



# NORTHWESTERN UNIVERSITY

Long-Term Disability Plan

Summary Plan Description

January 2009

## Plan Highlights

- The purpose of the Long Term Disability (LTD) Plan is to provide continued income in the event an eligible employee is unable to work due to a disability.
- The Long Term Disability Plan is a self-insured plan. The term “self-insured” refers to plans funded by employee and employer contributions and deposited to a trust. Claim payments are paid from the trust.
- Participation in the Plan is available to regular status faculty and staff scheduled to work a minimum of 17.5 hours per week, or
  - are appointed on at least a half-time (50%) basis, and
  - are at least age 24, and
  - have completed at least one year of continuous University service, or have participated in an employer-sponsored LTD plan for at least one year immediately prior to the Northwestern University employment date.
- Employees who waive coverage when first eligible and later wish to obtain coverage may apply for coverage by submitting evidence of good health during Open Enrollment, a life change or an employment status change.
- The Participant must submit a completed claim form to the Benefits Division no later than 31 days prior to the completion of the 6 months waiting period. ***If an application is not filed within that period, a Participant will have no rights to benefits under this Plan***
- Benefits begin the first day of the seventh month of continuous physical or mental disability.
- The Plan provides benefits equal to 60% of an individual’s last working salary (up to a maximum monthly benefit of \$11,500 and annual benefit of \$138,000). The maximum eligible University salary cap is \$230,000.
- The minimum monthly benefit is \$50.
- Benefits are paid the last working day of each month by check issued from the University’s payroll system.
- Premiums are age based and are deducted from employee paychecks on an after-tax basis and pay for that month of coverage.
- The cost of the Plan is shared equally between participating faculty and staff and the University.
- Participation in the LTD Plan stops at the end of the month employment terminates.

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## Purpose

The purpose of the Long Term Disability (LTD) Plan is to provide continued income to an Eligible Employee in the event he or she is unable to work due to Disability.

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## Plan Administrator

The Director of Benefits is the Plan Administrator, and as such has full authority to operate and interpret the Plan.

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## Claims Administrator

The Plan Administrator has delegated authority to review, approve or disapprove disability claim applications to Claims Administrators.

- Responsibility for reviewing and evaluating claim applications, as well as determining on a periodic basis that a claimant continues to qualify to receive disability benefits, is delegated to a designated individual in the University's Office of Risk Management
  - Responsibility for reviewing and evaluating an appeal of a denied claim is delegated to the Director of the Office of Risk Management.
  - Responsibility for reviewing and making a final decision on a claimant's appeal is the responsibility of the University's Associate Vice President for Human Resources.
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## Summary Plan Description (or SPD)

A "summary plan description," or SPD, is a legally required document intended to summarize the key features of the Plan. This booklet is the SPD for the Plan; it replaces any other summary plan materials effective at an earlier date and will remain in effect until modified by a "summary of material modifications" or replaced by another SPD.

Capitalized items have specific meanings that are explained in the SPD.

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## Continuation of the Plan

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.

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 is subject to the terms and conditions of the Plan Document.

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## **Eligibility**

This section summarizes eligibility requirements for participation in the Long Term Disability Plan.

### **Salary**

An Eligible Employee must receive a University Salary paid from the University's payroll system in an amount sufficient to cover the amount of monthly premium deductions. (Northwestern Medical Faculty Foundation income received by Medical School faculty does not count toward this amount,)

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### **Age and Service** (or prior coverage)

An Eligible Employee will only be eligible once he or she is at least 24 years old and has:

- completed at least 12 months of continuous regular status service in a benefits eligible position, or
  - Provided the Benefits Division with documentation of comparable Long Term Disability coverage for at least one continuous year immediately prior to the date of University employment. "Immediately" means within 31 days.
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### **Classification of Employees**

#### **Staff**

**Regular status staff.** Employees scheduled to work at least 17.5 hours per week (half time). Bargaining unit individuals should refer to union contracts.

**Reduced work calendar staff.** Employees whose department work schedule is less than the standard 26.1 pay periods per year is eligible.

