider who is NOT a member of the BCBSIL Vision Care Network) – reimbursement will be according to the plan's [maximum schedule of allowances](#).

After submission of a claim, the Claims administrator will notify the claimant of its decision regarding the claim within 30 days. The Claims administrator may apply a 15-day extension period.

Filing an Appeal

If a claim is denied in whole or in part, the notice the claimant receives from the Claims administrator will include:

- The reason(s) for the denial
- A reference to the plan provisions on which the denial is based
- A description of additional information which may be necessary to perfect the appeal, and
- An explanation of how the claimant may have the claim reviewed by the Claims administrator if the claimant does not agree with the denial.

If the claimant would like the claim to be reviewed, the claimant must submit a written request to the Claims administrator within 180 days after receipt of the notice of the denial. The request for review should be sent to:

First American Administrators
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

The appeal should include the following:

- Claim number and a copy of the denial or Explanation of Benefits (EOB)
- Item member feels was misinterpreted or inaccurately applied, and
- Additional information to assist in completing the review.

The Claims administrator will give the claimant a written decision within 60 days after it receives the request for review.

If you have any questions about the claims procedures or the review procedure, write or call the Claims administrator (see [Administrative Information](#)).

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.

Spending & Savings Accounts

The following guidelines apply to filing claims under the University-sponsored spending and savings accounts.

Account	How to File a Claim	Filing Deadline
Health Care FSA/ Limited Use FSA	<ul style="list-style-type: none"> Present your Inspira Financial debit card at time of service for Copayments; alternatively, you should use Express Claims online to file for reimbursement or complete and submit a Inspira Financial Health/Dependent Care Flexible Spending Account Claim Form. Note: If you are enrolled in the Value PPO health plan and participating in a Limited Use FSA, once you meet the Value PPO annual Deductible you must complete and submit a Inspira Financial Post-Deductible FSA Expense Reimbursement Certification Form before any eligible medical expenses can be reimbursed from this account. 	<ul style="list-style-type: none"> No later than March 31 each year for eligible expenses incurred from January 1¹ of the plan year through March 15² of the following calendar year
Dependent Care FSA	<ul style="list-style-type: none"> Use Express Claims online, or complete and submit a Inspira Financial Health/Dependent Care Flexible Spending Account Claim Form for reimbursement of eligible expenses; you cannot use a Inspira Financial debit card to pay eligible dependent care expenses. 	<ul style="list-style-type: none"> No later than March 31 each year for eligible expenses incurred from January 1¹ through December 31² of the prior plan year
Health Savings Account (HSA)	<ul style="list-style-type: none"> Present your Inspira Financial debit card at time of service; alternatively, you can go online to the Inspira Financial website and request funds to be sent to the provider or to you (as reimbursement). 	<ul style="list-style-type: none"> NA

1 Or, if later, the date during the prior calendar year on which your participation in the account began.

2 Or, if sooner, the date during the prior calendar year on which your employment terminated or you retired. You cannot file claims for expenses incurred after your termination or retirement date.

Note: If you are participating in a Flexible Spending Account, be sure to register online at www.inspirafinancial.com; you will need your Employee ID number, ZIP code, and the last 4 digits of the Inspira Financial debit card. Once you register, you can use this site to track your contributions and claims.

Important! You will forfeit any contributions from the prior calendar year that remain in a Health Care FSA, Limited Use FSA or Dependent Care FSA on April 1 of the following calendar year. If you have an HSA, unused contributions from the prior calendar year will roll over automatically and be available to use for eligible expenses you may incur during any subsequent calendar year.

Health Care FSA/Limited Use FSA

If you are participating in a Health Care FSA or Limited Use FSA you will receive a pre-activated debit card from the Claims administrator, Inspira Financial. You may use this debit card at the time of service if the service provider is an approved merchant (e.g., a member of your dental or vision plan's provider Network, Wal-Mart, Walgreen's). A complete listing of IRS-approved merchants is available at www.inspirafinancial.com. It is recommended that the card only be used to pay Copayments.

You can also submit claims using a claim form or online using Express Claims. You can download claim forms online at www.inspirafinancial.com through your online account with Inspira Financial. You will need to complete the claim form and attach a receipt; you can fax the form and receipt or other proof of the expense to Inspira Financial using the number provided on the claim form or upload the proof and submit the entire claim online.

Examples of documents that you can submit as proof of an eligible expense include:

- A receipt referencing the date of service, the provider, the amount billed and the type of service
- A canceled check accompanied by a third party statement as verification of the incurred health care expense, or
- An Explanation of Payment (EOP) statement received from a medical or dental insurance plan.

There is no minimum claim amount. If the amount for which you submit a claim exceeds the current balance in your account, the claim will be paid up to the total amount you have elected to contribute for the current year; if this results in a negative account balance, your contributions for the balance of the year will be used to make up this negative balance.

If a claim is denied in whole or in part, you will receive an Explanation of Benefits (EOB) providing the reasons for the denial. If you wish to appeal the denial, you may contact Inspira Financial, the Claims administrator at **800-284-4885**.

A decision will be made on your appeal within 60 calendar days after your request is received, unless special circumstances apply; in this case, you will receive notice that up to 60 additional days may be required.

Claims administrator decisions concerning claims appeals will be final and binding on you, your dependents and all other interested parties. In no event will you or a family member be entitled to challenge a decision of the Claims administrator in court or in another administrative proceeding until you exhaust all administrative procedures outlined above.

