



NORTHWESTERN UNIVERSITY

Health Care Plan

Summary Plan Description

January 2009

PLAN HIGHLIGHTS

Plan Highlights

- The purpose of the Health Care Plan is to provide health insurance coverage to eligible faculty and staff and their family members as protection from the financial burden of catastrophic illness or injury.
- Participation in the Health Care Plan is available to regular status staff scheduled to work at least 17.5 hours per week (half time) and to faculty and exempt staff who are appointed on at least a half-time (50%) basis.
- The University offers employees the selection of several options among two types of health care plans
 - Three Preferred Provider Organization (PPO) plans including a Health Savings Account (HSA) eligible high deductible plan
 - Two Health Maintenance Organization (HMO) plans
- Premiums are paid by payroll deduction on a pre-tax basis which means that deductions are not subject to income or Social Security and Medicare (FICA) taxes. Premiums deducted in a month pay for that month of coverage.
- The University pays 74% overall of the total premium cost for full-time employees (defined as staff scheduled to work a minimum of 35 hours per week and faculty with a 100% appointment). PPO premiums vary based on an individual's annual University benefits base salary.
- Unmarried dependent children are covered through age 26 regardless of student status.
- An employee may enroll his or her same-sex domestic partner and any eligible dependent children of the domestic partner.
- Pre-existing conditions are not covered for 365 days under the PPO Plans though may be reduced or waived by the submitting a certificate of creditable coverage.
- At termination of employment or loss of benefits eligibility, employees are eligible to temporarily continue health coverage under COBRA by paying the full monthly premium cost plus a 2% administrative fee.
- At retirement, employees are eligible to continue health coverage provided years of service and age requirements are met. Retirees pay the full monthly premium cost.

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Purpose	The purpose of the health care plan is to provide insurance protection from the financial burden of catastrophic illness or injury to eligible faculty and staff and their family members.
<u>Plan Administrator</u>	The University is the Plan Administrator and has the responsibility for operating and interpreting the Plan.
<u>Claims Administrator</u>	BlueCross BlueShield of Illinois and Walgreens Health Initiatives are claims administrators for the Premier and Select PPO Plans. BlueCross and Prime Therapeutics are the claims administrators for the Value PPO plan.
<u>Further Information</u>	<p>The information contained in this Summary Plan Description is intended to summarize the major features of the health care plan. It is not intended to be a complete explanation or list of benefits provided by the health care plan. An individual should review the schedule of monthly premium rates and the certificate of insurance issued by the sponsoring insurance company for additional information.</p> <p>An individual may also access information from the web sites of the sponsoring insurance companies.</p> <p>BlueCross BlueShield www.bcbsil.com</p> <p>HMO Illinois www.bcbsil.com</p> <p>UniCare HMO www.unicare.com</p> <p>Walgreens Health Initiatives www.mywhi.com (for Premier PPO, Select PPO and HMO Illinois members)</p> <p>Prime Therapeutics www.rxhealth.com (for Value PPO members)</p> <p>An individual may also contact a representative of the sponsoring insurance company or the University's Benefits Division with any questions.</p>
<u>Continuation of the Plan</u>	<p>The University intends to continue this Plan indefinitely, but reserves the right to modify or terminate the Plan at any time with or without notice.</p> <p>Participation in this Plan is provided to eligible faculty and staff and does not constitute a guarantee of employment. Participation in the Plan also requires continued employment and eligibility and is subject to the terms and conditions of the Plan Document.</p>

Eligibility

This section summarizes eligibility requirements for participation in the Health Care Plan.

Salary Requirement

An individual must receive University compensation paid by the University's payroll system and his or her University salary must be sufficient to cover the amount of monthly premium deductions.

Classification of Employee

Staff. Regular status staff must be scheduled to work at least 17.5 hours per week (half time).

Bargaining unit employees should refer to union contracts.

Faculty. Faculty must be appointed on a full-time or part-time basis (half-time or greater) 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 2 consecutive quarters.

Academic Full-Time and Half-Time Faculty. Such individuals must be compensated exclusively by one or more of the following affiliated McGaw Medical Center institutions including the University, Northwestern Memorial Hospital (NMH), Northwestern Medical Faculty Foundation (NMFF), Children's Memorial Hospital and its related faculty practice plans, the Rehabilitation Institute of Chicago, and the VA Lakeside Medical Center.

NMFF income does not qualify to cover the amount of monthly premium deductions. An individual's University salary must be sufficient to cover deductions.

Contributed Service Faculty. Medical School faculty who volunteer to participate in the academic activities of the Medical School without direct financial compensation. Such individuals are not eligible to participate in the Health Care Plan.

Phased Retirement Faculty. Faculty who enter into a Phased Retirement Agreement continue to be eligible for health insurance coverage and pay full time premium rates.

ROTC Faculty. Employees, who serve as full-time faculty for ROTC and NROTC programs on campus, while not paid by the University, are not eligible to participate in the Health Care Plan.