**Post Doctoral Fellows.** Post Doctoral Fellows appointed on at least a half-time basis are eligible to participate.

**Post Doctoral Fellows – NRSA.** Post Doctoral Fellows funded by NRSA and appointed on at least a half-time basis are not eligible to participate in this Plan. Periods of NRSA service do not count toward the one year waiting period.

**Faculty.** To be eligible to participate in the Plan, 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 (either one semester or 2 consecutive quarters).

#### ***Eligible***

**Academic Full-Time and Half-Time Faculty.** Faculty compensated exclusively by one or more of the following affiliated McGaw Medical Center institutions: the University, 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.

**Phased Retirement Faculty.** Faculty who enter into a Phased Retirement Agreement are eligible.

**Visiting Faculty Receiving University Salary.** Visiting faculty receiving University salary and appointed on at least a half time basis are eligible.

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**Eligible Employees on University-Approved Leave.** Employees on University-approved leaves of absence may continue participation in the Plan in three-month increments for up to 1 year under the University Leave of Absence policy, except that Eligible Employees may continue coverage for longer than 1 year if required by the Uniformed Services Employment and Reemployment Rights Act or other applicable law.

***Ineligible***

**Contributed Service Faculty.** Medical School faculty who volunteer to participate in the academic activities of the Medical School without direct financial compensation.

**ROTC Faculty.** ROTC and NROTC faculty

**Visiting Faculty Who Not Receive University Salary.** Visiting faculty who do not receive University salary.

**Other**

**Visiting Pre Doctoral Fellows and Visiting Scholars.** Individuals without academic appointments who are considered trainees and paid or not paid by the University are not eligible for this Plan.

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## **Enrollment Procedures**

### **Initial Eligibility**

An Eligible Employee who does not elect or waive coverage no later than 31 days of hire or initial benefits eligibility will be automatically enrolled in the Plan. Coverage will be effective the first of the month an Eligible Employee is age 24 and accrues one year of University service. If the Eligible Employee is enrolled when first eligible, he or she is guaranteed Plan coverage regardless of health status.

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### **Late Enrollment**

An Eligible Employee who has previously waived Plan coverage may apply for coverage in two specific cases, and in either case will have to demonstrate to the Claims Administrator that he or she is in good health.

**Change in status:** If an Eligible Employee experiences a change in family or employment status," he or she may apply for Plan coverage by completing the coverage application process (including providing evidence of good health) within 31 days of the change in status. Changes in status include a change in an Eligible Employee's, or his or her spouse's or dependent's, employment status; marriage, divorce or any other change in his or her marital status; or his or her having or adopting a child.

**Open Enrollment:** An Eligible Employee may apply for Plan coverage during Open Enrollment by completing the enrollment process (including providing evidence of good health).

When an Eligible Employee applies for coverage as a result of a change in status, coverage will become effective on the first of the month following the date that the Claims Administrator approves the enrollment. When an Eligible Employee applies for coverage during Open Enrollment, coverage will be effective January 1<sup>st</sup>.

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### **Dropping Coverage**

A Participant who experiences a "change in status" event may drop LTD coverage effective the first of the month following the date that he or she notifies the Benefits Division and completes the process for dropping coverage.

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### **Pre-existing Condition Limitation**

An Eligible Employee may waive coverage either when first eligible, during Open Enrollment or as a result of a change in status. When the Eligible Employee applies for coverage as described above, he or she is required to provide health information including specifics about any medical condition he or she has or is being treated for at the time of enrollment.

Preexisting conditions are defined as any disease, illness, sickness, malady or condition for which medical advice, diagnosis, care or treatment was received or recommended by a health provider within 6 months prior to the coverage effective date. Taking prescription drugs is considered medical treatment even if the condition was diagnosed more than 6 months before the coverage effective date. Pregnancy is considered a preexisting condition.

The Claims Administrator, in its discretion, will approve the application but limit a Participant's coverage under the Plan so that no claim related to any condition that was disclosed on the application or should have been disclosed would be payable for up to one year from the date coverage was approved. Similarly, if an Eligible Employee does not properly disclose a medical condition on the enrollment application, the Claims Administrator may, in its discretion, limit coverage under the Plan for any claim related to any undisclosed condition. Any Eligible Employee who fails to fully and properly disclose medical or other information that is required as part of the enrollment process shall also be subject to the full range of University disciplinary policies, including potentially the loss of his or her job.

