



2018 Benefit Guide



2018 Benefit Guide

McGaw Medical Center

Benefit Contact Information

McGAW PAYROLL & BENEFITS

888-449-0016 Phone

866-480-8867 Fax

mcgawpayroll@ey.com

Benefit Website: <http://mcgaw.northwestern.edu>

Payroll Website: <https://workforcenow.adp.com>

Registration Code: McGawNU-GME

VSP VISION PLAN (SIGNATURE)

GROUP ID: 12165164

MEMBER ID: HOUSESTAFF SSN

GROUP NAME: McGAW MEDICAL CENTER

800-877-7195

Call to find a VSP doctor or with general questions.

www.vsp.com

Website to find a VSP doctor.

BLUE CROSS/BLUE SHIELD OF ILLINOIS MEDICAL PLAN

GROUP ID: S59987/0100

800-346-7072

Call with questions or to request a duplicate ID card.

www.bcbsil.com

Website to select participating providers.

METLIFE MCGAW DENTAL PLAN

GROUP ID: 307257

MEMBER ID: HOUSESTAFF SSN

COMPANY NAME: McGAW MEDICAL CENTER

800-942-0854

www.metlife.com/mybenefits

Call with questions about coverage or claims.

CVS CAREMARK PRESCRIPTION PLAN

ID: CARDHOLDER SSN

GROUP ID: RX4994

RX BIN: 004336

RX PCN: ADV

866-818-6911

Call with questions or to request an ID card.

www.caremark.com

Website to select participating pharmacy or to download claim forms.

FIDELITY 401(k)/ROTH: PLAN 74471

800-343-0860

Call to set up your account, change your investment options, change your % invested, rollover funds, or to inquire on account balance.

Website to manage your account online.

www.fidelity.com/atwork

PAYFLEX FSAs, COMMUTER/TRANSIT AND COBRA

800-284-4885

www.payflex.com

Call with questions regarding your Flexible Spending Account (FSA), Commuter/Transit or COBRA.

FSA Member ID is your payroll ID# (find this on your electronic paystub).

PAYSTUBS

<https://workforcenow.adp.com>

Registration Code: McGawNU-GME

Address Changes

Address changes must be submitted in writing to McGaw Payroll & Benefits. Include your name, new address, and effective date of the change on the correspondence. You may mail, fax, or email this information to McGaw Payroll & Benefits.

If you move following completion of your program with McGaw, please notify our office by December 1. This will assist us in getting your Form W2 to you next January.

If you do not receive an insurance card or need to request a duplicate card, please contact the insurance providers above.

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General Open Enrollment Information

2018 BENEFIT GUIDE AND OPEN ENROLLMENT INFORMATION

This guide details the benefits offered by McGaw Medical Center of Northwestern University (McGaw Medical Center) and the process for enrolling in benefits. Please read the enclosed material carefully before determining your 2018 benefit elections. We recommend keeping this guide throughout the year as a quick reference to phone numbers and benefit information.

OPEN ENROLLMENT DATES

Monday, November 6 – Monday, November 20, 2017

DEADLINE FOR ENROLLING ONLINE

12:00 a.m. midnight, November 20, 2017

BENEFIT ENROLLMENT WEBSITE

<https://workforcenow.adp.com>

Registration Code: McGawNU-GME

EFFECTIVE DATE FOR BENEFIT CHANGES

January 1, 2018

or appointment date for mid-year appointees

EFFECTIVE DATES OF COVERAGE

Your coverage will be effective January 1, 2018 through December 31, 2018 for active Housestaff at McGaw the entire year. For new Housestaff, benefit coverage is effective on their appointment date. For Housestaff completing their program mid-year, insurance will be effective through the last day of the month in which they are active at McGaw.

After this time, Housestaff may be eligible to purchase COBRA coverage to continue group health plan coverage at their own expense.

CHANGES FOR 2018

Review this Benefits Guide for 2018 benefit changes including:

- The medical and prescription plan contribution rate for single coverage will increase by 3%, and the contribution rate for family coverage will increase by 1%. All other rates remain the same in 2018.
- McGaw now matches 2% of your per-pay-period gross stipend for each pay period that you contribute at least 2% to the 401(k)/Roth plan.

ANY QUESTIONS?

Call McGaw Payroll & Benefits (888-449-0016) or send an email to mcgawpayroll@ey.com with your questions.

Disclosure of Information: Ernst & Young, on behalf of McGaw Medical Center, discloses enrollment and disenrollment information to third-party administrators for purposes of benefits administration. Any disclosures will be made consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended.

Eligibility

All active McGaw Housestaff are eligible for the Life Insurance and AD&D and LTD Plans. All active Housestaff and their eligible dependent children may be covered under the Medical, Prescription, Dental and Vision Plans.

A Housestaff's legally married spouse may be covered under the Medical, Prescription, Dental and Vision Plans. If you enroll your legally married spouse, you will be required to complete the Group Health Plan Spouse Eligibility Form, on which you must indicate whether your spouse is eligible for group health plan coverage through his or her employer. If your spouse is eligible for group health plan coverage through his or her employer and you elect to enroll your spouse in the Plans, your cost for coverage will be increased by an additional amount each payroll period. In 2018, the cost is unchanged and is \$50 per payroll period. This amount is subject to change in future years, and any changes will be described in the Benefit Guide for the applicable plan year. Limited exceptions for spouses working part-time (whose employer does not subsidize premiums) will be granted if sufficient documentation is submitted to McGaw Payroll/Benefits within 30 days. If you are enrolling your legally married spouse for the first time, you will be required to submit a photocopy of your marriage certificate within 30 days of coverage as proof of marital status.

ELIGIBLE DEPENDENT CHILDREN

For the Medical, Prescription, Dental and Vision Plans, you may elect coverage for your child, adopted child, stepchild or eligible foster child if he or she is under the age of 26 (or any age if the child is dependent on you and incapable of sustaining employment because of a physical or mental disability).

If you enroll a grandchild, you may be required to provide proof that the child satisfies the dependency requirements listed above.

Which Benefits Do I Elect and What is My Cost?

DO I NEED TO ENROLL?

If you are already enrolled and do not participate in online Open Enrollment, your medical, dental, vision, prescription, and life insurance coverage will not change from 2017 coverage levels. However, the 2018 premium rates and any plan changes will automatically go into effect. If you want to have a medical or dependent day care FSA account, or change to family from single coverage or add/delete dental or vision then you must participate in Open Enrollment.

You must participate in Open Enrollment and submit enrollment electronically at <https://workforcenow.adp.com> by November 20, 2017 if you want to:

- Elect family coverage
- Elect vision coverage
- Elect a health care or dependent day care FSA

To waive all coverage, you must send an email to mcgawpayroll@ey.com stating your intention

You will need to make decisions on six benefits. Your cost (your share of the semimonthly premium) is printed on the enclosed Housestaff Insurance Premiums document.