Post Doctoral Fellows. Individuals classified as a Post Doctoral Fellow and appointed on at least a half-time basis are eligible to participate in the Health Care Plan.

Post Doctoral Fellows – NRSA. Individuals classified as a Post Doctoral Fellow funded by NRSA and appointed on at least a half-time basis and meet specified salary criteria are eligible to participate in the Health Care Plan though may not make contributions to an FSA or HSA account.

Visiting Personnel. Individuals with academic appointments of half time or greater appointment at the rank of professor, associate professor and assistant professor are eligible to participate in the University's benefit plans. Visiting personnel without academic appointments inclusive of Pre-Doctoral Fellows are eligible to purchase a general health insurance policy available through the Office of Risk Management.

Disabled Employees. An employee who becomes permanently and totally disabled while working for Northwestern University and is receiving University-sponsored Short or Long Term Disability benefits remains eligible to participate in the Health Care Plan. Individuals receiving Short Term Disability benefits may elect to enroll in the High Deductible Health Plan but may not make contributions to the Health Savings Account.

Employees on a leave of absence. An employee on a paid leave of absence may continue participation in the Health Care Plan.

An employee on a leave of absence without pay may continue Health coverage by paying the monthly premium to the University.

Reduced work calendar staff. An employee whose department work schedule is less than the standard 26.1 pay periods per year continues to be eligible for dental coverage and pay the full-time premium rates.

Duration of Eligibility

Active employees. Contributions to and participation in the Plan may continue to be made by payroll deduction for as long as an individual remains an eligible employee and receives a University salary.

Retired employees. Individuals who retire from University employment and have met specified age and service requirements and are a health plan participant as of the date of retirement are eligible to continue University sponsored health insurance coverage. Retirees must:

- be participating in a University sponsored health plan, and
- be at least age 55, and
- have accumulated at least ten years of continuous, full-time service.

Age at Retirement	Service Requirement	
	Full Time	Part Time
55	10	10
56	10	10
57	10	10
58	9	10
59	8	10
60	7	10
61	6	9
62	5	8
63	4	7
64	3	6
65+	2	2

Participation in the Plan may continue as long as the retiree submits the premium payment to the University.

Should the retiree die, the surviving spouse and dependent children may continue University sponsored health insurance coverage under the retiree plan. This eligibility ceases upon remarriage of the spouse or adoption or marriage of the child.

Employees, who leave NU at age 55 or older and have accumulated less than the specified service requirements for their age, may elect to continue health insurance coverage for a limited period under COBRA provisions.

Deceased Employees. A spouse or dependent child of a deceased employee is eligible for University sponsored health insurance coverage under the retiree plan for as long as he or she desires such coverage and continues to pay the established total monthly premium on a timely basis. This eligibility ceases upon remarriage of the spouse or adoption or marriage of the child.

Other Eligible
Individuals

Spouse. A spouse must be legally married to and have his or her principal residence with the eligible employee.

Surviving spouse and children of a deceased employee. An eligible spouse or dependent child of a deceased employee or retired employee may continue participation in the Health Care Plan.

Domestic Partner. An employee may enroll a same-gender domestic partner and eligible dependent children of the domestic partner in Health Care Plan. A Declaration of Same-Gender Domestic Partner Relationship must be completed and submitted to the Benefits Division. The Declaration form is available from the Benefits Division or electronically by download at www.northwestern.edu/hr/benefits.

An opposite gender domestic partner is not eligible to participate in the Health Care Plan.

Dependent child. Coverage is extended to a dependent child to age 26 regardless of student status.

Qualifications for dependent status include those individuals who have their principal resident with an employee, and who rely primarily on an employee for financial support.

Dependent children include unmarried natural, step, legally adopted children, and any children who are in an individual's custody under an interim court order prior to the finalization of adoption proceedings. Any children who are dependent upon an employee for financial support and maintenance because of mental retardation or physical disability will be covered regardless of age if they were covered prior to reaching the limiting age.

Dependent children do not include foster children or grandchildren.

The University reserves the right to require sufficient proof of dependent status in determining eligibility for health coverage.

No individual may be covered more than once under the University's benefit plans.

Parents and grandparents. An employee's parents, grandparents and in-laws are not eligible for University-sponsored health insurance coverage

Plan Options

This section highlights the choice of health care plans and coverage. The University's health care plans vary in the:

- choice of physician and hospital providers,
- coverage of health care services,
- amount of monthly premiums, and
- amount members will pay out of pocket at the time service is received or the amount owed when claims are processed.

An individual may choose from a choice of two types of health care plans, a PPO or an HMO plan. These types of plans vary in the degree of flexibility in choosing a health plan provider, premiums and the amount of out of pocket expenses. Each plan assures members with financial protection from expenses associated with a catastrophic illness or injury. While some individuals are more comfortable with paying more in premium and less in out of pocket expenses, others are more comfortable with paying less in premiums and more in out of pocket expenses. Individuals must therefore make decisions which are best for their personal circumstances.