Dependent Care FSA

If you are participating in a Dependent Care FSA, you must submit claims using a claim form or online using Express Claims. You can download claim forms online at www.Inspirafinancial.com through your online account with Inspira Financial. You will need to complete the claim form and attach a receipt; you can upload the proof and submit the entire claim online or fax the form and receipt or other proof of the expense to Inspira Financial using the number provided on the claim form.

When submitting a claim, you must include:

- The name, Social Security Number or federal tax ID number of the care provider and the amount paid for their services
- The dependent's name, relationship to you and age
- The dates of service, and
- Appropriate receipts, invoices or other documents.

Note: The Social Security Number and federal tax ID number are not necessary if the care provider is a tax-exempt group (such as a church or if the care is provided outside of the United States by a foreign citizen). If no receipts are available, the care provider may record this information on the claim form along with his or her signature.

There is no minimum claim amount. If the amount for which you submit a claim exceeds the current balance in your account, the claim will be paid up to the total amount available in your account at the time the claim is processed. If the claim exceeds the current account balance, you will be reimbursed the balance of your claim in installments as you make additional contributions to your account through payroll deductions.

If a claim is denied in whole or in part, you will receive an Explanation of Benefits (EOB) providing the reasons for the denial. If you wish to appeal the denial, you may contact Inspira Financial, the Claims administrator at 800-284-4885.

A decision will be made on your appeal within 60 calendar days after your request is received, unless special circumstances apply; in this case, you will receive notice that up to 60 additional days may be required.

Claims administrator decisions concerning claims appeals will be final and binding on you, your dependents and all other interested parties. In no event will you or a family member be entitled to challenge a decision of the Claims administrator in court or in another administrative proceeding until you exhaust all administrative procedures outlined above.

Health Savings Account (HSA)

You may use a Inspira Financial debit card to pay qualified medical expenses at the time of service; alternatively, you may go online to the Inspira Financial website and request funds to be sent to the provider or to you as reimbursement.

Disability Benefits

The following guidelines apply to filing a claim for benefits from the University-sponsored Long Term Disability Plan offered through MetLife.

Plan	How to File a Claim	Filing Deadline
Long Term Disability	<ul style="list-style-type: none"> • If MetLife is already managing Extended Sick Time (EST) benefits on your behalf, you will receive written notification from MetLife about 90 days prior to the scheduled start date of your LTD benefits • If MetLife is NOT already managing EST benefits on your behalf, you must provide MetLife initial written notice of your LTD benefits claim within the prescribed timeframe (as noted at right); if notice cannot be given within that time, it must be provided as soon as reasonably possible after that. • Notice must include your name, address and the policy number. • Within 15 days after receipt of notice, you will be sent forms with which to provide proof of loss (see definition below). 	<ul style="list-style-type: none"> • Initial written notification must be received within 20 days of the date on which Disability begins (unless MetLife is already managing EST benefits on your behalf)

Proof of Loss may include but is not limited to the following:

- Documentation of:
 - The date your Disability began
 - The cause of your Disability
 - The prognosis of your Disability
 - Your Pre-Disability Earnings, Current Monthly Earnings or any income, including but not limited to copies of your filed and signed federal and state tax returns, and
 - Evidence that you are under the Regular Care of a Physician
- Any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes
- The names and addresses of all:
 - Physicians or other qualified medical professionals you have consulted
 - Hospitals or other medical facilities in which you have been treated, and
 - Pharmacies which have filled your prescriptions within the past three years
- Your signed authorization for MetLife to obtain and release:

- Medical, employment and financial information; and
- Any other information MetLife may reasonably require
- Your signed statement identifying all Other Income Benefits, and
- Proof that you and your dependents have applied for all Other Income Benefits which are available.

You will not be required to claim any retirement benefits, which you may only get on a reduced basis. All proof submitted must be satisfactory to The Harford.

To assist in determining if you are Disabled, or to determine if you meet any other term or condition of the policy, MetLife has the right to require you to:

- Meet and interview with our representative, and
- Be examined by a physician, vocational expert, functional expert, or other medical or vocational professional of MetLife's choice.

Any such interview, meeting or examination will be:

- At MetLife's expense, and
- As reasonably required by MetLife.

Your Additional Proof of Loss must be satisfactory to MetLife. Unless MetLife determines you have a valid reason for refusal, MetLife may deny, suspend or terminate your benefits if you refuse to be examined or meet to be interviewed by MetLife's representative.

Written Proof of Loss must be sent to MetLife within 90 days after the start of the period for which MetLife is liable for payment. If proof is not given by the time it is due, it will not affect the claim if:

- It was not possible to give proof within the required time, and
- Proof is given as soon as possible, but
- Not later than 1 year after it is due, unless you are not legally competent.

MetLife may request Proof of Loss throughout your Disability. In such cases, MetLife must receive the proof within 30 days of the request.

Filing an Appeal

If a claim for benefits is wholly or partly denied, you will be furnished with written notification of the decision. This written notification will:

- Give the specific reason(s) for the denial
- Make specific reference to The Policy provisions on which the denial is based
- Provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary, and
- Provide an explanation of the review procedure.

On any claim, you or your representative may appeal to MetLife for a full and fair review. To do so you:

- Must request a review upon written application within:
 - 180 days of receipt of claim denial if the claim requires MetLife to make a determination of Disability,
 - or

- 60 days of receipt of claim denial if the claim does not require MetLife to make a determination of Disability, and
- May request copies of all documents, records, and other information relevant to Your claim; and
- May submit written comments, documents, records and other information relating to your claim.