1. MEDICAL AND PRESCRIPTION INSURANCE

The single contribution rate is \$73.94/month, and the family contribution rate is \$284.66/month. If you enroll in the medical plan, you will automatically be enrolled for prescription coverage. See page 5 for medical plan details and page 13 for prescription plan details.

2. DENTAL INSURANCE

There are no rate changes. Single coverage is \$12.30/month, and \$26.64/month for family coverage. See page 9 for plan details.

3. VISION PLAN

There are no rate changes. Single coverage is \$6.50/month, and \$17.04 for family coverage. See page 14 for plan details.

4. FLEXIBLE SPENDING ACCOUNTS (FSA)

Health Care and Dependent Day Care. The annual contribution limit is \$2,000 for a Health Care FSA and \$5,000 per family for a Dependent Care FSA. See page 15 for important guidelines.

5. COMMUTER/TRANSIT PRE-TAX BENEFIT

McGaw offers up to \$260/month pre-tax payroll deduction for your commuter expenses. See page 17 for details.

6. 401(k) TAX DEFERRED SAVINGS PLAN

McGaw now matches 2% of your per-pay-period gross stipend for each pay period that you contribute at least 2% to the 401(k) or Roth. See page 18 for details.

7. LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT

McGaw provides Unum life insurance and AD&D equal to your annual stipend at no cost to you. You can increase coverage up to 4 times your annual stipend for a semi-monthly premium. See page 19 for details.

8. LONG-TERM DISABILITY

Housestaff are automatically enrolled in LTD. No action is required. See page 20 for details.

9. PERSPECTIVES (A HOUSESTAFF ASSISTANCE PROGRAM)

A 24-hour, strictly confidential service is offered to all housestaff at no cost. No enrollment activity is required. See page 22 for details.

10. USMLE SAVINGS PROGRAM

McGaw offers a savings program for the United States Medical Licensing Exam (USMLE). See page 22 for alternative savings options.

11. SHORT-TERM DISABILITY

Housestaff are automatically enrolled in STD. No action is required. See page 24 for details.

TAX IMPLICATIONS OF HOUSESTAFF BENEFIT PREMIUMS

Your medical, dental, vision, life and FSA contributions are deducted on a pre-tax basis. Please note, since your medical, dental, vision, life and FSA contributions are paid with pre-tax dollars, those pre-tax contributions reduce your gross wages for the purposes of calculating your Social Security and Medicare taxes and in computing your annual stipend for Social Security benefit purposes. Tax implications of your life insurance premiums are discussed on page 19 of this guide.

Open enrollment website: <https://workforcenow.adp.com> Registration code: McGawNU-GME

Changing Your Elections Mid-Year

Be sure to review your options carefully because the choices you make during the enrollment period remain in effect for the entire year. Your benefits are effective on a calendar year (Jan – Dec), **not** on an academic year. In the event of an eligible change in status, you may change certain benefits.

Examples of changes in status include:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Death of your spouse or child
- Spouse's job change that results in loss of coverage
- Loss of your spouse's medical coverage dependent status
- Loss or reinstatement of a child's dependent status
- Loss of eligibility under Medicaid or a state child health plan.
- Gain eligibility for a premium assistance subsidy through Medicaid or a state child health plan.

You must submit information in writing (send email to mcgawpayroll@ey.com) regarding your change in status to McGaw Payroll & Benefits within 30 days of the eligible change in status (within 60 days of a change in status due to eligibility for Medicaid or a state child health plan). Otherwise, your next opportunity to make changes will be during Open Enrollment next November. Contact McGaw Payroll & Benefits with any questions about changes in status. You may be required to supply proof of change in status such as marriage certificate, Group Health Plan Spouse Eligibility Form, divorce decree, or letter from an employer.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you do not enroll yourself, your spouse, or your dependents when first eligible under the Plan because of other health coverage, you may be eligible to enroll in the Plan without waiting for the next Open Enrollment. If the other coverage was COBRA coverage, special enrollment will be available only if the coverage is lost because the COBRA rights are exhausted (but not, for example, if you, your spouse, or dependents simply stop paying premiums).

If the other coverage is non-COBRA coverage, special enrollment will be available if the employer sponsoring the other coverage stops contributing towards that coverage, or if coverage ends because of a loss of eligibility (by, for example, legal separation, divorce, or loss of dependent status). Losing coverage for other reasons, including failure to pay premiums and for cause, such as for filing a false claim for benefits, will not entitle you to special enrollment. Special enrollment must be requested within 30 days after your spouse's or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage, 60 days if the coverage is lost due to change in eligibility under Medicaid or a state child health plan).

If you are participating in the Plan and during the year you acquire a new dependent by birth, marriage, adoption, or placement for adoption, your dependent will be eligible for special enrollment. If you are not participating in the Plan, but are eligible to do so, and during the year you acquire a new dependent by birth, marriage, adoption, or placement for adoption, you, your spouse and your dependents may be eligible for special enrollment.

Depending on the reason for the special enrollment right, you may be able to enroll without enrolling your dependents, or you and your spouse may be able to enroll without enrolling your dependent children, as long as the enrollment is consistent with the reason for the special enrollment right. But your spouse or dependent children may not enroll unless you do. You must request special enrollment within 30 days of the relevant birth, marriage, adoption, or placement for adoption. Enrollments following a birth, adoption, or placement for adoption will be effective as of the date of the event. Any other enrollment will be effective as stated in the Plan.

Medical Insurance

McGaw Medical Center offers one medical plan, Blue Cross/Blue Shield IL PPO. The benefit period is January 1 to December 31. Read the following pages and the booklet titled *Your Health Care Benefit Program* which is available on the benefits website: <http://mcgaw.northwestern.edu>, to learn more about your benefits.

To identify non-PPO and PPO hospitals and facilities, you should contact the claim administrator at BCBSIL by calling the customer service toll-free number on your identification card (800-346-7072) or on line at www.bcbsil.com, click on provider finder and select participating provider organization (PPO). To locate a Tier1 physician within the plan, visit www.nmg.org and filter on Northwestern Medical Group

PRENATAL CARE

Upon delivery, you **must** notify BCBSIL by calling Medical Service Advisory at 800-635-1928 within two business days. If you call the Medical Service Advisory when you find out you are pregnant, the Claim Administrator will provide you information on support programs to assist you during your pregnancy.

INFERTILITY TREATMENT

Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis and/or treatment of infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection. Please read the Infertility Treatment section under Special Conditions and Payment of the booklet titled *Your Health Care Benefit Program* for additional information and limitations.

RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are not limited to:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Inpatient care following a mastectomy for the length of time determined by your attending Physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation and a follow-up Physician office visit or in-home nurse visit within 48 hours after discharge; and
4. Protheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.
5. The removal of breast implants when the removal of the implants is a Medically Necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered. Cosmetic changes performed as reconstruction resulting from sickness or injury is not considered cosmetic surgery.