Out of Pocket Expenditures

Each of the health care plans provide for members to pay a portion of the costs of health care services at the time care is received or after a health claim is processed by the sponsoring insurance company. The different ways members pay for health plan services are the following:

Co-payment. The term "co-payment" refers to the portion of the total expense paid by the member while the plan pays the difference. Co-payments are usually a flat dollar amount and apply to physician office visits, emergency room visits and prescription drugs. Co-payments are paid at the time each service is received and represent a small fraction of the total cost of care.

Co-insurance. The term "co-insurance" refers to a percentage, usually 10% to 30%, of the total expense paid by the member while the plan pays the difference.

Deductible. The term "deductible" refers to the flat dollar amount an individual pays out of pocket for an inpatient hospitalization or outpatient hospital surgery. The Deductible is also the amount of covered expenses an individual pays in full each year before the plan pays.

Out of pocket maximum. The term "out of pocket maximum" refers to the maximum amount an individual will pay in certain co-payments and co-insurance during a year.

Choice of Coverage

An individual may also choose among four levels of coverage based on whether he or she wishes to cover only him or herself or certain family members. These four levels are also referred to a premium coverage tiers.

- You
- You and spouse
- You and child(ren)
- You and spouse and child(ren)

HMOs

The term “HMO” is an abbreviation for Health Maintenance Organization. An HMO plan covers health care services received from a network of hospital and physician providers, HMO plans only cover expenses which are authorized in advance by an individual’s primary care physician. Plan members must therefore select a primary care physician to help coordinate care with other network specialists, such as surgeons, cardiologists, dermatologists and allergists.

The amount of plan coverage is usually 100% after the payment of annual deductibles and co-payments. The co-payment is the portion of the total expense paid by the member while the plan pays the difference. Co-payments usually apply to physician office visits, emergency room visits and prescription drugs.

HMO plans are generally considered fully insured plans. The term “fully insured” means that the plan is funded by both employee and employer contributions paid directly to the HMO. The HMO pays plan expenses and the HMO retains any remaining monies at year-end. It also means that such plans must provide coverage mandated by state law.

HMO-Illinois is an HMO plan offered by BlueCross BlueShield of Illinois. The physician network includes physician groups affiliated with, Advocate and Resurrection (including St Francis of Evanston) hospitals. Northwestern Medical Faculty Foundation (NMFF) physicians are not part of the HMO Illinois provider network.

The prescription drug program for HMO Illinois members is administered by Walgreens Health Initiatives.

UniCare HMO was originated as a joint venture by Rush Presbyterian St. Luke's Medical Center and The Prudential Insurance Company of America. It is now a subsidiary of Wellpoint, a national managed care company. Network hospitals include Northwestern Memorial but not, NorthShore University HealthSystems

The prescription drug program for Unicare HMO members is administered by Wellpoint.

PPOs

The term “PPO” is an abbreviation for Preferred Provider Organization. A PPO plan enables members to choose care from any licensed provider including physicians, hospitals and other health care professionals. Plan benefits are higher if the provider is a member of the BlueCross PPO provider network. The University offers the choice of three PPO plans each differing in plan features such as deductibles, co-payments, co-insurance and monthly premiums. The three plans are:

- Premier PPO Plan
- Select PPO Plan
- Value PPO with an optional HSA Plan

The University’s Premier and Select PPO Plans are self insured plans administered by BlueCross BlueShield of Illinois for hospital and physician services, and by Walgreens Health Initiatives (WHI) for prescription drug services.

The Value PPO plan is also a self insured plan administered by BlueCross for hospital and physician. Prime Therapeutics administers the prescription drug program.

The term “self-insured” refers to plans funded by employee and employer contributions deposited to a trust. Claims and other plan expenses are paid from the trust managed by The Northern Trust Company. Any monies remaining at year-end are retained as plan assets for the payment of future claims and other plan expenses. Self-insured plans 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 BlueCross group (employer sponsored) or individual plans in Illinois or in other states.

Pre-Existing
Conditions Waiting
Period

PPO members are subject to a pre-existing condition waiting period of 365 days. This waiting period means that any medical care an individual received within the 6 months prior to employment with Northwestern University will not be covered for one year. New employees submitting a certificate of health coverage from their previous employer will be given credit for such coverage toward the pre-existing conditions waiting period provided the employee's coverage begin date is within 63 days from the date of leaving their former employer's policy.

Pre-existing condition restrictions do not apply to the prescription drug program or maternity care or to any employees who enroll in or change to any of the three PPO plans during the Open Enrollment period.

Medical Services
Advisory Program

BlueCross BlueShield established the Office of the Medical Services Advisor (MSA) to perform pre-admission review and length of stay review for inpatient services. The Office of the Medical Services Advisor is staffed by trained, registered nurses and consulting physicians under the supervision of the Medical Director.