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## **Effective Date of Coverage**

### **Initial Eligibility**

The effective date of LTD coverage is the first of the month following the month an Eligible Employee has completed one year of service and is at least age 24. However, this one-year waiting period is waived if he or she provides documentation to the Benefits Division that he or she had other employer-sponsored LTD coverage immediately before he or she began University employment. "Immediately" means within 31 days.

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### **Late Enrollment**

If an Eligible Employee waives coverage and later applies for coverage as explained above as a result of qualifying change in status event, coverage will be effective the first of the month following the date the Claims Administrator approves his or her application. Coverage applied for during Open Enrollment will be effective January 1<sup>st</sup>.

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## **Continuation or Termination of Coverage**

### **Coverage During Leaves of Absence**

Participants may in certain cases continue Plan coverage during an approved leave of absence.

**Leaves of absence under University leave policies.** A Participant on an approved medical leave (including FMLA or other leave to care for an ill family member), parental, military or any other paid leave may continue the Plan coverage in effect when the leave began by paying the regular employee premium. Similarly, a Participant who is a reduced work calendar employee may continue Plan coverage by paying the regular employee premium during the leave. The University continues to pay its employer portion of the total monthly premium.

**Other, unpaid leaves of absence.** A participant on an approved, unpaid leave of absence (other than any leave described above) may continue the coverage that was in effect when the leave began by paying the full monthly premium. The University will not pay its employer portion of the premium.

**Leave coverage continuation procedures.** When the Benefits Division is notified that a leave was approved, it will forward information to a Participant detailing his or her benefit coverage, the monthly premium rate during the leave, and a form to complete and return to the Benefits Division electing or waiving continuation of 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 Eligible Employee may resume LTD coverage not continued during the leave by notifying the Benefits Division within 31 days of the return.

**Does not return from leave.** If a Participant does not return from a leave of absence, Long Term Disability coverage ends when his or her University-approved leave ends.

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### **Termination of Employment**

Long Term Disability coverage ceases at the end of the month of termination of University employment.

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## **Benefits**

### **Disability Defined**

A Participant will be considered "disabled" under this Plan if the Claims Administrator determines that, due to sickness, pregnancy or injury, he or she is receiving Regular and Appropriate Care from a Doctor on a continuing basis, and:

- (a) During the first two years of Disability, the Participant is continuously mentally or physically unable to perform the Material and Substantial Duties of his or her Regular Occupation
- (b) After two continuous years of Disability, the Participant is continuously mentally or physically unable to engage in any occupation for which he or she is or becomes qualified by education, training or experience, and is not working for wages in any occupation for which he or she is or becomes qualified by education, training or experience.

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### Key Terms

**"Covered salary"** means that portion of a Participant's University salary that is taken into account in determining benefits under the Plan, as described in this section. Overtime, summer salary and bonus payments are not included. The maximum eligible salary is \$230,000.

If a Participant is paid on a bi-weekly basis, his or her covered salary is the bi-weekly scheduled hours multiplied by the hourly rate and then multiplied by 26.1 (there are 26.1 bi-weekly paid periods in a year) or the number of pay periods if different from 26.1. For faculty, covered salary is the academic or contract year salary and excludes any summer salary, honoraria, consulting fees, etc. A Participant's covered salary for purposes of this Plan will be his or her salary as of the relevant date of Disability and any change in salary is reflected immediately in his or her Covered Salary. If a Participant is on an approved Leave of Absence Without Pay when disability begins, the covered salary will be the salary received immediately prior to the start of the leave of absence.

**"Injury"** means bodily injury caused by an accident which occurs to a Participant and which results, directly and independently of all other causes, in Disability.

**"Material and Substantial"** means the necessary functions of a Participant's Regular Occupation which cannot, as determined by the Claims Administrator, be reasonably altered or omitted.