Blue Cross/Blue Shield of Illinois (BCBSIL) provided this benefit before it was required and will continue to provide this coverage, if the procedures are provided by a licensed physician in accordance with the law and the terms of the applicable plan. If you receive any of these mastectomy-related benefits, these benefits will be subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the medical plan. Deductible and coinsurance details are provided in the Medical Benefit Highlights on the following pages.

Your coverage may also include benefits for annual mammograms. See your certificate/benefit booklet or call BCBSIL at the phone number on the back of your ID Card.

Medical Benefit Highlights

Your health care benefits are highlighted below. However, to fully understand your benefits, it is very important that you read the entire benefit booklet: *Your Health Care Benefit Program* available on the benefits website: <http://mcgaw.northwestern.edu> or request a copy via email at: mcpayroll@ey.com

The Utilization Review Program	A special program designed to assist you in determining the course of treatment that will maximize your benefits.
Lifetime maximum for all benefits	Unlimited
Individual deductible Tier 1 Tier 2 Tier 3	\$0 per benefit period (calendar year) \$225 per benefit period (calendar year) \$550 per benefit period (calendar year)
Family deductible Tier 1 Tier 2 Tier 3	\$0 per benefit period (calendar year) \$675 per benefit period (calendar year) \$1,650 per benefit period (calendar year)
Private duty nursing service Benefit maximum	8 visits per month
Chiropractic and osteopathic Manipulation benefit maximum	15 visits per year
Physical therapy services Benefit maximum	20 visits per year
Occupational therapy Benefit maximum	20 visits per year
Speech therapy Benefit maximum	50 visits per year
Temporomandibular joint dysfunction and related disorders Benefit period maximum	Unlimited

HOSPITAL BENEFITS

When you receive Inpatient Hospital or certain Outpatient Hospital Covered Services from a McGaw Medical Center Hospital, benefits will be provided at 90% of the eligible charge. Coinsurance does apply to Outpatient Hospital Surgery and diagnostic services. McGaw Medical Center Hospitals include Ann & Robert H. Lurie Children's Hospital of Chicago, Lake Forest Hospital, Northwestern Memorial Hospital, Swedish Covenant Hospital, Shirley Ryan AbilityLab, and Jesse Brown V.A. Medical Center.

	Payment level for Covered Services from a Tier 1 (Home Hospital/NMG)	Payment level for Covered Services from a Tier 2 (BCBSIL Participating Provider)	Payment level for Covered Services from a Tier 3 (Non-Participating Provider)
Inpatient copay	\$100 per admission*	\$275 per admission*	\$275 per admission*
Inpatient covered services	90% of the eligible charge	80% of the eligible charge	60% of the eligible charge
Inpatient substance abuse rehabilitation treatment and inpatient treatment of mental illness	90% of the eligible charge	80% of the eligible charge	60% of the eligible charge
Outpatient covered services	90% of the eligible charge	80% of the eligible charge	60% of the eligible charge
Wellness care	100% of the eligible charge, no deductible	100% of the eligible charge, no deductible	100% of the eligible charge, no deductible
Outpatient treatment of mental illness and outpatient substance abuse rehabilitation treatment	90% of the eligible charge	80% of the eligible charge	60% of the eligible charge

*Copay is due until out-of-pocket maximum (OPX) is met

McGaw Medical Center of Northwestern University

Home Hospitals: McGaw Medical Center Hospitals – Network Hospitals: Ann & Robert H. Lurie Children’s Hospital of Chicago, Lake Forest Hospital, Northwestern Memorial Hospital, Swedish Covenant Hospital, Shirley Ryan AbilityLab and Jesse Brown VA Medical Center

Lifetime Comprehensive Major Medical Coverage		Unlimited		
		Tier 1 (Home Hospital/NMG)	Tier 2 (Participating Provider)	Tier 3 (Non-Participating Provider)
Deductible (Separate PPO and Non-PPO facilities)				
	Individual:	\$0	\$225	\$550
	Family:	\$0	\$675	\$1,650
Out-of-Pocket Maximum:	Single:	\$2,200	\$4,000	10,000
	Family:	\$4,400	\$8,000	20,000
Hospital		Tier 1 (Home Hospital/NMG)	Tier 2 (Participating Provider)	Tier 3 (Non-Participating Provider)
Inpatient Hospital Services		90%	80%	60%+
Room allowance is based on the hospital’s most common semi-private room rate. Pre-Admission Testing, Skilled Nursing Facilities, Hospice and Coordinated Home Health Care are also paid on the same basis.		\$100 copay per admission	\$275 copay per admission.	\$275 copay per admission.
Outpatient Hospital Surgery and Diagnostic Tests		90%	80%	60%+
Outpatient Hospital Service		90%	80%	60%+
Including Radiation and Chemotherapy.				
Hospital Emergency Medical/Accident Care		100%	100%	100%
Initial treatment in hospital of accidental injuries or sudden and unexpected medical conditions with severe life-threatening symptoms. If an inpatient admission occurs, MSA must be contacted within two business days or benefits will be reduced.		\$125 copay	\$125 copay	\$125 copay
Physician Services		Tier 1 (NMG)	Tier 2 (Participating Provider)	Non-Participating Provider
(Based on SMA-Schedule of Maximum Allowances)				
Physician Office Visits only**		100%	100%	60%+
Office Visit Copay/Urgent Care Copay		\$30*# office visit urgent care copay	\$30*# office visit urgent care copay	
Medical/Surgical Benefits or Outpatient Physician Services		90%	90%	60%+
(Including radiologist’s, anesthesiologist’s and surgeon’s charges)				
Physician Services		Participating Provider		Non-Participating Provider
Well Care Benefits		100%		100%
(Including physical exams, diagnostic tests and immunizations)				
Physical, Speech, and Occupational Therapy		80%		60%+
Other Covered Services		80%		
<ul style="list-style-type: none"> • Ambulance • Blood and blood components • Leg, arm, and neck braces • Private duty nursing • TMJ • Allergy shots • Oxygen (includes administration) • Surgical dressings • Casts and splints 				

Applies to out-of-pocket maximum

* Does not apply to deductible

+ Deductible applies

** Tier I Physicians are only those Physicians that are Participants in Northwestern Medical Group or Pediatric Facility Foundation. Find a list at www.nm.org (Filter on Northwestern Medical Group) or for Pediatric Faculty Foundation check with the provider.

Basic Provisions

Home Hospitals: McGaw Medical Center Hospitals – Network Hospitals: Ann & Robert H. Lurie Children’s Hospital of Chicago, Lake Forest Hospital, Northwestern Memorial Hospital, Swedish Covenant Hospital, Shirley Ryan AbilityLab and Jesse Brown VA Medical Center

Durable Medical Equipment (DME):	Covered benefit. Please refer to Certificate for details.
Transplant Coverage:	Cornea, Kidney, bone marrow, heart valve, heart, heart/lung, pancreas, and pancreas/kidney, muscular-skeletal or parathyroid human organ or tissues. Transplants are paid as any other condition but must have prior procedural and facility approval.
Infertility treatment:	Covers state mandated services. Four attempts per lifetime.
Dependent Eligibility:	To age 26 .
Coordination of Benefits:	This program coordinates benefits with other group plans.