MetLife will respond to you in writing with its final decision on the claim.

If you have any questions about the claims procedures or the review procedure, write or call the Claims administrator (see [Administrative Information](#)).

Life Insurance & Other Financial Protection Plans

The following guidelines apply to filing a claim for benefits from the University-sponsored life insurance plans offered through MetLife.

Plan	How to File a Claim	Filing Deadline
Basic Term Life Insurance Supplemental Term Life Insurance Spouse Term Life Insurance Child Term Life Insurance	<ul style="list-style-type: none"> ▪ Provide initial written notice of death or accidental injury to Benefits and submit proof of loss (e.g., death certificate) as soon as possible. ▪ Benefits will forward the proof of loss – and, if applicable, a Death Claim Form, your Beneficiary Designations and proof of enrollment – to the Claims administrator. ▪ In the event of: <ul style="list-style-type: none"> • A non-death loss – you will receive the benefit paid either through a benefits checkbook (if benefits are \$5,000 or more) or a lump sum check made out to you. • The death of a spouse, partner or child – you will receive the benefit paid either through a benefits checkbook (if benefits are \$5,000 or more) or a lump sum check. • Your death – your designated Beneficiary(ies) will receive the benefit paid either through a benefits checkbook (if benefits are \$5,000 or more) or a lump sum check. 	<ul style="list-style-type: none"> • Initial written notification must be received within 30 days of date of loss • Written proof of loss (e.g., death certificate) must be received within 90 days of date of loss
Business Travel Insurance	<ul style="list-style-type: none"> • Provide initial written notice of a loss to Benefits and submit proof of loss as soon as possible • Benefits will forward the proof of loss – and, if applicable, a Death Claim Form, your Beneficiary Designations and proof of enrollment – to the Claims administrator • In the event of: <ul style="list-style-type: none"> – A non-death loss – you will receive the benefit paid in a lump sum check made out to you. – Your death – your designated Beneficiary(ies) will receive the benefit paid in a lump sum check. 	<ul style="list-style-type: none"> • Written proof of loss (e.g., death certificate) must be received within 90 days of date of loss

The Claims administrator will pay all life insurance claims within 90 days of receipt of due proof of loss or, if special circumstances apply (such as the need to obtain additional information) within 180 days of that date. The Claims administrator will provide written notice when all information required to process and pay the claim has been received.

Note: You may designate a representative to act for you in the review process. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.

After submission of a claim by you, your Beneficiary or your authorized representative acting on behalf of you (each a “claimant”), the Claims administrator will notify the claimant of its decision regarding the claim.

Filing an Appeal

If a claim is denied in whole or in part, the notice the claimant receives from the Claims administrator will include:

- The reason(s) for the denial
- A reference to the plan provisions on which the denial is based
- A description of additional information which may be necessary to perfect the appeal, and
- An explanation of how the claimant may have the claim reviewed by the Claims administrator if the claimant does not agree with the denial.

If the claimant would like the claim to be reviewed, the claimant must submit a written request to the Claims administrator within 60 days after receipt of the notice of the denial. The claimant should send the request – which should include the reason(s) why the claimant does not agree with the denial – to:

MetLife
Attn: Group Life Claims Dept.
P. O. Box 6100
Scranton, PA 18505-6100

If you have any questions about the claims procedures or the review procedure, write or call the claim administrator (see [Administrative Information](#)).

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

Tuition Benefits

To qualify for tuition benefits under the Employee Reduced Tuition Plan, Employee Portable Tuition Plan, Employee NU Certificate Tuition Plan, Dependent Reduced Tuition Plan or Dependent Portable Tuition Plan, you must be a full-time employee as of the first day of the term for which the benefit is being requested. **Note:** If you lose eligibility during a term of study, the tuition benefit will be provided through the end of that term.

To file an application for tuition benefits:

- Complete the appropriate tuition benefits application [online](#)
- Include a signed copy of your most recently filed IRS Form 1040 as proof of dependency for the Dependent Reduced Tuition Plan or Dependent Portable Tuition Plan.
- Attach additional documentation (e.g., an invoice, proof of payment, proof of full-time student status) – if you are applying for benefits from the Employee Portable Tuition Plan, Employee NU Certificate Tuition Plan or the Dependent Portable Tuition Plan.

Submit your completed application and supporting materials online at AskHR@northwestern.edu.

The application should be submitted within:

- The calendar year for which the benefit is being requested – if you are applying for benefits from the Reduced Tuition Plans.
- Within one year after the first day of the term of study for which the benefit is being requested – if you are applying for benefits from the Portable Tuition Plans.

Coordination of Benefits and Right of Reimbursement

Coordination of Benefits

Coordination of Benefits (COB) applies when you have health care coverage through more than one group program. The purpose of COB is to ensure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify the Claims Administrator of the existence of such group coverages.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

- The coverage under which the patient is the eligible person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining allowable charges.
- When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this "birthday" type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary. However, when the parents are:
 - Separated or divorced and the parent with custody of the child has not remarried – the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody.
 - Divorced and the parent with custody of the child has remarried – the benefits of a contract that covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract that covers that child as a dependent of the stepparent. The benefits of a contract that covers that child as a dependent of the stepparent will be determined before the benefits of a contract that covers that child as a dependent of the parent without custody.

Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract that covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract that covers the child as a dependent child. It is the obligation of the person claiming benefits to notify the Claims administrator, and upon its request to provide a copy, of such court decree.