MSA Penalties. Failure to contact the Medical Services Advisory (1 800: 247-9211) or to comply with the recommendations of MSA will result in LESS benefits for a member of the PPO plans. For example, an assessed benefit reduction for not contacting MSA following an emergency admission will amount to a \$500 reduction in benefits.

Pre-admission review. MSA must be contacted immediately upon notification of a scheduled inpatient hospital admission including:

- Non-emergency inpatient hospital admission
- Non-maternity inpatient hospital admission

Upon notification, MSA will review the medical information provided and discuss the benefits available to a covered individual. The admitting physician may receive a recommendation from the MSA to have care performed on an outpatient basis or to obtain an additional surgical opinion, if surgery has been recommended by a physician.

NOTE: While an individual may be asked by a hospital representative (i.e., Emergency Room Registration staff member) for a BlueCross Identification Card, this request is for registering the type of insurance. Obtaining such information will expedite the submittal of the hospital bill to BlueCross.

A covered individual must still notify MSA or have his or her spouse or other individual contact MSA on the individual's behalf once it is determined that the individual will be admitted

Length of stay review. Upon completing the pre-admission review, the Medical Services Advisor will assign a length of stay for the proposed admission. The hospital will contact MSA in the event the admitting physician recommends an extension of the assigned length of stay. MSA will review the assigned length of stay with the individual's physician to examine the possibility of an alternative to continued hospitalization. MSA will determine whether or not continued hospitalization is medically necessary. Upon completing this review, MSA will decide to either extend the assigned length of stay or to terminate benefits at the expiration of the assigned length of stay due to the finding that continued inpatient hospitalization is not medically necessary.

Prescription Drug
Program

The prescription drug program offered to Northwestern University faculty and staff is established to be competitive with the prescription drug programs offered by other employers, and which follow generally accepted and safe treatment protocols, and which is priced at reasonable levels.

The program covers most of the commonly prescribed medications approved by the Food and Drug Administration (FDA). As with other health plan benefits, the prescription drug program has coverage limitations and exclusions which include the following:

- over the counter medications and other items,
- vitamins other than prenatal medications requiring a prescription,
- topical acne medications,
- Viagra and related medications (PPO),
- weight loss medications,
- blood and blood products,
- cosmetic products, and
- experimental or investigational medications.

Formulary

The term “formulary” refers to an extensive list of available prescription drugs offered by a plan to serve the member pharmaceutical needs of patients. As each plan’s formulary may include or exclude certain medications, individuals should contact the applicable health plan for additional information. The plans cover Neocate and related food supplements.

Co-payments

After an HMO Illinois as well as a PPO Premier or Select plan member obtains a prescription from his or her doctor, he or she has the choice of obtaining the medication from a retail pharmacy or by mail order. These two University’s PPO plans cover the majority (approximately 80%) of prescription costs with plan members paying a small portion or fraction (approximately 20%) of the overall cost. Plan members pay his or her portion of the prescription cost on the basis of a co-payment.

Three tier co-payment structure. Co-payments for prescription drugs are based on a three tier structure. The amount that a health plan member pays for a prescription depends largely upon the medical plan in which he or she is enrolled, the prescribed drug and whether the drug is obtained from a retail or mail order pharmacy. The co-payment amount a member is charged for a specific drug also depends on the co-payment tier where a drug is placed.

Generic drugs are typically set at the lowest co-payment tier, with some brand name drugs set at the second or middle tier and other brand name drugs set at the highest or third tier. The co-payment for a branded drug will be paid whenever the branded drug is purchased, even if a generic alternative is not available

Generic drug (tier one). A generic drug is identical, or bioequivalent to a brand name drug in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. Although generic drugs are chemically identical to their branded counterparts, they are typically sold at substantial discounts compared to the price of a brand name drug. According to the Congressional Budget Office, generic drugs save consumers an estimated \$8 to \$10 billion a year at retail pharmacies. Even more billions are saved when hospitals use generic drugs. To gain FDA approval, a generic drug must:

- contain the same active ingredients as the innovator drug (inactive ingredients may vary)
- be identical in strength, dosage form, and route of administration
- have the same use indications
- be bioequivalent
- meet the same batch requirements for identity, strength, purity, and quality
- be manufactured under the same strict standards of FDA's good manufacturing practice regulations required for innovator products

United States trademark laws do not allow a generic drug to look exactly like the brand-name drug. However, a generic drug must duplicate the active ingredient. Colors, flavors, and certain other inactive ingredients may be different.

Generic drugs are less expensive because generic manufacturers don't have the investment costs of the developer of a new drug. New drugs are developed under patent protection. The patent protects the investment—including research, development, marketing, and promotion—by giving the company the sole right to sell the drug while it is in effect. As patents near expiration, manufacturers can apply to the FDA to sell generic versions. Because those manufacturers don't have the same development costs, they can sell their product at substantial discounts. Also, once generic drugs are approved, there is greater competition, which keeps the price down. Today, almost half of all prescriptions are filled with generic drugs.