For provider information, visit the BCBSIL website: www.bcbsil.com

**This sheet only highlights the general program. Specific details are contained in the Master Policy issued to the group.
Provider charge is separate from the Home Hospital charge and will be paid at the PPO/Non-PPO rate.**

Dental Insurance

The McGaw Dental Plan is administered by MetLife. For more detailed information about the plan, please consult the Summary Plan Description (SPD). In addition, you may contact MetLife at 800-942-0854.

MetLife Preferred Dental Program (PDP) allows members to see any dentist at any time (full freedom-of-choice), ID cards are not required or provided. Eligibility and plan design information can always be verified in real time at the time of service through multiple customer service systems (MyBenefits, metdental.com, fax, or interactive voice response system).

McGaw Dental Plan — Coverage with freedom of choice and savings!

BENEFIT SUMMARY

COVERAGE TYPE	PDP IN-NETWORK	OUT-OF-NETWORK
Type A – cleanings, oral examinations	100% of PDP Fee*	100% of R&C**
Type B – fillings	80% of PDP Fee*	80% of R&C**
Type C – bridges and dentures	50% of PDP Fee*	50% of R&C**
Type D – orthodontia (Dependents until their 18th birthday)	50% of PDP Fee*	50% of R&C**
DEDUCTIBLE***	IN-NETWORK	OUT-OF-NETWORK
Individual	\$75.00	\$75.00
Family	\$225.00	\$225.00
ANNUAL MAXIMUM BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Per Person	\$1,000	\$1,000
ORTHODONTIA LIFETIME MAXIMUM	IN-NETWORK	OUT-OF-NETWORK
Per Person	\$1,000	\$1,000

* PDP fee refers to the fees that participating PDP dentists have agreed to accept as payment in full, subject to any copayments, deductibles, cost sharing, and benefits maximums.

** R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of: (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

*** Applies only to type B & C Services.

AN EXAMPLE OF SAVINGS WHEN YOU VISIT A PARTICIPATING PDP DENTIST:

This hypothetical example* shows how receiving services from a PDP dentist can save you money.

<p style="text-align: center;">Your Dentist says you need a crown, a Type C service: PDP Fee: \$670.00 R&C Fee: \$1,462.00 Dentist's Usual Fee: \$1,462.00</p> <p style="text-align: center;">*Please note: This example assumes that your annual deductible has been met.</p>	
IN-NETWORK	OUT-OF-NETWORK
When you receive care from a participating PDP dentist:	When you receive care from a non-participating dentist:
Dentist's Usual Fee is: \$1,462.00	Dentist's Usual Fee is: \$1,462.00
The PDP Fee is: \$670.00	R&C Fee is: \$1,462.00
Your Plan Pays:	Your Plan Pays:
50% X \$670 PDP Fee: – \$335.00	50% X \$1,462 R&C Fee: – \$731.00
Your Out-of-Pocket Cost: \$335.00	Your Out-of-Pocket Cost: \$731.00
<p>In this example, you save \$396.00 (\$731.00 minus \$335.00) by using a participating PDP dentist.</p>	

LIST OF PRIMARY COVERED SERVICES & LIMITATIONS

<p>Type A – Preventive</p> <p>Prophylaxis (cleanings)</p> <p>Oral Examinations</p> <p>Topical Fluoride Applications</p> <p>X-rays</p> <p>Space Maintainers</p> <p>Sealants</p>	<p>How Many/How Often:</p> <ul style="list-style-type: none"> • Two per calendar year. • Two exams per calendar year. • Two fluoride treatment per calendar year for dependent children up to 19th birthday. • Full mouth X-rays and Bitewing X-rays: one set per calendar year. • Space maintainers for dependent children up to 19th birthday. • One application of sealant material every 5 years for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to 19th birthday.
<p>Type B – Basic Restorative</p> <p>Fillings</p> <p>Simple Extractions</p> <p>Crown, Denture, and Bridge Repair</p> <p>Endodontics</p> <p>General Anesthesia</p> <p>Oral Surgery</p> <p>Periodontics</p>	<p>How Many/How Often:</p> <ul style="list-style-type: none"> • When dentally necessary in connection with oral surgery, extractions, or other covered dental services. • Periodontal scaling and root planing once per quadrant, every 12 months. • Periodontal surgery once per quadrant, every 12 months. • Total number of periodontal maintenance treatments and prophylaxis cannot exceed 4 treatments in a calendar year.
<p>Type C – Major Restorative</p> <p>Implants</p> <p>Bridges and Dentures</p> <p>Crowns/Inlays/Onlays</p>	<p>How Many/How Often:</p> <ul style="list-style-type: none"> • Initial placement to replace one or more natural teeth, which are lost while covered by the Plan. • Dentures and bridgework replacement: one every 5 years. • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed. • Replacement: once every 5 years.
<p>Type D – Orthodontia</p>	<p>How Many/How Often:</p> <ul style="list-style-type: none"> • Dependent children are covered until their 18th birthday. • All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia. • Payments are on a repetitive basis. • Benefit for initial placement of the appliance will be made representing 20% of the total benefit. • Orthodontic benefits end at cancellation of coverage.

COMMON QUESTIONS...IMPORTANT ANSWERS

Who is a participating Preferred Dentist Program (PDP) dentist? A participating dentist is a general dentist or specialist who has agreed to accept MetLife's negotiated fees as payment in-full for services provided to plan participants. PDP fees typically range from 15-45%* below the average fees charged in a dentist's community for the same or substantially similar services.

*Based on internal analysis by MetLife.

How do I find a participating PDP dentist? There are more than 187,000 participating PDP dentist locations nationwide, including over 45,000 specialist locations. You can receive a list of these participating PDP dentists online at www.metlife.com/mybenefits or call 1-800-942-0854 to have a list faxed or mailed to you.

What services are covered by my plan? All services defined under your group dental benefits plan are covered. Please review the enclosed plan benefits to learn more.

Does the Preferred Dentist Program (PDP) offer any discounts on non-covered services? MetLife's negotiated fees with PDP (in-network) dentists may extend to services not covered under your plan and services received after your plan maximum has been met, where permitted by applicable state law. If you receive services from a PDP dentist that are not covered under your plan or where the maximum has been met, in those states where permitted by law, you may only be responsible for the PDP (in-network) fee.

May I choose a non-participating dentist? Yes. You are always free to select the dentist of your choice. However, if you choose a dentist who does not participate in the MetLife PDP, your out-of-pocket expenses may be more, since you will be responsible to pay for any difference between the dentist's fee and your plan's payment for the approved service. If you receive services from a participating PDP dentist, you are only responsible for the difference between the PDP in-network fee for the service provided and your plan's payment for the approved service. Please note: any plan deductibles must be met before benefits are paid.