If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

The Claims administrator has the right in administering these COB provisions to:

- Pay any other organization an amount, which it determines to be warranted if payments that should have been made by the Claims administrator have been made by such other organization under any other group program.

- Recover any overpayment, which the Claims administrator may have made to you, any provider, insurance company, person or other organization.

Right of Reimbursement

If you or one of your covered family members incur expenses for sickness or injury that occurred due to negligence of a third party and benefits are provided for Covered Services under a plan described in this handbook, you agree:

- The Claims administrator has the rights to reimbursement for all benefits the Claims administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of sickness or injury, in the amount of the total allowable charge or provider's claim charge for Covered Services for which the Claims administrator has provided benefits to you, reduced by any average discount percentage applicable to your claim or claims.
- The Claims administrator is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Claims administrator provided for that sickness or injury.

The Claims administrator shall have the right to first reimbursement out of all funds you, your covered dependents, or your legal representative, are or were able to obtain for the same expenses for which the Claims administrator has provided benefits because of that sickness or injury.

You are required to furnish any information, assistance, or documents that the Claims administrator may reasonably require in order to obtain its rights under this provision. This provision applies whether the third party admits liability.

9 Important Terms

This section provides an alphabetic listing of key terms used in this handbook (and which are shown with initial caps throughout). For many of these terms a definition is provided with their first reference within this handbook. Definitions of additional terms are also available in plan-specific Certificates of Coverage.

Accelerated Death Benefit

A feature of your University-sponsored life insurance coverage that will provide payment of a portion of your Basic Term Life Insurance and, if elected, Supplemental Term Life Insurance in the event you are diagnosed with a terminal illness and a life-expectancy of 24 months or less. For more information, see [Accelerated Death Benefit](#).

Accidental Death and Dismemberment Insurance/AD&D Insurance

AD&D coverage is included in all four types of University-sponsored term life insurance – Basic, Supplemental, Spouse, and Child, as well as in University-sponsored Business Travel Insurance. This coverage provides a benefit in an amount up to the applicable life insurance amount if you – or your covered spouse, partner, or child – experience a loss of life, limb, sight, or hearing, become paralyzed or suffer certain other losses as the result of an accident. For more information, see [Accidental Death and Dismemberment \(AD&D\) Insurance](#).

After-tax Contributions/Premiums

Contributions or Premiums deducted from your pay after your taxes are calculated. After-tax Contributions and After-tax Premiums have no impact on your taxable income.

Annual Base Benefits Rate (ABBR)

For purposes of determining your health insurance premium, this is the University salary you are receiving on an annual basis as of September 1 of the preceding year (or, if newly hired, your new hire salary). Your ABBR does not include any bonus payments, honoraria, summer salary or overtime pay you may receive. The ABBR is only calculated once per year and will only change if you transition from full-time to part-time or part-time to full time. Otherwise, any salary adjustment will not change your ABBR.

Annual Base Salary

For purposes of determining your life insurance coverage, this is the University salary you are receiving on an annual basis as of September 1 of the preceding year (or, if newly hired, your new hire salary). Your Annual Base Salary does not include any bonus payments, honoraria, summer salary or overtime pay you may receive.

Note: If you are paid on a bi-weekly basis, the benefits base amount is your bi-weekly scheduled hours multiplied by your hourly rate and multiplied by 26.1 (because there are 26.1 bi-weekly pay period in a calendar year).

Appropriate Care / Treatment

For purposes of your long term disability benefits, this means medical care and treatment that is given by a physician whose medical training and clinical specialty are appropriate for treating your Disability; consistent in type, frequency, and duration of treatment with relevant guidelines of national medical research, health care coverage and governmental organizations; consistent with a physician's diagnosis of your Disability; and intended to maximize your medical and functional improvement.

Beneficiary(ies)

The person(s) – parent, spouse, child or other relative or friend – designated to receive life insurance benefits in the event of the death of the covered individual. You may also designate a Trust as a Beneficiary.

Beneficiary Designation

The individual(s) and/or Trust you name to receive life insurance benefits in the event of your death.

Benefits

This University office – within the Office of Human Resources – oversees and administers the University-sponsored health & welfare, and educational assistance benefits described in this handbook. If you have any questions about this summary, you may contact Benefits at **847-491-4700**.

Benefits-eligible Employee

This is a University employee who works in a Benefits-eligible Employee Classification and otherwise meets all eligibility criteria for a benefit plan. Eligibility guidelines may vary from plan-to-plan. If you have any questions regarding your eligibility for a particular plan, see [Eligibility](#) or call Benefits at **847-491-4700**.

Certificate of Coverage

This is the legal document that governs the operation of a benefit plan.

Coinsurance

The percentage of your health care cost that you must pay after meeting the Deductible or Copayment. For example, a plan may cover 80% of the cost of a service and leave you responsible for 20% of the cost; the 20% you pay is your Coinsurance.

Consolidated Omnibus Budget Reconciliation Act/COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1986 is a federal law that regulates the conditions and manner under which an employer can offer continuation of group health insurance to employees and their eligible family members whose coverage would otherwise end.

Contingent Beneficiary

An individual who will receive life insurance benefits only if the primary beneficiaries are deceased. For example, an individual who has a spouse and two children may designate benefits to be paid first to the spouse and then to the children if the spouse is deceased. The children are considered Contingent Beneficiaries. It is not mandatory to designate a Contingent Beneficiary, though it is recommended.

Conversion of Coverage

This term refers to the opportunity to convert your University-sponsored life insurance coverage from a University-sponsored group insurance plan to an individual policy. For more information, see [Conversion of Coverage](#).