**"Regular and Appropriate Care"** means regularly visiting a doctor as frequently as medically required to meet a Participant's basic health needs, as determined by the Claims Administrator. Appropriate means of demonstrable medical value in attaining or maintaining the level at which, based on reasonable medical probability, further material recovery from, or lasting improvement to, the Injury or sickness can no longer be reasonably anticipated, as determined by the Claims Administrator.

**"Regular Occupation"** means the occupation that a Participant was performing for income or wages on the date he or she became Disabled. It is not limited to the specific position he or she held at the University.

### **Benefit Amount**

If the Claims Administrator determines that an Eligible Employee enrolled in the Plan has been Disabled, the Plan will provide continued income of up to 60% of Covered Salary beginning with the first day of the seventh month of continuous disability. Benefits are pro-rated for any partial month.

Benefit payments are paid by a University payroll check issued the last working day of each month. Based upon the taxable status of premium contributions, one-half of the benefit is taxable income, the other one-half is not. The maximum monthly benefit is \$11,500. The minimum monthly benefit is \$50. Benefits are pro-rated for any partial month.

**Benefits Begin**

If a Participant properly applies for LTD benefits and is determined by the Claims Administrator to be Disabled, benefit payments will start after he or she has been continuously Disabled for six months, A Participant exhaust all his or her accrued vacation, sick and floating holiday leave, .

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**Coordination of Benefits**

Benefits are coordinated with any benefit paid or payable from any of the sources listed below so that the total combined benefit does not exceed 70% of the Covered Salary:

- disability benefits payable under any Workers' Compensation or Occupational Disease Law;
- Social Security benefits (both primary and dependents) on account of disability;
- salary payment or disability income payable under any employer or employer-sponsored plan or any government-sponsored plan;
- Any amount paid as retirement benefits under Social Security or under any pension or retirement plan sponsored or contributed to by Northwestern.

An increase in benefits under any of the above due to an amendment or application of a cost-of-living adjustment that becomes effective after benefit payments begin will not be applied to reduce the benefits payable under this Plan.

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**Social Security Disability Income (SSDI)**

A Participant's benefit increases from 60% to 70% of the Covered Salary, less the estimated amount of Social Security Disability Income (SSDI). The Participant is required by the Plan to apply for SSDI income. Failure to apply within 31 days of commencement of the LTD benefit will result in the Benefits Division estimating the SSDI benefit amount and calculating the University benefit using the estimate.

**Denial and Repayment of SSDI Income**

If Social Security denies the Participant's original claim, the Participant is expected to appeal the decision. Upon the initial denial, the University will adjust the Participant's Benefit to 60% with no SSDI offset.

If the SSDI claim is denied after the second appeal, the University will adjust the Participant's Benefit, to reflect such, and determine the method by which the repayment of the previous offset is made to him/her. We require a copy of the denial letter in order to make an adjustment to the Participant's benefit.

If SSDI is approved, the University will adjust the Benefit to reflect the SSDI offset and determine the method by which any over/underpayment will need to be repaid. The University will determine the method by which the over/underpayment is corrected.

**Maximum benefit period**

If the disability benefit commences at age 60 or younger, disability benefits will continue until age 65 or the age an individual qualifies for Social Security income.

If the disability benefit commences at age 61 or older, disability benefits will continue for 5 years.

When disability benefits end, the Participant's status with the University will be terminated though the Participant may elect to continue University sponsored health, dental and vision coverage as a retiree member.

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**Recurrence of Disability**

A new period of Disability is continuation of the previous period of Disability for purposes of determining when benefits begin if a Participant:

- is Disabled for at least 14 days but for less than six months, and
- returns to regular work for less than 14 days, and
- suffers a recurrence of the previous Disability from the same or related causes as determined by the Claims Administrator.

Otherwise, the later period of Disability is a new Disability and the waiting period will begin again.