Preferred brand name drugs (tier two). Brand-name drugs are generally given patent protection for 20 years from the date of submission of the patent. This provides protection for the innovator who laid out the initial costs (including research, development, and marketing expenses) to develop the new drug. The second co-pay tier includes the majority of brand name drugs available today, over 850 drugs. Brand-name drugs are patent-protected and product-trademarked

Non-preferred brand name drugs (tier three). The third tier exists for high expense drugs, often the newer or highly advertised medications. Many of the drugs have a brand or generic equivalent.

Co-Insurance

Plan members enrolled in the Value PPO (PPO – HSA) Plan pay 100% of the cost of a prescription drug up to the annual deductible and then as a percentage of total drug costs after satisfying the annual deductible. The most an individual will pay is limited to an annual maximum out of pocket expense limit described below.

Stop Loss

An un-expectedly high number of prescriptions and their associated co-payment or co-insurance costs during a year's period can impose a large financial burden on a plan member. To protect a member against possible catastrophic financial loss and his or her financial security due to his or her prescription needs, the University has established an overall annual limit on the amount of money a plan member will pay for medications.

This feature is called stop-loss protection and is offered to members enrolled in the three PPO and HMO Illinois plans. This feature parallels stop-loss protection which limits the amount of money a member pays for inpatient and outpatient hospital services, diagnostic tests and physician services.

Health Savings Account
(HSA)

A Health Savings Account (HSA) is available to faculty and staff who enroll in the University's High Deductible PPO – HSA Plan. An HSA provides a tax savings means for participants to accumulate monies to fund qualifying out of pocket medical expenses and carry over any Account balance to the next year.

Health Savings Accounts were established by the Federal legislation referred to as the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 which added Section 223 to the Internal Revenue Code permitting eligible individuals to establish Health Savings Accounts.

An individual may participate in an HSA only if he or she is enrolled in a high deductible health plan (HDHP). An HSA qualified HDHP is a health plan that satisfies certain legal requirements including deductibles and out of pocket expenses that are set annually by the United States Treasury Department. A HDHP generally provides catastrophic health insurance coverage offering lower premiums in exchange for higher annual deductibles when compared to traditional health plans.

Contributions to the HSA Account, potential earnings, and distributions from the Account are exempt from Federal taxes. The funds may be used to pay for plan deductibles; uncovered plan services or saved for use in the future. Each individual participant decides which health expenses to pay from the Account. Features of an HSA include:

- HSA contributions are tax-deductible
- Interest earned on the Account is tax-free
- Withdrawals for [qualified medical expenses](#) are also tax free
- Participants own the HSA and it is theirs to keep — even when if the individual change health plans, terminates or retires
- Qualified medical expenses must be incurred on or after the date the HSA account was established
- HSAs are administered by a trustee/custodian or bank

Unlike FSA Plans, there is:

- no deadline for seeking reimbursement from an HSA.
- no need for the date of the service to be in a specific calendar year.
- no requirement that receipts must be attached to reimbursement requests. IRS regulations place the responsibility on the owner of the HSA to make sure that a distribution is for a qualified medical expense. The HSA account holder should however, keep receipts for all qualified medical expenses, should they be required for substantiation with the IRS. They do not need to be substantiated with the University.
- no risk of losing account balances at year end – the “use or lose it” feature of FSAs.

The University's PPO – HSA Plan is administered by BlueCross. HSA contributions are deposited to an account managed by Mellon Bank.

The University makes a **onetime matching contribution** to an individual's HSA account to help cover health care expenses before his or her contributions begin accumulating in the account.

Limited Use Flexible
Spending Account
(FSA)

HSA participants may at the same time participate in a “limited use” Flexible Spending Account (FSA) Plan. The term “limited use” means that participants may be reimbursed for out of pocket dental and vision services from his or her FSA Account and health related expenses only after they have been reimbursed the full annual deductible amount from the HSA.

Chicago area	The University offers eligible faculty and staff who work in the Chicago area with the choice of five health insurance plans including three preferred provider organization (PPO) options and two health maintenance organization (HMO's) options.
Washington, DC area	The University offers eligible faculty and staff working in the Washington, DC area with coverage with the PPO plan (BlueCross)
New York City area	The University offers eligible faculty and staff working in the New York City area with coverage with the PPO plan (BlueCross)
Miami area	The University offers eligible faculty and staff working in the Miami, Florida area with coverage with the PPO plan (BlueCross)
Qatar	The University offers eligible faculty and staff working on the Qatar campus coverage through the CIGNA international health insurance plan.

Contributions

This section summarizes premium contributions for the Health Care Plan.

Premium Tiers

Premiums are established on the basis of:

- the level of coverage, and
- plan selected, and
- full-time and part-time employment status.

Full-time employees. For staff employees scheduled to work a minimum of 35 hours per week and faculty and exempt staff with a 100% appointment and enrolled in an HMO, the University overall pays 74% of the total monthly premium cost, employees overall pay 26%.