Copayment

The flat dollar amount that you pay at the time you receive health care services. For example, you may pay a \$25 Copayment for a physician's visit. Copayments do not count toward your annual Deductible. Health care Copayments do count toward your Out-of-pocket Maximum.

Coverage Tier

The different categories or "tiers" defining the eligible family members to whom you wish to extend coverage under your University-sponsored health, dental or vision plans.

Covered Services

Specified services or supplies for which a medical, dental, or vision plan will provide benefits.

Current Monthly Earnings

Your monthly base salary excluding any bonuses, honoraria, and overtime wages earned.

Deductible

The Deductible is the dollar amount that you need to pay out-of-pocket before your health care plan begins to pay benefits. (Generally, the larger your Deductible, the smaller your Premium contribution.)

Disabled or Disability

Disability (or being Disabled) means that, due to Sickness or as a direct result of an accidental injury:

- You are receiving Appropriate Care and Treatment and complying with the requirements of such treatment;
- You are, during the Elimination Period and for the next 24 months: .
 - Unable to earn more than 80% of your Pre-disability Earnings at your own occupation for any employer in the National Economy; and
 - Unable to perform each of the material duties of your own occupation for any employer in the National Economy; and
- You are, after such period:
 - Unable to earn more than 60% of your Pre-disability Earnings at any gainful occupation for any employer in the National Economy; and
 - Unable to perform the duties of any gainful occupation for any employer in the National Economy for which you are reasonably qualified taking into account your training, education and experience.

If you are Disabled and have received a monthly benefit for 12 months, your Pre-disability Earnings will be adjusted only for purposes of determining whether you continue to be Disabled and for calculating the Return to Work Incentive, if any. The initial adjustment and annually thereafter, MetLife will add to your Pre-disability Earnings the lesser of 10% or the annual rate of increase in the Consumer Price Index for the prior calendar year.

Elimination Period

For purposes of qualifying for Long Term Disability benefits, your Elimination Period is the longer of the number of consecutive days at the beginning of any one period of Disability which must elapse before benefits are payable or the expiration of any Northwestern sponsored short term disability benefits or salary continuation program, excluding benefits required by state law. **Note:** If you become Disabled, satisfy the 180-day Elimination Period, and are approved for LTD benefits, the Premiums you pay for buy-up benefit coverage will be waived during your Disability.

Employee Retirement Income Security Act/ERISA

The Employee Retirement Income Security Act of 1974 (as amended), which specifies certain rights for benefit plan participants and responsibilities for benefit plan “fiduciaries” (those responsible for the operation of a plan). ERISA also specifies guidelines participants may follow to enforce their rights.

Evidence of Insurability

A statement of your medical history provided on an [Evidence of Insurability](#) form. Any increase in Supplemental or Spouse Term Life Insurance coverage beyond the Guaranteed Coverage limits that apply under those two plans will not take effect until MetLife approves your Evidence of Insurability. Evidence of Insurability is also required if you enroll in the additional 10% of voluntary coverage under the LTD plan more than 31 days after your date of hire.

Flexible Spending Account/FSA

A tax advantaged account into which you make contributions to pay for eligible health or dependent care expenses, such as Deductibles, Copayments, and some health care services not covered by the health care plan. Northwestern offers three FSAs: a Health Care FSA, a Dependent Care FSA and, for participants in the Value PPO health plan, a Limited Use FSA (in place of the Health Care FSA).

Genetic Nondiscrimination Act/GINA

The Genetic Information Nondiscrimination Act of 2008, which prohibits the use of genetic information in health insurance and employment. GINA prohibits group health plans and health insurers from denying coverage to a healthy individual or charging that person higher Premiums based solely on a genetic predisposition to developing a disease in the future. The legislation also bars employers from using individuals' genetic information when making hiring, firing, job placement, or promotion decisions

Guaranteed Coverage

This is the amount of life insurance coverage for which you are eligible without having to provide Evidence of Insurability.

Health Insurance Portability and Accountability Act/HIPAA

The Health Insurance Portability and Accountability Act of 1996 sets standards and guidelines which are designed to protect the security and privacy of personal health information. These standards and guidelines are also meant to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in the U.S. health care system.

Health Maintenance Organization/HMO

A Health Maintenance Organization, or HMO, is a health plan that pays benefits only for health care services received from a Network of physicians and hospital providers, and (except in the case of an emergency) only for services approved in advance by your Primary Care Physician (PCP).

Health Savings Account/HSA

A special investment account established by people who are enrolled in a high-deductible health care plan such as the Value PPO plan; it is used to pay for current and future medical expenses.

Hospice Care

A centrally administered program designed to provide for the physical, psychological and spiritual care of a dying person and his or her family. The goal of Hospice Care is to allow the dying process to proceed with minimum discomfort while maintaining dignity and quality of life.

Illinois Infertility Mandate

An Illinois law that requires insurance companies and fully-insured plans to provide coverage for infertility to employee groups of more than 25 members. The law does not apply to self-insured plans or to Trusts or insurance policies written outside of Illinois. For details, see [Illinois Infertility Mandate](#).

Imputed Income

Any University-paid Basic Life Insurance in excess of \$50,000 will be treated as Imputed Income; the Premium cost that applies to these coverage amounts will be included as taxable income on your annual Form W-2 for tax reporting purposes.

In-Network

Treatment and services received from a provider that is a member of the provider Network offered through a University-sponsored health, dental or vision plan. The plans are designed to provide a higher level of benefits for In-Network services than for treatment and services received Out-of-Network.