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**Benefits during  
Rehabilitation  
Employment**

A Participant may be employed primarily for the purpose of rehabilitation provided that he or she otherwise continues to satisfy the standards for Disability. During rehabilitation employment, he or she would continue to receive LTD payments under the Plan subject to the following:

- rehabilitative employment must be approved by a physician **and** the Claims Administrator;
- the status of employment must be reviewed by the Claims Administrator whenever work duties change but at least every three months;
- the amount of the benefit during rehabilitative employment will be the greater of the benefit reduced by two-thirds of the earnings from rehabilitative employment, or \$50 per month; and
- The period of rehabilitative employment is limited to 2 years. In no event will benefits be paid beyond the "maximum benefit period."

**Vocational  
Rehabilitation**

The Plan provides rehabilitation services to assist a Participant in returning to Gainful Employment. These services include job training, job placement and other services. Eligibility for these services is determined by the Claims Administrator and would be based on training, education, work experience and physical or mental capacity (or both). To be considered for rehabilitation services:

- A Participant's Disability would have to prevent him or her from performing his or her Regular Occupation;
- A Participant would have to have physical and mental capabilities needed to successfully complete a rehabilitation program; and
- The Claims Administrator would have to determine that there is a reasonable expectation that these rehabilitation services will help his or her return to Gainful Employment.

**"Gainful employment"** means the performance of any occupation for wages, remuneration, or profit, for which a Participant is qualified by education, training or experience on a full- or part-time basis, for the University, another employer, or the Participant, and which the Claims Administrator approves and for which the Claims Administrator reserves the right to modify approval in the future.

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**Return to Work  
Incentive Benefit**

A Participant may resume work on a part-time basis and continue to receive LTD benefits. The benefit amount in combination with his or her part-time pay will not exceed the Participant's pre-disability income minus the disability benefit amount.

For Example:

Employee's scheduled pay period hours are 80 hours with a per pay period salary of \$1,684.80

Returns to work and works 48 hours with a salary of \$1,010.88

Receives LTD benefit of 60% of \$1,010.88 (\$1,684.80 minus \$1,010.88) or \$606.53.

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**Return to Full  
Employment**

Should the Participant's condition improve enabling him or her to return to work, the Participant may apply for a University or non University job. If the Participant is not able to obtain a job within 31 days from the date he or her was determined to be able to return to work, the Participant's University status will be terminated.

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**Exclusions**

The Plan will not pay disability benefits if the Claims Administrator determines that the Disability was caused, in whole or in part, by: declared or undeclared war or any act of war, service in the armed services of any country of international authority,

- declared or undeclared war or any act of war
- service in the armed services of any country of international authority
- intentionally self-inflicted injury or sickness, or attempted suicide while sane or insane, or
- Commission of, or attempt to commit, an act which would be a felony in the jurisdiction in which it was committed.
- Workers Comp, occupational injuries are not covered.

**Continuation of other University benefits**

Participants receiving LTD benefits are eligible to continue other University benefits, including health and dental insurance, life insurance, long term care and tuition assistance.

**Health, Dental and Vision Care Plans.** The University continues to make its contribution toward the payment of insurance premiums. A Participant may continue such coverage by making premium payments by payroll deduction. Should a Participant die while receiving LTD benefits, his or her surviving spouse and dependent child (ren) may continue coverage under the retiree plan by paying the monthly premium directly to the University. Dependent children may be covered through age 25 regardless of full time student status.

**Flexible Spending and Health Savings Account Plans.** While a Participant receives LTD benefits, he or she may continue to make contributions to and receive reimbursement from his or her FSA or HSA Account.

**Basic Term Life Insurance Plan.** While a Participant receives LTD benefits, he or she continues to be covered under the Basic Term Life Insurance Plan. In the event of the Participant's death, benefits will be made payable to the named beneficiary.

**Supplemental, Spouse and Dependent Child Term Life Insurance Plan.** A Participant in the Supplemental Term Life plan may apply to have monthly premium payments waived. Applications are available by contacting the Benefits Division and the completed forms must be returned to the Benefits Division. In the event of a Participant's death, benefits will be paid to the named beneficiary.

**Long Term Care Plan.** A Participant covered under the Long-Term Care Plan continues coverage and continues premium payments for his or her coverage by payroll deduction.

**Retirement Plan.** If a Participant had been participating in the University's Basic Retirement Plan when he or she became Disabled, the University will contribute 7% of his or her last monthly working salary and deposit such contributions to the Participant's investment company account.