Part-time employees. For staff employees (defined as staff schedule to work at least 17.5 hours per week) and faculty and exempt staff with a 50% or greater appointment), the University pays 37% of the total monthly premium, employees pay 63%.

PPO premiums are based on an employee's University annual benefits base salary as of September 1, 2008 or as of the date of hire if hired in 2009.

Premium Tax Status

Premiums including Health Savings Account (HSA) contributions are deducted from paychecks on a pre-tax basis. This means that the premium amount is excluded as taxable earnings and W-2 statements. Premiums are based on the coverage option selected.

HSA Contribution Amounts

Contributions to a HSA Account are made by payroll deduction and pro-rated based on the number of months of the year an individual is eligible for an HSA.

Premium Deduction Schedule

For individuals who are paid on a bi-weekly basis, premium deductions and HSA contributions are taken from the first and second payroll of each month.

For individuals who are paid on a monthly basis, deductions and HSA contributions are taken from the paycheck issued the last working day of each month.

Premium Coverage Period

Premiums deducted in a month pay for coverage for that month's coverage. For example, premiums deducted in March pay for March coverage.

Employees on Leave

Employees on a paid leave of absence continue to pay monthly premiums by payroll deduction. Employees on an unpaid leave of absence pay monthly premiums by check payable to Northwestern University and submitted to the Benefits Division.

Employees Receiving Long Term Disability

Employees receiving Long Term Disability benefits may continue health coverage. Premiums continue to be paid by payroll deduction on a pretax basis.

Employees Receiving Short Term Disability

Employees receiving Short Term Disability benefits may continue health coverage. Premiums are paid by payroll deduction on an after-tax basis.

Employees on a reduced work calendar

Employees working on a reduced work calendar continue to pay the full time monthly premium. Payment for the period the employee will not be working may be paid from their last paycheck or by submitting payment by personal check.

**Enrollment
Procedures**

This section summarizes enrollment procedures and deadlines.

Initial Hire or Benefits
Eligibility

An individual must enroll in a University sponsored health plan by completing the online enrollment process using Self Service no later than 31 days from the date of hire or initial benefits eligibility. Should an individual not elect or waive coverage, coverage will be automatically waived.

After Hire or Initial
Benefits Eligibility

After hire or initial eligibility, an individual may elect coverage, change his or her premium coverage tier or add coverage for a new family member as a result of marriage, birth or adoption of a child provided the individual completes the enrollment process within 31 days from the date of a qualifying change in family or employment status.

Open Enrollment

Open Enrollment is the one time each year when plan changes and premium rates for the next calendar year are communicated to benefits eligible faculty and staff. During Open Enrollment, an individual may elect coverage or elect to waive coverage or add or drop coverage for a spouse or dependent child. An individual may also change from one health plan to another.

**Effective Date of
Coverage**

This section summarizes coverage effective dates for Health Care Plan coverage.

Initial Eligibility

The effective date of health plan coverage is the first of the month following the date of hire or initial benefits eligibility. An individual may elect coverage from the date of employment by paying the full monthly premium.

After Initial Eligibility

The effective date of coverage is the date of the event such as the date of marriage, birth of a child, adoption of a child, loss of spouse employment, etc.

Open Enrollment

The effective date of Health Care Plan coverage is January 1st.

Claim Submittal Procedures

This section summarizes claim filing procedures and deadlines.

PPO Plans

Hospital and Physician Claims

PPO Premier and Select Plans. In order to obtain hospital and physician benefits under the PPO Premier and Select Plans, a provider or participant must submit a completed claim form to BlueCross BlueShield. To file a claim, usually all an individual has to do is to show his or her BlueCross BlueShield membership card to the hospital or physician (or other provider). They will file a claim for the individual. Remember, however, it is the covered individual's responsibility to insure that the necessary claim information has been provided to BlueCross.

Once BlueCross receives a claim, it will be processed, charges applied to the annual deductible, co-payment, co-insurance and annual out of pocket expense maximum. Payment will be sent directly to the hospital or physician. The covered individual will receive an Explanation of Benefits (EOB) statement telling how much was paid. If a physician or other provider is paid first, BlueCross will send the reimbursement payment directly to the covered individual.

If a provider will not file a claim, the covered individual will have to do so by sending BlueCross the following:

- An itemized bill from the hospital, physician or other provider, including the provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service.
- Name and BlueCross ID number
- The patient's name, age and sex.

Mail the completed claim form, available at <http://www.northwestern.edu/hr/benefits/forms>, within 6 months from the date of service to:

Comprehensive Major Medical Department
BlueCross BlueShield of Illinois
233 N. Michigan Ave
Chicago, IL 60601

BlueCross will process claims no later than 90 days after receiving them. In some cases, an additional 90 days may be needed and the covered individual will be notified of this extension during the first 90 day period. If a claim is denied (in whole or in part), a written explanation of the denial will be sent to the covered individual.

Failure to file the claim within six months will result in denial of the claim.

