



NORTHWESTERN UNIVERSITY

Short Term Disability Plan

Summary Plan Description

January 2009

Plan Highlights

- The purpose of the Short Term Disability (STD) Plan is to provide continued income in the event an eligible employee is unable to work due to a disability caused by a non-work related accident or illness.
- The Short 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. Plan expenses are paid from the trust.
- Participation in the Plan is available to regular status staff scheduled to work a minimum of 17.5 hours per week and have completed least one year of continuous University service. Employees who waive coverage when first eligible and later wish to obtain coverage may apply for coverage during Open Enrollment of within 31 days from the date of a qualifying change in family or employment status by submitting evidence of good health.
- A Participant seeking benefits must submit a completed claim form to the Benefits Division no later than the 14th day of continuous disability. ***If the claim form is not filed within that period, a Participant will have no rights to benefits under this Plan.***
- Benefits begin after 14 days of continuous disability, accumulated sick, personal floating holiday, and vacation time is exhausted, whichever is later.
- The Plan provides benefits equal to 60% of an individual’s last working salary (up to certain annual and monthly maximums). Benefits are paid the last working day of each month by check issued from the University’s payroll system for exempt staff and by check issued on a bi-weekly basis for non-exempt staff.
- Premiums are deducted from employee paychecks on an after-tax basis and pay for that month of coverage.
- The cost of the Plan is fully paid by Participants.
- Participation in the STD Plan stops at the end of the month of termination of University employment.
- The Short Term Disability Plan is only available to Staff members.

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Purpose	The purpose of the Short Term Disability (STD) Plan is to provide continued income to an Eligible Employee in the event he or she is unable to work due to Disability caused by a non-work related accident or illness.
Plan Administrator	The Director of Benefits is the Plan Administrator, and as such has full authority to operate and interpret the Plan.
Claims Administrator	<p>The Plan Administrator has delegated authority to review, approve or disapprove disability claim applications to Claims Administrators.</p> <ul style="list-style-type: none">• 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 delegated to the University's Associate Vice President for Human Resources.
Summary Plan Description	<p>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.</p> <p>Capitalized items have specific meanings that are explained in the SPD.</p>
Continuation of the Plan	<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 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 Short Term Disability Plan.
<u>Salary</u>	An Eligible Employee must receive University Salary paid from the University's payroll system in an amount sufficient to cover the amount of monthly premium deductions.
<u>Age and Service</u> (or prior coverage)	An Eligible Employee will only be eligible once he or she has completed at least 12 months of continuous regular status service in a benefits eligible position.
<u>Eligible Employees</u>	<p>Regular Status Staff. Employees scheduled to work at least 17.5 hours per week (half time). Bargaining unit individuals should refer to union contracts.</p> <p>Reduced Work Calendar Staff. Non-exempt Employees whose department work schedule is less than the standard 26.1 pay periods per year, or exempt Employees whose department work schedule is less than the standard 12 pay periods per year.</p> <p>Post Doctoral Fellows. Post Doctoral Fellows (except NRSA) appointed on at least a half-time basis.</p> <p>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 policies, 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.</p>
<u>Ineligible Employees</u>	<p>Faculty. Faculty are <u>not</u> eligible to participate in this STD Plan and should refer to the Faculty Handbook for information on continued pay during sickness or injury.</p> <p>Post Doctoral Fellows funded by NRSA.</p> <p>Visiting Pre Doctoral Fellows and Visiting Scholars. Individuals without academic appointments who are considered trainees are not eligible for this Plan (whether or not they receive University Salary).</p>

Enrollment Procedures

Initial Eligibility

An Eligible Employee who does not enroll or waive coverage by completing the enrollment or waiver process within 31 calendar days of hire or initial benefits eligibility will have coverage automatically waived. If the Eligible Employee is enrolled when first eligible, he or she is guaranteed Plan coverage regardless of health status.

After Initial Eligibility

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" under the Northwestern University Flexible Spending Account Plan, 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.

A Participant who experiences a "change in status" event may drop STD 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.

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

Pre-existing Condition Limitation

An Eligible Employee may waive coverage either when first eligible or during Open Enrollment or may drop coverage as a result of a change in status. When the Eligible Employee later 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.

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.

Effective Date of Coverage

Initial Eligibility

The effective date of STD coverage is the first of the month following the month an Eligible Employee who has properly enrolled has completed one year of service.

After Initial Eligibility

If an Eligible Employee waives coverage and later applies for coverage as explained above as a result of a 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 1st.

Actively at Work

If an Eligible Employee is absent from work on the day Plan coverage would otherwise start, coverage will instead begin on the date he or she returns to active employment.

Continuation or Termination of Coverage

Coverage During a Leave 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 whose work year is reduced by his or her department may continue Plan coverage by paying the regular employee premium during the leave.