Can my dentist apply for PDP participation? Yes. If your current dentist does not participate in the PDP and you'd like to encourage him or her to apply, tell your dentist to visit www.metdental.com, or call 1-877-MET-DDS9 for an application. The website and phone number are designed for use by dental professionals only.

How are claims processed? Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive e-mail alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits or request one by calling 1-800-942-0854.

Can I find out what my out-of-pocket expenses will be before receiving a service? Yes. MetLife recommends that you request a pre-treatment estimate for services in excess of \$300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you're still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

How can I learn about what dentists in my area charge for different procedures? If you have MyBenefits you can access the Dental Procedure Fee Tool provided by go2dental.com where you can learn more about approximate fees for services such as exams, cleanings, fillings, crowns and more. Simply visit www.metlife.com/mybenefits and use the Dental Procedure Fee Tool to help you estimate the in-network (PDP fees) and out-of-network fees* for dental services in your area.

* Out-of-network fee information is provided by go2dental.com, Inc., an industry source independent of MetLife. This site does not provide the benefit payment information used by MetLife when processing your claims. Prior to receiving services, we recommend that you obtain pre-treatment estimates through your dentist.

Can MetLife help me find a dentist outside of the U.S. if I am traveling? Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.

*International Dental Travel Assistance services are administered by AXA Assistance USA, Inc. AXA Assistance is not affiliated with MetLife, and the services they provide are separate and apart from the benefits provided by MetLife.

** Refer to your dental benefits plan summary for your out-of-network dental coverage.

How does MetLife coordinate benefits with other insurance plans? Coordination of benefits provision in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan.

EXCLUSIONS

This plan does not cover the following services, treatments and supplies:

- Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature;
- Services for which you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic;
- Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
 - Scaling and polishing of teeth; or
 - Fluoride treatments;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to: water picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
 - Covered under any workers' compensation or occupational disease law;
 - Covered under any employer liability law;
 - For which the employer of the person receiving such services is not required to pay; or
 - Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- The following when charged by the Dentist on a separate basis
 - Claim form completion;
 - Infection control such as gloves, masks, and sterilization of supplies; or
 - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
- Caries susceptibility tests;
- Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance;
- Other fixed Denture prosthetic services not described elsewhere in the certificate;
- Precision attachments, except when the precision attachment is related to implant prosthetics;
- Initial installation of a full or removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance;
- Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- Implants including, but not limited to any related surgery, placement, restorations, maintenance, and removal;
- Repair of implants;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders;
- Repair or replacement of an orthodontic device;
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and
- Intra and extraoral photographic images

Alternate Benefits: Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pretreatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's reimbursement for those services, and your out-of-pocket expense. Procedure charge schedules are subject to change each plan year. You can obtain an updated procedure charge schedule for your area via fax by calling 1-800-942-0854 and using the MetLife Dental Automated Information Service. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

This dental benefits plan is made available through a self-funded arrangement. MetLife administers this dental benefits plan, but has not provided insurance to fund benefits.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force.

Prescription Drug Program

CVS Caremark provides your outpatient prescription drug benefits. This benefit is not part of your BCBS medical PPO insurance, requires its own prescription identification card, and is provided to all members enrolled in the McGaw medical plan.

CVS Caremark Customer Care: 866-818-6911

Website effective January 1, 2014: www.caremark.com

THERE ARE THREE WAYS TO OBTAIN YOUR OUTPATIENT

PRESCRIPTION DRUGS:

1. RETAIL PHARMACY

The CVS Caremark retail pharmacy benefit allows you to obtain covered prescriptions for up to a 30-day supply from a nationwide network of more than 67,000 pharmacies, including CVS, Walgreens, Costco, Kroger, Target and WalMart. Pharmacies can be identified by calling CVS Caremark Member Services at 866-818-6911 or by simply entering your zip code via the website pharmacy locator at www.caremark.com.

2. HOME DELIVERY

You can receive a 90-day supply by using CVS Caremark Mail Service Pharmacy. CVS Caremark Mail Service Pharmacy suggests that you request two prescriptions from your doctor. One prescription is to obtain the initial 30-day supply from a retail pharmacy. The second prescription, which you will send to the mail service facility, should be written for a 90-day supply with 3 refills.

3. RETAIL90

In addition to being able to receive maintenance medications from CVS Caremark Mail Service Pharmacy, you will also have the option, choice and convenience to purchase a 90-day supply at the following select participating network pharmacies: CVS, Walgreens, Albertsons, Osco and Sav-on. Your Retail90 co-pays will be the same as mail service.

OTHER IMPORTANT INFORMATION

- You will need to present your ID card to your pharmacy
- Clinical prior authorization monitors medications to ensure appropriate utilization.
- Specialty prior authorization now through Specialty Guideline Management (SGM), provides personalized and dependable support for a variety of complex health conditions.
- A one-time set-up for CVS Caremark Home Delivery prescriptions is required. Included in the mailing when you receive your new prescription drug benefit card, you will receive a brochure-sized form called "Mail Service Pharmacy-Order Form." Please follow the directions provided to get your mail order prescription set up for the first time with CVS Caremark Home Delivery.
- Visit www.caremark.com to check drug coverage and co-pay, find generic alternatives, review your prescription history, confirm eligibility, register for CVS Caremark Home Delivery and order refills, print a temporary ID card and search for a nearby pharmacy.

RX Co-PAY

- \$15 Generic
- \$50 Single Source Brand
- \$50 Multi Source Brand
- \$30 Generic (90-day supply)
- \$100 Single Source Brand (90-day supply)
- \$100 Multi Source Brand (90-day supply)

Vision Plan

VSP Coverage Effective Date: 01/01/2018

Visit vsp.com for more details on your vision benefit and for exclusive savings and promotions for VSP members

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with VSP Doctors and Affiliate Providers*			
WellVision Exam	<ul style="list-style-type: none"> Focuses on your eyes and overall wellness 	\$10	Every calendar year
Prescription Glasses		\$20	See Frame and Lenses
Frame	<ul style="list-style-type: none"> \$130 allowance for a wide selection of frames \$150 allowance for featured frame brands 20% savings on the amount over your allowance \$70 Costco® frame allowance 	Included in Prescription Glasses	Every other calendar year
Lenses	<ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for dependent children 	Included in Prescription Glasses	Every calendar year
Lens Enhancements	<ul style="list-style-type: none"> Standard progressive lenses Premium progressive lenses Custom progressive lenses Average savings of 35%-40% off other lens enhancements 	\$50 \$80-\$90 \$120-\$160	Every calendar year
Contacts (Instead of glasses)	<ul style="list-style-type: none"> \$130 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation) 	Up to \$60	Every calendar year
Diabetic Eyecare Plus Program	<ul style="list-style-type: none"> Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. 	\$20	As needed
Extra Savings and Discounts	<p>Glasses and Sunglasses</p> <ul style="list-style-type: none"> Extra \$20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam. <p>Laser Vision Correction</p> <ul style="list-style-type: none"> Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor 		
Your Coverage with Out-of-Network Providers			
Visit vsp.com for details if you plan to see a provider other than a VSP network provider.			
Examup to \$50	Single Vision Lenses up to \$50	Lined Trifocal Lenses up to \$100	Contact Lensesup to \$105
Frameup to \$70	Lined Bifocal Lenses up to \$75	Progressive Lenses..... up to \$75	
Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.			
Your Monthly Contribution			
\$6.50 Member Only		\$17.05 Member + Family	