Leave of Absence/LOA

The University grants leaves of absence for medical care for oneself, family care, some personal reasons, and for military duty. With a Leave of Absence, you may under some circumstances temporarily leave a University position with an intention to return to active University employment and during the leave maintain a relationship with the University that provides access to certain benefits and does not break service. For more information, see [Leaves of Absence](#).

Length of Stay Review

A feature of the Medical Services Advisory (MSA) Program which requires PPO health plan participants to get MSA approval for any extension of a hospital stay beyond the length of stay set upon completing the initial preadmission or emergency review. For details – including information about penalties that apply for not contacting the MSA (or not following the MSA’s recommendations), see [Medical Services Advisory Program](#).

Limited Use FSA

This type of account is offered as an alternative to a Health Care FSA if you elect coverage under the Value PPO health plan; if you are enrolled in that plan you cannot participate in a Health Care FSA. Like a Health Care FSA, this type of account is designed to help you set aside tax-free dollars to pay your share of eligible expenses. Until you meet the Value PPO health plan’s annual Deductible each year, you may use the account to reimburse only eligible dental and vision care expenses; once you meet the Value PPO’s annual Deductible, however, you may use contributions in your Limited Use FSA to reimburse eligible health care expenses, too. For more information, see [Limited Use FSA](#).

Loss of Use Benefit

This benefit is paid under Accidental Death and Dismemberment (AD&D) Insurance coverage if you or a covered spouse or child experiences permanent, total and irreversible paralysis of a limb – or irrecoverable loss of speech or hearing in both ears – as the result of an accidental injury. For more information – including details regarding the circumstances under which this benefit will be paid – see [Loss of Use Benefit](#).

Medical Services Advisory Program/MSA Program

A program under the Premier, Select and Value PPO health plans which requires that certain services be subject to preadmission and length of service review by Blue Cross BlueShield’s Office of the Medical Services Advisor. This program is designed to maximize the benefits you can receive through your PPO coverage. For details – including information about penalties that apply for not contacting the MSA (or not following the MSA’s recommendations), see [Medical Services Advisory Program](#).

Monthly Benefit

If you are Disabled, this is the benefit payment you are entitled to receive each month, as calculated by MetLife.

Network

A group of doctors, hospitals, and pharmacies organized by a health care plan to provide health care services to covered participants. To get the maximum coverage for the lowest cost, you generally must use the plan’s Network. (In a PPO, you have the option to use Out-of-Network providers, but you will usually pay more for these services.)

Ombudsman

This is a person who investigates and attempts to resolve complaints and problems.

Other Income Benefits

Other Income Benefits means the amount of any benefit for loss of income, provided to you or your family, as a result of the period of Disability for which you are claiming benefits under the policy.

Out-of-Network

Treatment and services received from a provider that is not a member of the provider Network offered through a University-sponsored medical, dental or vision plan. The plans are designed to provide a lower level of benefits for Out-of-Network services than for treatment and services received In-Network.

Out-of-pocket Maximum

The maximum amount that you pay out-of-pocket each year for health care services. This includes Deductibles, Coinsurance and health care Copayments. Most health care plans have a yearly maximum for out-of-pocket

expenses. Once you reach the maximum for the period, the plan pays 100% for any remaining covered health care expenses.

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act of 2010 is a comprehensive health reform law that is designed to expand coverage, control health care costs and improve the health care delivery system. The law includes certain provisions that affect employer-sponsored benefit plans.

Portability of Coverage

This term refers to the opportunity to “port” your Basic and/or Supplemental Term Life Insurance coverage if this coverage – or any portion of it – terminates. If you elect to port this coverage, it will continue in effect as long as you pay the required Premiums MetLife. **Note:** This feature also applies to any coverage you elect for your spouse or partner under Spouse Term Life Insurance. For more information, see [Portability of Coverage](#).

Post-service Claim

A claim for payment of benefits after care has been received. For example, a claim that is submitted after you go to the doctor’s office is a Post-service Claim, as is a claim for reimbursement from your Health Care Flexible Spending Account.

Pre-Disability Earnings

Your Pre-Disability Earnings is your contracted annual rate of pay from Northwestern University divided by the number of pay periods occurring in the pay cycle established by you and the University prior to your date of Disability. So, Pre-Disability Earnings for:

- **Faculty** – means your contracted annual rate of pay from the University in effect prior to your date of Disability divided by 12. This does not include summer salary, honoraria or consulting fees.
- **Hourly employees** – means your bi-weekly scheduled hours multiplied by your hourly rate of pay from the University in effect prior to your date of Disability and then multiplied by 26.1 (there are 26.1 bi-weekly pay periods in a year) divided by 12. This does not include overtime.
- **All other employees** – means your contracted annual rate of pay from the University in effect prior to your date of Disability divided by 12. This does not include overtime, summer salary, or bonus payments.

Pre-existing Condition

For purposes of Long Term Disability benefits, a Pre-existing Condition means an accidental injury or sickness for which you:

- received medical treatment, consultation, care, or services; or
- took prescribed medication or had medications prescribed;

in the six months before Your insurance takes effect.

Benefits will not be paid, or any increase in benefit amounts due to an elected increase in the amount of your insurance for a Disability that results from a Pre-Existing Condition if you have been actively at work for less than 12 consecutive months after the date disability insurance, or the elected increase in the amount of insurance takes effect.