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.

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 STD 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, Short Term Disability coverage ends when his or her University-approved leave ends.

Termination of Employment

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

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 is continuously mentally or physically unable to perform the Material and Substantial Duties of his or her Regular Occupation and is not working for wages in any occupation

Caring for a newborn, absent sickness or injury as described above, is not a Disability.

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 calculated each year and disclosed at Open Enrollment.

If a Staff 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 Staff Participants paid on a monthly basis, covered salary is the monthly compensation rates multiplied by 12 (12 pay periods). 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 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 his or her Covered Salary beginning after 14 calendar days of Disability, and after all accumulated sick pay and vacation time is used. 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 for exempt staff and the first two bi-weekly payrolls for non-exempt staff. 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 \$7,500. The minimum monthly benefit is \$50. Benefits are pro-rated for any partial month.

Benefits Begin

If a Participant properly applies for STD benefits and is determined by the Claims Administrator to be Disabled, benefit payments will start after he or she has been continuously Disabled for 14 days. A Participant must exhaust all his or her accrued vacation, sick and floating holiday leave.

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.

Maximum Benefit Period

Benefit payments may be received for up to 24 weeks (6 months).

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 14-day waiting period will begin again.

Return to Work Incentive Benefit

A Participant may resume work on a part-time basis and continue to receive a portion of his or her standard STD 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.

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

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 she was determined to be able to return to work, the Participant's STD benefits will be terminated and the Participant will be terminated as an Employee.

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
 - 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
 - Occupational injuries having arisen from work related injuries.
-

**Continuation of
Other
University Benefits**

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

Health, Dental and Vision Care Plans. The University continues to make its contribution toward the payment of health, dental and vision premiums. A Participant may continue such coverage by making premium payments by payroll deduction. Should a Participant die while receiving STD benefits, his or her surviving spouse and dependent child(ren) may be eligible to 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 Account (FSA) and Health Savings Account (HSA) Plans. While a Participant receives STD benefits, he or she may continue to make contributions to and receive reimbursements from his or her healthcare or limited use FSA. He or she may not receive reimbursement from his or her Dependent Care FSA Account while receiving STD benefits. A participant may continue to make contributions to and receive reimbursements from his or her HSA account while receiving STD benefits.

Basic Term Life Insurance Plan. While a Participant receives STD 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 Plans. A Participant who is covered under the above named Term Life Insurance Plans continues coverage and continues premium payments by payroll deduction. He or she may apply to waive these plans while receiving STD benefits. Applications are available by contacting the Benefits Division and the completed forms must be returned to the Benefits Division.

Long Term Care Plan. A Participant covered under the Long-Term Care Plan continues coverage and continues premium payments by payroll deduction.

Retirement Plan. If a Participant becomes Disabled, the University discontinues retirement plan contributions beginning with the issuance of the first STD benefit payment.

Educational Assistance and Tuition Plans. An STD 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 STD 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	Premiums are fully employee paid and vary by age
Payroll Deductions	Contributions are deducted from paychecks on an after-tax basis. This means that the premium amount is included as taxable earnings. <ul style="list-style-type: none">• Non-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.• 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 in a month pay for coverage for that month. For example, deductions in March pay for March coverage.
Employees Receiving STD benefits	A Participant’s contributions (deductions) are not waived during the period he or she is receiving STD benefits.

Claim Submittal Procedures

Applying for STD 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 STD benefits. A Participant must be unable to work for 14 continuous days due to disability. Then 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.

2 **Apply for Short Term Disability continued income.** Once all available sick, vacation, and personal floating holiday time is used, a Participant should obtain the STD claim application form from the Benefits Division or online from the Benefits Division web site 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.

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.

The Participant must submit a completed STD claim form to the Benefits Division no later than 31 days from the date of disability. ***If a completed claim form 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 deny 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 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.

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 de 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.)

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. 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 denied, the Claims Administrator will send the participant a written notice that will:

- be written in a manner designed to be understood;
- include the specific reasons for the denial;
- 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, 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.

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.

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
(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 not be biased by the earlier decisions and will take into account all comments, documents, records, and other relevant information that you submit 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 STD 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.

ERISA Rights

As a Participant in Northwestern University Short 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:

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.

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 terminate your employment or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA

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

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

Assistance with Your Questions

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

Summary

Name of Plan	Northwestern University Short Term Disability Plan
Plan Number	
Date Established	January 1, 1999
Type of Plan	Self insured welfare benefit plan
Plan Year	January 1 st through December 31 st
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 for HR
Agent for Service of Legal Process	Office of General Counsel 633 Clark Street Evanston, IL 60208-1143
Contributions	Employee paid