Flexible Spending Accounts

Legislation effective 1/1/11 impacts healthcare Flexible Spending Accounts (FSAs):

- **Over-the counter (OTC) drugs and medicines will be considered ineligible expenses unless you have a prescription from your physician.**
- **Healthcare debit cards cannot be used to purchase OTC drugs and medicines. You will need to pay for these purchases out-of-pocket and submit a claim to receive a reimbursement.**

Please read the PayFlex brochure included in your Open Enrollment materials titled PayFlex.

Flexible Spending Accounts (also referred to as FSAs) let you take full advantage of existing laws by allowing you to pay for certain qualified medical and dependent day care expenses with pre-tax contributions. Depositing money throughout the year into a FSA allows you to avoid certain taxes (federal withholding, state withholding, OASDI and Medicare) on those amounts.

FSA DEBIT CARDS

The debit card is given to Housestaff who elect to contribute to a FSA. Housestaff can use their debit card to cover out-of-pocket health care and dependent day care related expenses. The debit card can be used only at eligible FSA locations wherever MasterCard® or Visa® are accepted. Contact PayFlex at 800-284-4885 for additional information.

McGaw offers two FSAs – Health Care and Dependent Day Care

It is advisable not to elect a Flexible Spending Account unless you are fully aware of the guidelines of the program and the ramifications of not complying. You may review IRS Publication 502 (Health) and 503 (Dependent Care) for qualifying expenses.

FILING A CLAIM

PayFlex administers the FSAs. To file a claim, go to www.mypayflex.com. Submit the claim online or print a reimbursement form and mail the completed form and receipts to the address on the form. Keep copies of ALL documentation you submit in the event it is lost in the mail.

To receive a reimbursement from your 2018 FSA account, the expenditure must have occurred from January 1, 2018 (or appointment date for mid-year appointees) through March 15, 2019 (or termination of your coverage, if earlier). Expenditures must be incurred only during active Housestaff duty. The deadline for submission of 2018 receipts is March 31, 2019. To receive a reimbursement from your 2017 FSA account the expenditure must have occurred from

January 1, 2017 (or appointment date for mid-year appointees) through March 15, 2018 and must be submitted by March 31, 2018. Please make sure you mail the forms well in advance of the deadline so that you ensure timely receipt. **Late receipts will not be honored.**

APPROPRIATE DOCUMENTATION FOR FSA REIMBURSEMENT

Health Care Claims:

- Proof of expense – Explanation of Benefits (EOB) or physician/hospital invoice describing service
- Proof of payment – Canceled check, receipt, or physician/hospital invoice indicating patient payment

Dependent Day Care Claims:

- Proof of expense – Day care receipt or canceled check to individual with SSN and dates of service
- Proof of payment – Day care receipt indicating payment or canceled check

SOME ISSUES TO CONSIDER BEFORE SIGNING UP FOR A FSA

1. Health Care and Dependent Care FSAs cannot be started, stopped, or changed outside of the Open Enrollment period, unless a qualifying change in status, or a special enrollment event occurs.
2. The expenditure period for a 2018 FSA is January 1, 2018 – March 15, 2019, unless you are a mid-year appointee, in which case your expenditure period begins on your appointment date or your end of training date.
3. Claim forms for 2018 expenses must be received no later than March 31, 2019. Funds in your account not claimed by March 31, 2019, will be forfeited.
4. Appropriate forms of documentation must accompany the reimbursement claim form.
5. Establishing a FSA will have an impact on your cash flow, since amounts are deducted from your stipend before you actually incur (and pay) the expense. You do not realize the full benefit until you get your tax-free reimbursement.
6. You cannot take a tax deduction for any health care expense for which you received reimbursement from the FSA, and you cannot submit to the FSA any expense that will be reimbursed from another source.
7. Having a Dependent Day Care FSA may offset any tax credits you may be able to take for childcare expenses. Check with your personal tax advisor to find out which approach is right for you.
8. You cannot transfer money between FSA accounts.

HEALTH CARE FSA

Health Care FSAs are governed by the following rules:

Elections cover a full plan year (January-December). Housestaff must determine the amount to be withheld for the entire year during Open Enrollment. Estimate carefully what you expect to spend because changes cannot be made after the close of the benefit enrollment period. The annual contribution limit is \$2,000.00.

Amounts you elect to have contributed to a FSA are subject to the rule that you “use it or lose it.” Housestaff forfeit any amount in a FSA that remains unused at the end of the expenditure period. The balance may not be used for the reimbursement of another benefit or carried forward to the following year. This means Housestaff must be very careful in estimating covered medical care expenses when making a fund election before the beginning of each plan year.

Claims Substantiation

Medical expenses may be reimbursed only if the Housestaff provides two written statements:

1. From an independent third party (e.g., doctor, hospital) stating the amount and date expense was incurred and the services rendered.
2. From the Housestaff stating the expense has not yet been reimbursed and is not reimbursable under any other health coverage (claim form).

Examples of eligible health care expenses include:

- Medical and dental plan deductibles, co-payments and other non-covered expenses
- Eye exams, glasses and contacts not covered by insurance
- Hearing exams and aids
- Prescription drug co-payments
- Certain over-the-counter purchases. Visit the PayFlex website at: www.payflex.com.

Examples of ineligible health care expenses include:

- Cosmetic dentistry (bleaching/bonding)
- Childbirth classes
- Cosmetic medical care (breast augmentation)
- Family counseling
- Massage therapy

DEPENDENT DAY CARE FSA

The rules for Dependent Day Care FSAs are similar to those that apply to the Health Care FSA. The Dependent Day Care FSA may be used for **child care expenses** for an eligible dependent child up to age 13, and other eligible child care or elder care expenses that allow you (and your spouse) to work, look for work or for your spouse to attend school full time. There is an IRS annual limit of \$5,000 per family (\$2,500 for married filing separately) on the amount you can contribute to a Dependent Day Care FSA. You must provide the Social Security number or taxpayer identification number of the provider when you file your income tax return.