**Educational Assistance and Tuition Plans.** An LTD Plan Participant who continues to be eligible will be able to continue participating in the Educational Assistance and Tuition plan provided that he or she met the years of continuous full-time service immediately prior to the onset of the Disability. In the event of the Participant's death, the surviving spouse or dependent child (ren) may continue to receive tuition benefits based on the years of qualified service at the time of death. This eligibility ceases upon remarriage of the spouse or adoption or marriage of the child.

## **Contributions**

### **Self-insured Plan**

The LTD Plan is a self-insured plan and differs from a fully insured plan in a number of ways. The term “self-insured” refers to a plan funded by employee and employer contributions that are deposited to a trust. Claims and other plan expenses are paid from the trust. Any remaining monies at the end of a Plan year are retained as Plan assets by the Trust for the payment of future claims and administrative costs.

### **Premium Rate**

The premium rate is based on age and per \$100 of coverage.

For Example:

An employee is age 32 and has an annual salary of \$23,530.

\$23,530 is rounded up to \$23,600

\$23,600 divided by 100 = \$236

\$236 times \$.15 = \$35.40 = annual premium

\$23.60 divided by 12=\$2.95 = monthly premium

### **Payroll Deductions**

Contributions are deducted from paychecks on an after-tax basis. This means that the premium amount is included as taxable earnings.

- **Exempt staff paid on a bi-weekly basis.** For Participants paid on a bi-weekly basis, deductions are taken from the first and second payroll of each month.
- **Faculty and staff paid on a monthly basis.** For Participants paid on a monthly basis, deductions are taken from the paycheck issued the last working day of each month.

### **Coverage Period**

Deductions pay for coverage for the current month. For example, deductions in March pay for March coverage.

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### **Employees Receiving LTD Benefits**

A Participant’s contributions are waived during the period he or she is receiving LTD benefits.

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## Claim Submittal Procedures

### How to Apply for LTD Benefits

A Participant who is unable to work as a result of an extended and medically certifiable non work related illness or injury may be eligible to receive LTD benefits. A Participant must be unable to work for six months. He or she should follow the steps listed below.

**1 Apply for a leave of absence due to disability.** To apply for a Leave of Absence, a Staff Participant should send a written request to the Human Resources Consulting Service Office on either the Chicago or Evanston campus.

**2 Use available sick, vacation and personal floating holiday time.** After all available time has been used, a Participant should:

**3 Apply for Short Term Disability continued income.** If the Staff Participant is enrolled in the University's Short Term Disability (STD) Plan, he or she should obtain the STD claim application form from the Benefits Division when the Participant believes the disability will continue beyond 14 days. The form includes a section for the Participant and his or her physician to complete. A completed form should be submitted to the Benefits Division, 720 University Place, Evanston, IL 60208. The form will be reviewed and a decision made by the Claims Administrator.

**4 Apply for Long Term Disability (LTD) continued income.** A Participant should obtain the claim application form from the Benefits Division after four months of continuous disability. The form includes a section for the Participant and his or her physician to complete.

The Participant should submit the form to his or her physician for completion and return the completed form to the Benefits Division

Participants are responsible for any costs associated with the completion of the claim form.

A faculty Participant's extended absence may interrupt scheduled teaching duties and need special prior planning and consideration and should be discussed with the department chair before the beginning of the affected academic term. The faculty Participant will be paid sick leave while absent.

The Participant must submit a completed claim form to the Benefits Division no later than 31 days prior to the completion of the 6 months waiting period. ***If an application is not filed within that period, a Participant will have no rights to benefits under this Plan.***

The Benefits Division will forward the completed statement to the Claims Administrator. The Claims Administrator will then review the submitted information and either approve or disapprove the claim.

**Initial Claim Review**

The claims procedures described in this SPD apply to all claims for benefits under this Plan.