Pre-tax Contributions/Premiums

Contributions or Premiums deducted from your pay before your taxes are calculated. Pre-tax Contributions or Premiums reduce your taxable income (the income used to calculate your taxes) and so they reduce the income taxes you pay.

Preferred Provider Organization/PPO

A type of health plan that enables members to choose to receive care from ANY licensed doctor, hospital or facility but that pays higher benefits for “In-Network” services (that is, services performed by members of a

“preferred” provider Network). The Premier, Select and Value PPO health plans – and the Dental PPO plan – offer PPO coverage.

Premium

This is the dollar amount you pay toward the cost of your coverage.

Preventive Care

The term used for regularly scheduled checkups with your doctor to identify health risks and prevent, diagnose, and treat illnesses so they can be found in early, more treatable stages.

Primary Beneficiary

An individual who is designated to receive life insurance benefits, in the event of the employee’s death. For example, an individual who has a spouse and two children may designate benefits to be paid first to the spouse and then to the children if the spouse is deceased. The spouse is considered the Primary Beneficiary.

Primary Care Physician/PCP

A physician you choose to have primary responsibility for overseeing your health care and to provide referrals to specialists, as required. If you enroll in an HMO, you usually must select a PCP.

Qualified Domestic Relations Order/QDRO

A decree or order issued by a court that establishes the rights of another person under a benefit plan.

Qualified Medical Child Support Order/QMCSO

A judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under a group health plan, and which satisfies certain conditions. For details, see [Qualified Medical Child Support Order](#).

Qualifying Event/Qualifying Change in Family or Employment Status

A change in family or employment status – as defined by the IRS – after which you may change your health and welfare elections. For more information, see [Benefit Changes](#).

Trust

A legal and financial arrangement used to manage an individual’s assets in the event of his or her death. There are a variety of Trust arrangements. If an individual is interested in learning more about Trusts or establishing a Trust, he or she should consult a licensed attorney experienced with Trusts and estate planning.

Trustee

This is the manager of a trust, usually a bank or Trust company.

Uniformed Services Employment and Reemployment Rights Act/USERRA

The Uniformed Services Employment and Reemployment Rights Act protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Urgent Care/Expedited Clinical Claim

A claim for medical care or treatment when a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your health condition, could cause severe pain that cannot be adequately managed without the requested care or treatment.

VESSA

The Victims' Economic Security and Safety Act (VESSA) promotes employment security, economic stability, and safety for employees coping with domestic or sexual violence. VESSA permits eligible employees to take unpaid, job-guaranteed leave from employment to deal with domestic violence, sexual violence, dating violence, or stalking. VESSA also prohibits covered employers from discrimination regarding the conditions or privileges of employment based on an employee's status as a survivor of domestic or sexual violence or as an employee with a family or household member who is a survivor of domestic or sexual violence or based on any request for leave or other accommodations allowed under the law.

Will

A legal document that provides instructions on how an individual wishes his or her personal property, financial assets and personal belongings to be distributed in the event of his or her death. It may also specify instructions for funeral and related arrangements. An individual should write a Will in order to appoint guardians for any minor children, and Trustees to manage their property. If an individual does not leave a Will, the court may appoint a guardian. A Will should be updated following family and other status changes. A Will must be witnessed and signed by an individual who is not a spouse, Beneficiary or executor.

Wellness Benefits

University-sponsored benefits and programs designed to encourage Faculty, Staff and other employees to practice healthy lifestyles. These benefits and programs are offered throughout the year to teach and support healthier behaviors.

10 Administration Information

This section provides administrative facts and details for each plan, including plan sponsor, employer ID number, plan administrator, agent for service of legal process, as well as plan numbers, group numbers (where applicable), type of plan, plan year, Claims administrator, Trustee (where applicable) and contributions.

Applicable to All Plans	Plan Sponsor	Northwestern University 1800 Sherman Ave Evanston, IL 60201 847-491-4700
	Employer ID Number	36-2167817
	Plan Administrator	Director, Benefits Northwestern University 1800 Sherman Ave Evanston, IL 60201 847-491-4700
	Agent for Service of Legal Process	Office of General Counsel 633 Clark Street Evanston, IL 60208-1143
Medical Plans	Plan Name	Northwestern University Medical PPO Premier Plan Northwestern University Medical PPO Select Plan Northwestern University Medical HDHP Plan/ Northwestern University HSA Value Plan Northwestern University HMO Illinois
	Plan Number	PPO: 506 HMO: 514
	Group Numbers	PPO: 906161, 806161, 006168, 006171 HMO: H56670
	Date Established	PPO: May 1, 1974 HMO: January 1, 1989
	Type of Plan	PPO: Self-insured welfare benefit plan HMO: Fully insured welfare benefit plan
	Plan Year	January 1 – December 31
	Claims Administrator	BlueCross BlueShield of Illinois 300 East Randolph Street Chicago, IL 60601 800-654-7385 Express Scripts, Inc. Attn: STD Accts PO Box 66538 St. Louis, MO 63166-6583 800-451-6245
	Trustee	PPO and HMO prescription drugs: Northern Trust 50 South LaSalle Street Chicago, IL 60603
	Contributions	Employer and employee paid