Examples of eligible dependent day care expenses include:

- Wages paid to a person who provides care to your eligible dependents
- Licensed nursery school fees
- Childcare center costs
- Day camp fees
- After-school care – including costs for transportation to such care furnished by the dependent care provider
- Certain indirect expenses, including day-care application and agency fees

FSA CLAIM ADDRESS:
PAYFLEX SYSTEMS USA, INC.
FLEX DEPT.
P.O. BOX 981158
EI PASO, TX 79998-1158

Commuter/Transit Pre-Tax Benefit

Effective 1/1/16 McGaw Medical Center of Northwestern University is offering a pre-tax payroll deduction program for your commuter/transit expenses.

Housestaff will need to purchase their Ventra cards in advance and register their card on-line at www.payflex.com. Then you'll be able to place your order by the 10th of the month for the following month's commuter/transit expenses. Example, log-in and place your order by 12/10/17 so that your Ventra card will be loaded for 1/1/18. Your payroll deduction for your commuter/transit fees will be withheld from the stipend payment occurring on the last day of the month prior to the benefit month. In the above example, your stipend will be reduced on your 12/31/17 stipend deposit for your January transit pass.

Currently, the IRS limit for pre-tax commuter/transit expenses is \$260.00 per month. If you will be ordering commuter/transit funds of more than the IRS limit, the amount over the limit must be charged to your credit card; thus \$260 would be deducted from your stipend on a pre-tax basis and anything over \$260 would show up as a charge to your credit

card account.

Commuter/Transit benefits are not limited to the Open Enrollment period. Set-up your account and place your order as needed (by the 10th of the month prior to the month you want to utilize the benefit) or you may place a recurring order to streamline the process.

IMPORTANT:

Housestaff that will be finishing their training in June must cancel recurring orders no later than June 10th to avoid paying for commuter/transit benefits for the month of July.

Questions may be sent to mcgawpayroll@ey.com or you may call McGaw Payroll & Benefits at 888-449-0016.

CONTACT PAYFLEX FOR ADDITIONAL INFORMATION AT

800-284-4885 OR WWW.PAYFLEX.COM

MEMBER ID IS YOUR PAYROLL ID # (SEE PAYSTUB)

401(k) Tax Deferred Savings Plan/Roth Post Tax Savings

You may contribute up to the maximum amount allowable by law, \$18,000 in 2017 and \$18,500 in 2018. If you will be at least age 50 by the end of the taxable year you may be able to make additional “catch-up” contributions to the 401(k) plan of up to \$6,000 in 2018.

McGaw will match 2% of your earnings each pay period you contribute at least 2% to the 401(k) or Roth. The McGaw match continues to be 1% for those contributing 1% per pay period. If you contribute the IRS maximum before the end of the year, you will not receive the McGaw match for each pay period you are not able to contribute.

McGaw end of training:

- Your last 401(k)/Roth deduction, if applicable, will be on your last stipend check. We strongly encourage you to contact Fidelity and rollover your existing 401(k)/Roth balance to your new employer’s plan or an IRA. However, if you do not rollover your existing balance the following will apply:
 - Your balance is \$1,000 or less. You will be required to take a mandatory distribution. This distribution will be mailed to your home. If you do not rollover the distribution to a qualified plan within 60 days you may incur taxes and penalties.
 - Your balance is more than \$1,000 but does not exceed \$5,000. Unless you provide instruction otherwise, your balance will be automatically rolled over to a Fidelity IRA. You will not incur any taxes or penalties. Account opening and maintenance fees may apply.
 - Your balance is more than \$5,000. You may leave your funds in the McGaw 401(k); however, we strongly encourage you to rollover to your new employer’s plan or to an IRA. Account opening and maintenance fees may apply.

Questions? You may contact Fidelity directly at 800-343-0860 AFTER your final stipend check to request rollover paperwork.

401(k) LOANS

You may take a loan against a portion of your account up to a maximum dollar amount. Contact Fidelity for limitations and restrictions. It is your responsibility to ensure your loan is repaid in full prior to your last day of training at McGaw Medical Center. All loans not paid in full as of your end of training date are subject to IRS penalty and taxation. The unpaid loan

becomes an early distribution. If you have taken a loan and you notice loan repayments are not being withheld from your stipend check, contact McGaw Payroll & Benefits immediately.

FREQUENTLY ASKED QUESTIONS

How do I set-up a 401(k)/Roth account?

Contact Fidelity to set-up your 401(k)/Roth account. The Fidelity Enrollment guide provides more detailed information on setting up your account and the 21 investment options you may elect. Follow the instructions in the guide to set-up your account directly with Fidelity. Fidelity requires your SSN, appointment date, and birth date to enroll. If you do not have a Fidelity Enrollment guide, contact McGaw Payroll & Benefits at mcgawpayroll@ey.com

Can I change my investment options or amount being deducted during the year?

Yes. Contact Fidelity at 800-343-0860.

How does the McGaw 2% match work on my Fidelity 401(k) or Roth account?

McGaw matches 2% of your per-pay-period gross stipend for each pay period that you contribute at least 2% to the 401(k) /Roth plan. The McGaw match continues to be 1% for those contributing 1% per pay period. Therefore, it is more advantageous to have your deductions withheld throughout the year, instead of larger deductions in a few stipend checks.

I am terminating employment, how do I rollover my account?

Contact Fidelity at 800-343-0860.

Life Insurance and Accidental Death and Dismemberment

McGaw Medical Center provides Unum life insurance and AD&D equal to your annual stipend at no cost to you. You can increase coverage to 2, 3 or 4 times your annual stipend for a semimonthly premium. Life insurance is available only to active Housestaff and not family members. This plan is a double indemnity. For example, in the event of death during an accident and your election is one times your annual stipend level, your beneficiary will receive one times your stipend for life insurance and one times your stipend for AD&D. In the event of death during a non-accident, your beneficiaries will receive one times your annual stipend level only.

Life insurance provided by McGaw is a tax-free benefit for amounts up to \$50,000 per year. The Internal Revenue Service requires you to pay taxes on the value of coverage exceeding \$50,000 per year.

Your benefit is determined by taking your annual stipend and then rounding to the nearest thousand. For example, if you earn \$43,595 annually, your benefits stipend is \$44,000.

CHOOSING A BENEFICIARY

You must elect a beneficiary to receive the insurance proceeds in the event of loss of life. If you do not have a signed and dated beneficiary form on file at McGaw Medical Center, or wish to change beneficiary, please contact McGaw Payroll & Benefits at mcgawpayroll@ey.com

EVIDENCE OF INSURABILITY

Current Housestaff may increase current coverage levels only if approved by Unum. Call or email McGaw Payroll & Benefits for an Evidence of Insurability Form.

Newly appointed Housestaff may apply for coverage of 1, 2 or 3 times their annual stipend without evidence of insurability. If you apply for coverage more than 30 days after your eligibility date, or change coverage above your previously elected amount, you will be required to provide evidence of insurability and be approved by Unum in order to qualify for coverage. Call McGaw Payroll & Benefits for an Evidence of Insurability Form.