Value PPO (PPO – HSA) Plan. Members enrolled in the Value PPO Plan (PPO – HSA Plan) must submit a completed claim form to BlueCross BlueShield. To file a claim, usually all an individual has to do is to show his or her BlueCross BlueShield membership card to the hospital or physician (or other provider). They will file a claim for the individual. Remember, however, it is the covered individual's responsibility to insure that the necessary claim information has been provided to BlueCross.

Once BlueCross receives a claim, it will be processed applying charges to either the annual deductible, co-insurance, and annual out of pocket expense maximum. Payment will be sent directly to the hospital or physician. The covered individual will receive an Explanation of Benefits statement telling how much was paid. If a physician or other provider is paid first, BlueCross will send the reimbursement payment directly to the covered individual.

Prescription Drug
Claims

Generally, members enrolled in the PPO Premier and Select Plans submit their WHI prescription membership card to a retail pharmacy, pay the pharmacist the specified co-payment and receive the medication. The co-payment amount is usually a small fraction of the cost of the medication.

When a member does not have his or her prescription card and obtains medication from a non-Walgreens Health Initiative network pharmacy or obtains medications outside of the continental US, the member should send a completed claim form to Walgreens Health Initiatives.

Mail the completed claim form within 6 months from the date a prescription is filled to Walgreens Health Initiatives

Claim forms are available online at <http://www.northwestern.edu/hr/benefits/forms>.

Members enrolled in the Value PPO (PPO – HSA Plan) may pay for prescriptions from their HSA Account by presenting their Mellon debit card to the retail pharmacist. In contrast to the PPO Premier and Select Plans which charge a co-payment, the Value PPO (PPO – HSA) Plan charges 100% of the actual cost of the medication up to the specified deductible and then a percentage up to the maximum out of pocket amounts. The cost of the medication to the member may be substantially more than a typical co-payment.

Failure to file a claim to BlueCross or WHI within 6 months from the date the prescription is filled will result in the claim being denied.

Coordination of Benefits

Benefits provided by health plans vary substantially. Coordination of Benefits (COB) applies when an individual has health care coverage through more than one group program. The purpose of COB is to insure that the individual receives all of the coverage for which the individual is entitled, but no more than the actual cost for the care received. In other words, total payments from all of the insurance coverage combined cannot be more than the total charges incurred.

Coordination with
Medicare

If an employee is actively employed, is age 65 or older and/or the employee's spouse is also age 65 or older, the University's plan is considered primary and Medicare secondary. This means that claims are first paid by the University's plan and then by Medicare. At retirement, Medicare becomes primary and the University's plan, secondary.

HSA Accounts

The financial institution administering the HSA Account, Mellon Bank, will set up the account and will provide participants with a checkbook and/or debit card for withdrawals from the Account. Participants may submit payment requests directly to Mellon. There is no deadline for submitting requests for reimbursement from an HSA Account.

Appeals

Hospital and Physician Services

Should a hospital or physician claim be denied (or if 180 days has elapsed since it was filed and the covered individual has not received a written explanation), the claim may be reviewed. To do so, a written request should be sent no later than 60 days after the denial to:

Claim Review Section
Health Care Corporation
P.O. Box 2401
Chicago, IL 60609

Additional information may be sent to support the appeal as long as an individual does so within 30 days of the date the review was requested. Within 60 days of receiving the request for review, BlueCross will send its decision on the claim. In unusual circumstances, an additional 60 days may be needed for the review and an individual will be notified of this during the first 60 day period. In any case, no more than 120 days can be taken for a review, even at the individual's request.

Prescriptions

Individuals who submit claims for prescription drugs should expect claims to be processed no later than 30 days from the date of receipt. If the claim is denied, Walgreens Health Initiatives will send a written explanation of the denial to the member.

The member may then appeal the claim denial to the Benefits Division within 60 days from the date of the denial. The appeal must be in writing.

A decision will be made on the denial within 60 days after the request for review is received, unless special circumstances arise. In such cases, an individual will be notified that up to an additional 60 days may be required.

Changes in Employment or Family Status

This section summarizes the impact of changes in employment or family status on health plan coverage.

Changes in Family Status

An individual may change his or her premium coverage tier or add coverage for a new family member as a result of marriage, birth or adoption of a child provided the individual completes the enrollment process within 31 days from the date of a change in family status. The employee must be covered by the plan in order to add coverage for a family member.

An individual may add coverage for the newborn child, the employee's spouse and any eligible dependent children not previously covered. Any pre-existing condition a spouse or child may have will not be covered by the PPO Plan for up to 12 months. The employee must be covered by the plan in order to add coverage for a family member.

An individual may similarly change his or her premium coverage tier at any time as result of divorce, death or legal separation. An individual may drop coverage for a specific family member and continue family coverage by submitting a completed enrollment form to the Benefits Division or to the Chicago Campus Human Resources Office.

An individual may also change his or her HSA Account contribution amount at any time provided the individual completes the enrollment process within 31 days from the date of a change in family status.

Changes in Employment Status

An individual may enroll in the Health Plan or make coverage changes provided the individual completes the enrollment process within 31 days from the date of a change in employment status.