The Claims Administrator will review and either approve or deny the claim. The Claims Administrator will notify the Participant of its decision within 45 days after receipt of the claim, unless an extension of up to 30 days is necessary. The Claims Administrator will notify the Participant if an extension is needed within the initial 45-day period. The extension notice will state why the extension is necessary and the date the Claims Administrator expects to make its decision. The Claims Administrator may notify the Participant (during the initial 30-day extension) that an additional extension of up to 30 more days is needed.

Any extension notice will explain the standards on which entitlement to the disability benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. A Participant will have 45 days to provide any information requested in the extension notice. (The Claims Administrator or its designee will periodically evaluate the Disability status of people receiving benefits under the Plan. A finding that a person is no longer Disabled would be considered a denied claim for purposes of these claims procedures.)

The Claims Administrator will review the claim and at its discretion may seek additional information from the Participant and or the Participant's physician about his or her job duties and medical condition and how the condition prevents the Participant from performing his or her job duties. In addition, the Claims Administrator may consult with an experienced occupational medicine specialist about the claim. Based on the specialist's clinical judgment, he or she may contact the Participant's physician for additional or clarifying information.

The specialist may also seek consultation with other clinicians which may necessitate obtaining Participant medical records and the Participant undergoing additional physical examination and diagnostic tests. The selection of such health care professionals will be based the Participant's medical condition and individuals who, based on their training and specialty practice, are considered qualified to consult on a specific claim.

When there are differences of opinion between the Participant's physician and the specialist, the Claims Administrator may seek review by an independent physician.

Costs associated with obtaining such additional information will be paid by the Plan and may include payment of reasonable Participant travel, lodging and meal costs.

Failure of the Participant to respond to the Claim Administrator's request for additional information will result in the claim being denied.

**Claim Decision**

When the Claims Administrator makes a claim decision, the Participant will be notified in writing.

If the claim is approved, the written notice will specify the effective date for receiving disability income. It will also state the Plan's requirement that the claim will be reviewed on a periodic basis in order to reevaluate the Participant's eligibility for continued disability benefits. The frequency of this reevaluation will be determined by the Claims Administrator based on the Participant's illness or injury.

If the claim application is not approved, the Claims Administrator will send the Participant a written notice that will:

- be written in a manner designed to be understood;
- include the specific reason for the disapproval;
- refer to the Plan provisions on which the decision was based;
- describe any additional material or information necessary to perfect the claim and explain why the additional material is necessary;
- let the Participant know that, upon request and free of charge, he or she may have reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;
- explain the Plan's review procedures, including the relevant time limits;
- indicate that the Participant would be able to bring a civil action under Section 502(a) of ERISA within 180 days after receiving a determination upon final appeal; and
- include a copy of any internal rule, guideline, protocol or criterion that was relied on in making the adverse determination, or indicate that such a rule, guideline, protocol or criterion was relied on and that a copy is available free of charge upon request; and
- If the decision was based on medical necessity, experimental treatment or similar exclusion or limit, either explain the scientific or clinical judgment made or indicate that such an explanation is available free of charge upon request.

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**Requesting an  
Appeal of a Denied  
Claim**

A Participant is entitled to appeal the Claims Administrator's decision to deny a claim. To appeal a disapproved claim, a Participant or his or her authorized representative must notify the Claims Administrator in writing within 180 days of receiving the initial decision. The Participant may submit written comments, documents, records, and other information relating to the claim for benefits and will be given reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The appeal will be conducted by the Claims Administrator by an individual who was neither the individual who made the initial decision nor a subordinate of that individual. This Claims Administrator will not be biased by the initial adverse decision and will take into account all comments, documents, records, and other relevant information submitted relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

If the disapproval was based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience. This health care professional will not be an individual who was consulted in connection with the initial decision or the subordinate of any such individual. Finally, the Claims Administrator will identify, upon request, any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the decision, without regard to whether the advice was relied upon in making the benefit determination.