Dental Plans	Plan Name	PPO: Northwestern University Dental Plan HMO: Northwestern University Guardian DMO Dental Plan
	Plan Number	PPO: 509 HMO: 517
	Group Numbers	PPO: F019106-0001 HMO: 378954
	Date Established	PPO: January 1, 1991 HMO: January 1, 1991
	Type of Plan	PPO: Self-insured welfare benefit plan HMO: Fully insured welfare benefit plan
	Plan Year	January 1 – December 31
	Claims Administrator	PPO: BlueCross BlueShield of Illinois 300 East Randolph Street Chicago, IL 60601 800-654-7385 HMO: Guardian P.O. Box 659010, Sacramento, CA 95865-9010 888-715-0760
	Trustee	PPO: Northern Trust 50 South LaSalle Street Chicago, IL 60603
	Contributions	Employer and employee paid
Vision Care Plan	Plan Name	Northwestern University Vision Plan
	Group Number	F019106
	Date Established	January 1, 2011
	Type of Plan	Fully insured welfare benefit plan
	Plan Year	January 1 – December 31
	Claims Administrator	EyeMed Vision Care 4000 Luxottica Place Mason, OH 45040
	Contributions	Employee paid
Flexible Spending Account (FSA)	Plan Name	Northwestern University Flexible Spending Account Plan
	Plan Number	512
	Date Established	April 1, 1985
	Type of Plan	Fringe benefit
	Plan Year	January 1 – December 31
	Claims Administrator	Inspira Financial Flex Dept. P.O. Box 981158 El Paso, TX 79998-1158 www.Inspirafinancial.com 800-284-4885
	Contributions	Employer and employee paid

Health Savings Account (HSA)	Plan Name	Northwestern University Health Savings Account Plan
	Plan Number	512
	Date Established	January 1, 2007
	Type of Plan	Fringe benefit
	Plan Year	January 1 – December 31
	Claims Administrator	Inspira Financial Flex Dept. P.O. Box 981158 El Paso, TX 79998-1158 www.inspirafinancial.com 800-284-4885
	Contributions	Employer and employee paid
Long Term Disability Plan	Plan Name	Northwestern University Long Term Disability Plan
	Plan Number	523
	Policy Number	236559-1-G
	Date Established	September 1, 2025
	Type of Plan	Fully insured welfare benefit
	Plan Year	January 1 – December 31
	Claims Administrator	MetLife Disability P. O. Box 4590 Lexington, KY 40512-4590 800-396-8876
Term Life Insurance Plans	Contributions	Employer and employee paid
	Plan Name	Northwestern University Basic Term Life & Voluntary AD&D Insurance Plan Northwestern University Supplemental Term Life Insurance Plan Northwestern University Basic Term Life Insurance Plan Northwestern University Supplemental Term Life Insurance Plan
	Plan Number	236559-1-G
	Date Established	January 1, 2025
	Type of Plan	Welfare benefit plan
	Plan Year	January 1 – December 31
	Claims Administrator	MetLife Group Life Claims P. O. Box 18505-6100 Lifeclaimsubmit@metlife.edu 800-396-8876
	Contributions	Basic Term Life Insurance Plan – employer paid Supplemental Term Life Insurance Plan, Spouse Term Life Insurance Plan and Child Term Life Insurance Plan – employee paid

Business Travel Insurance Plan	Plan Name	Northwestern University Business Travel Insurance Plan
	Plan Number	SR227384
	Date Established	January 1 2008
	Type of Plan	Welfare benefit plan
	Plan Year	January 1 – December 31
	Claims Administrator	Reliance Standard Life Insurance Company 2001 Market Street #1500 Philadelphia, PA 19103 800-351-7500
	Contributions	Employer paid
Tuition Benefits	Plan Name	Employee Reduced Tuition Plan Enhanced Employee Reduced Tuition Plan Employee Northwestern Certificate Tuition Plan Employee Portable Tuition Plan Employee Reduced Satellite Tuition Plan Enhanced Employee Reduced Satellite Tuition Plan Dependent Reduced Tuition Plan Dependent Portable Tuition Plan Music Lessons Reduced Tuition Plan
	Plan Number	513
	Date Established	All plans except Employee Portable & Employee NU Certificate Tuition Plans: September 1, 1985 Employee Portable Tuition Plan: September 1, 2011 Employee NU Certificate Tuition Plan: January 1, 2014
	Type of Plan	Tuition assistance plan
	Plan Year	January 1 – December 31
	Claims Administrator	Northwestern University 1800 Sherman Ave Evanston, IL 60201 847-491-4700
	Contributions	Employer paid
Employee Assistance Plan	Plan Name	Northwestern University Employee Assistance Program
	Plan Number	524
	Type of Plan	Employee Assistance Program
	Plan Year	January 1 – December 31
	Claims Administrator	CuraLinc, LLC 314 West Superior Street, Suite 601 Chicago, IL 60654 888-881-5462
	Contributions	Employer paid

11 Your ERISA Rights

All participants are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Participant Rights

ERISA provides that all participants shall be entitled to:

- Receive Information about the University-sponsored benefit plans.
- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing each plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan administrator with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The plan administrator may make a reasonable charge for the copies.
- Receive a summary of each plan's annual report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, your spouse, or your dependents (including civil union partners and their children) if there is a loss of coverage under a plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing these plans on the rules concerning your COBRA continuation coverage rights.
- Reduce or eliminate, if applicable, exclusionary periods of coverage for preexisting conditions under the group health programs, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 University-sponsored plans. The people who operate these plans (called "fiduciaries") have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including the University 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 a plan's latest annual report 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 a plan administrator.

- If you have a claim for a welfare benefit that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan administrator's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.
- If it should happen that the fiduciaries of a plan 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 a University-sponsored benefit plan, you should contact Benefits at **847-491-4700**.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the University, you should contact the nearest office of the Pension and Welfare Benefits 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 NW, Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.