Change in Spouse Employment Status

An individual may enroll in the Health Plan provided the individual completes the enrollment process within 31 day from the date of a change in a spouse's employment status.

Leaves of Absence

Employees may continue health coverage during a leave of absence. Employees may not change plans as a result of a leave of absence

Leaves of absence for health or medical reasons. Employees pay the regular employee premium. The University continues to pay its employer portion of the total monthly premium.

Leaves of absence for personal reasons. Employees pay the full monthly premium.

Leave coverage continuation procedures. Upon notification of approval of the leave, the Benefits Division will forward information to the employee detailing his or her benefit coverage, the monthly premium rate during the leave and a form for the employee to complete requesting and return to the Benefits Division electing continuation of health coverage. Failure to pay the monthly premium in a timely manner will result in the termination of coverage.

Return from leave. Upon return from a leave of absence, an individual may resume health coverage not continued during the leave.

Does not return from leave. An individual who decides not to return from a leave of absence has option of temporarily continuing participation in the health plan under the Consolidated Omnibus Reconciliation Act (COBRA). Under COBRA, participants are responsible for the payment of the full monthly premium plus a 2% administrative fee.

Termination of
Employment

An employee may continue health coverage following termination of University employment. Active coverage ends at the end of the month in which termination of employment occurs.

These rights are extended to employees under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Participants pay the total monthly premium plus a 2% administrative fee directly to Northwestern University.

These rights do not extend to the HSA Account. However, while an individual may not make further contributions to the Account, he or she may continue to seek reimbursement.

Retirement

An individual may continue health coverage following retirement provided the individual is at least age 55 and has accumulated at least 10 years of service. Please see the chart below for further information.

Premiums

Participants pay the total monthly premium directly to Northwestern University.

HSA

While an individual may no longer make contributions to his or her HSA Account after retirement, they may continue to seek reimbursement from the Account.

Plan Choice

Retirees under age 65 may chose coverage from either of the two HMO Plans or the PPO Premier Plan.

Employees not Eligible
to Retire from NU

Employees, who leave NU at age 55 or older and have accumulated less than the specified service requirements for their age, may elect to continue health insurance coverage for a limited period under COBRA provisions.

Death

Should the retiree die, the surviving spouse and dependent children may continue University sponsored health insurance coverage under the retiree plan. This eligibility ceases upon remarriage of the spouse or adoption or marriage of the child.

ERISA Rights

Each participant in University sponsored benefit plans is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants will be entitled to:

- Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports (if any) and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may impose a reasonable charge for the copies.

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans.

The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries. No one, including the employer or other person, may terminate an individual's employment or otherwise discriminate against the individual in any way to prevent him or her from obtaining a benefit or exercising his or her rights under ERISA.

If a claim is denied in whole or in part, an individual must receive a written explanation of the reason for the denial. He or she has the right to have the Plan Administrator review and reconsider the claim. Under ERISA, there are steps an individual can take to enforce these rights. For instance, if an individual requests certain materials from the Plan and does not receive them within 30 days, he or she may file suit. In such a case, the court may require the Plan Administrator to provide the materials and pay the individual up to \$100 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If an individual has a claim for a benefit plan which is denied or ignored, in whole or in part, he or she may file suit. If it should happen that Plan fiduciaries misuse the Plan's money (if benefits ever become funded), or if an individual is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or he or she may file suit. The court will decide who should pay court costs and legal fees. If the individual is successful, the court may order the person sued to pay these costs and fees. If an individual loses, the court may order him or her to pay these costs and fees if, for example, it finds the claim frivolous. If an individual has questions about this Plan, he or she should contact the Plan Administrator. If there are any questions about this statement or about an individual's rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor. The Plan Administrator shall have the maximum authority permitted by law to construe and apply the provisions of the Plan.

Summary

BlueCross BlueShield PPO	
Name of Plan	Northwestern University Medical Hospitalization Plan (BlueCross BlueShield PPO Plan)
Plan Number	506
Date Established	May 1, 1974
Type of Plan	Self insured welfare benefit plan
Plan Year	September 1 through August 31
Plan Sponsor – Employer	Northwestern University 720 University Place Evanston, IL 60208-1143 847 491-7513
Employer Identification Number	36-2167817
Plan Administrator	Northwestern University 720 University Place Evanston, IL 60208-1143 847 491-7513
Claim Administrator	BlueCross BlueShield of Illinois 300 East Randolph Street Chicago, IL 60601 Walgreens Health Initiatives Lake Cook Road Deerfield, IL
Trustee	Northern Trust 50 South La Salle Street Chicago, IL 60675
Agent for Service of Legal Process	Office of General Counsel 633 Clark Street Evanston, IL 60208-1143
Contributions	Employer and employee paid

HMO Illinois	
Plan Number	514
Date Established	January 1, 1989

Unicare HMO	
Plan Number	511
Date Established	January 1, 1985