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**Decision on the First Appeal**

The Claims Administrator will notify a Participant of its decision on the Participant's appeal within 45 days of receipt of the request for review, unless special circumstances require an extension of time of up to 45 days for processing the appeal. If an extension is required, the Claims Administrator will notify the Participant before the expiration of the initial 45-day period. The notice will indicate the special circumstances that require an extension of time and will include the date by which the Claims Administrator expects to issue the Plan's determination on the appeal. If the decision is to uphold the claim disapproval, the Claims Administrator will provide a written or electronic notice that will:

- be written in a manner designed to be understood;
- include the specific reasons for the determination;
- refer to the Plan provisions on which the determination was based;
- inform the Participant that, upon request and free of charge, he or she is entitled to reasonable access to and copies of all documents, records, and other information relevant to the claim;
- explain the Plan's appeal procedures (including relevant time limits) and of the right to bring legal action under Section 502(a) of ERISA within 180 days of receipt of notice on final appeal;
- include a copy of any internal rule, guideline, protocol or criterion that was relied on in making the benefit determination, or indicate that such a rule, guideline, protocol or criterion was relied on and that a copy is available free of charge upon request; if the decision was based on medical necessity, experimental treatment or similar exclusion or limit, either explain the scientific or clinical judgment made or indicate that such an explanation is available upon request, free of charge.

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**Requesting a Second and Final Appeal**

The Participant may make a second appeal. The decision reached on this appeal shall be considered the final decision and no other appeals may be made. To make such an appeal, the Participant must notify the Claims Administrator within 90 days of receiving the first appeal decision. The Participant may submit written comments, documents, records, and other information relating to the claim for benefits and will be given reasonable access to, and copies of, all documents, records, and other information relevant to the claim. The appeal will be conducted by the Associate Vice President Human Resources as a Claims Administrator and Named Fiduciary. This review will be based by the earlier decisions and will take into account all comments, documents, records, and other relevant information that the participant submitted relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

If the final appeal decision was based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience. This health care professional will not be an individual who was consulted in connection with the earlier decisions or the subordinate of anyone who was. Finally, the Claims Administrator will identify upon request any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the disapproved claim, without regard to whether the advice was relied upon in making the benefit determination.

**Decision on Final Appeal**

The Claims Administrator will notify the Participant of its determination within 45 days of receiving the request for review, unless special circumstances require an extension of time of up to 45 days for processing the appeal. If an extension is required, the Claims Administrator will notify him or her before the expiration of the initial 45-day period. The notice will indicate the special circumstances that require an extension of time and will include the date by which the Claims Administrator expects to issue its determination on the appeal. If the decision is to deny the appeal, the Claims Administrator will provide the Participant with a written or electronic notice that will:

- be written in a manner designed to be understood;
- include the specific reasons for the determination;
- refer to the Plan provisions on which the determination was based;
- inform the Participant that, upon request and free of charge, you may have reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;
- indicate that the Participant may bring legal action under Section 502(a) of ERISA within 180 days after receiving a final notice upon appeal;
- include a copy of any internal rule, guideline, protocol or criterion that was relied on in making the determination, or indicate that such a rule, guideline, protocol or criterion was relied on and that a copy is available free of charge upon request; and
- If the determination was based on medical necessity, experimental treatment or similar exclusion or limit, either explain the scientific or clinical judgment made or indicate that such an explanation is available upon request, free of charge.

**Decision to Terminate Benefits during a Periodic Claim Review**

When the Claims Administrator conducts a periodic claim reevaluation and determines that the Participant is no longer eligible for continued LTD benefits, he or she will notify the Participant in writing. This notice will contain similar information that is included in a claim denial notice.

The Participant has the same appeal rights associated with a denied claim.

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## **ERISA Rights**

As a Participant in Northwestern University Long Term Disability Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Participants shall be entitled to:

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### **Receive Information About Your Plan Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the 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 collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

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### **Prudent Actions by Plan Fiduciaries**

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

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### **Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court within six months of the date you receive a denial of your claim on final appeal under this Plan

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with Your Questions**

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

**Summary**

Name of Plan	Northwestern University Long Term Disability Plan
Plan Number	508
Date Established	October 1, 1967
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	Director of Benefits
Claim Administrator	For initial determinations: Office of Risk Management For initial appeals: Director of Office of Risk Management For final appeals: Associate VP-HR
Agent for Service of Legal Process	Office of General Counsel 633 Clark Street Evanston, IL 60208-1143
Contributions	Employer and employee paid