LIMITATIONS/EXCLUSIONS/TERMINATION OF COVERAGE

Life benefits for additional life coverage will not be paid for deaths caused by suicide in the first 24 months after your effective date of coverage.

AD&D benefits will not be paid for losses caused by, contributed by, or resulting from:

- Disease of the body or diagnostic, medical or surgical treatment or mental disorder;
- Suicide, self-destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while insane;
- War, declared or undeclared, or any act of war;
- Active participation in a riot;
- Attempt to commit or the commission of a crime under state or federal law;
- The voluntary use of any prescription or non-prescription drug, poison, fume, or other chemical substance unless used according to the prescription or direction of your doctor; and
- Operating any motorized vehicle while intoxicated.

Contact McGaw Payroll & Benefits for more detailed information on the plan.

Long-Term Disability

House staff are automatically enrolled. No action required on your part/for your information only

Guardian insures Housestaff with a benefit of 60% of your stipend up to \$3,000 per month for total disability. Provisions are also available for a partial disability. This benefit is available at no cost to Housestaff. [Group No. 426034](mailto:Group.No.426034) • [Phone 800-214-7039](tel:800-214-7039) • www.insmedinsurance.com/mcgaw.

A 90-day elimination period between the start of the disability and the time long-term disability (LTD) payments (90 continuous days) begin is normally covered by short-term disability benefits. However, if some of these short-term disability benefits were used previously, a leave without stipend will be required between the end of short-term disability and the beginning of LTD benefits.

DEFINITION OF DISABILITY

You may be considered disabled and eligible for benefits because of sickness or injury if:

- You are limited from performing the material and substantial duties of your regular occupation, as determined by the plan administrator; and
- You have a 20% or more loss in indexed monthly earnings due to the same sickness or injury.

Your LTD benefit will not be reduced by additional coverage you purchase on your own. Any disability payments you receive from the McGaw plan are fully taxable.

LIMITATIONS/EXCLUSIONS/TERMINATION OF COVERAGE

Benefits are not paid for disabilities caused by, contributed to, or resulting from:

- Intentionally self-inflicted injuries;
- Active participation in a riot;
- War, declared or undeclared, or any act of war;
- Conviction of a crime under state or federal law;
- Loss of professional license, occupational license or certification;
- Pre-existing conditions.

PRE-EXISTING CONDITION EXCLUSION

Because LTD insurance is intended to provide payments to people who become disabled while they are insured rather than to those whose disabling condition actually started prior to the insurance coverage, pre-existing condition exclusions/limitations are applied to insureds upon their eligibility for LTD coverage.

The pre-existing condition exclusion makes an individual ineligible for benefits for any disability that is due to a pre-existing condition if the disability begins within a specified period of time after the insured's eligibility date, as follows:

- You received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage (appointment date); or
- You had symptoms for which an ordinarily prudent person would have consulted a health care provider in the 3 months just prior to your effective date of coverage; and
- The disability begins in the first 12 months after your effective date of coverage.

MENTAL AND NERVOUS

LTD benefits are paid for up to 24 months per lifetime for disabilities caused by mental illness that meets the definition of disability. Mental and nervous benefits would continue beyond 24 months only if you are institutionalized or hospitalized as a result of the disability.

Contact McGaw Payroll & Benefits for more detailed information on the plan.

Housestaff exceeding 90 days of short-term disability must personally call McGaw Payroll & Benefits immediately to discuss the application process and qualifications for LTD. Approval/denial of LTD claims and payments come directly from Guardian.

Long-Term Disability Plan Overview

McGaw Medical Center of Northwestern University provides you with disability coverage that will pay you a monthly benefit in the event you become disabled due to a sickness or injury and guarantees you the right to maintain coverage when you complete a residency or fellowship program. This coverage is automatically provided when your residency begins and does not require enrollment forms. The plan also provides you with important options when you complete your residency or fellowship.

The following summary is intended to provide general information about your coverage.

<p>Maximum Monthly Benefit During Residency/Fellowship:</p>	<p>Full Time Housestaff Officers: 60% of income up to \$3,000 per month. The disability must start while you are insured and you must satisfy a period of 90 days during which you are disabled (totally or partially). Benefits are provided until you reach Social Security normal retirement age or recover (whichever occurs first).</p> <p>Disability is defined as your inability to perform your own specialty during the first two years of a claim. Thereafter, you are insured as a doctor of medicine for the balance of the benefit period. Maternity is covered as an illness.</p>
<p>Restrictions and Limitations During the Residency Plan/ Fellowship:</p>	<p>If you are totally or partially disabled due to a mental, nervous or emotional disorder, alcoholism or drug dependency, but are not hospitalized, a maximum of 24 monthly payments will be paid to you while the disability continues. During a period of hospitalization, benefits will be paid as for any other disability.</p> <p>Benefits will cease at the end of the maximum benefit period (Social Security Normal Retirement Age), the date your disability ends, the date you die, or the date you fail to give the Insurer proof of your continuing total disability, whichever occurs first.</p> <p>Benefits will not be paid for a disability due to war (declared or undeclared) or any act of war, intentionally self-inflicted injuries, or active participation in a riot.</p>
<p>Supplemental Coverage Opportunity During Residency/Fellowship:</p>	<p>You are eligible to apply for a supplemental policy that may raise the level of income protection to more than 100% of your current salary and guarantee the right to obtain up to \$15,000 of total coverage later without additional medical underwriting. This policy is offered with unisex rates (greatly reducing the cost for women) and does require medical and financial underwriting.</p>
<p>Your Conversion Opportunity Upon Completion of Your Residency/Fellowship:</p>	<p>You may apply for an individual non-cancelable disability policy when you complete residency or fellowship without any medical qualification (but subject to financial underwriting). The maximum benefit available with this conversion is \$5,000 per month. To apply for this individual policy, you must complete a simple application with a representative from the InsMed Insurance Agency, Inc.</p>

This is only a general overview. For specific contract language please refer to your Guardian benefit booklet. Additional information is available from your benefits office or you can contact the plan administrator, InsMed Insurance Agency, Inc., at (800) 214-7039, info@insmedinsurance.com, or www.insmedinsurance.com.

Perspectives (A Housestaff Assistance Program)

House staff are automatically enrolled. No action required on your part/for your information only

Perspectives is a Housestaff assistance program offered to all McGaw Medical Center Housestaff at no cost to the Housestaff. It is handled in a strictly confidential manner and the program director is not notified if you call or use the services.

Perspectives provides 24-hour confidential service for any non-medical life issue, such as substance abuse, marriage problems, finding child care, mental health counseling, problems with personal or work relationships, legal problems, financial problems, moving to a new area, etc. Housestaff can receive up to 3 free counseling sessions without the use of medical insurance. In addition, with referral from Perspectives, Housestaff may receive a half hour of legal advice and discounted rates on future visits.

Perspectives Online provides convenient and confidential online access to a vast and continually refreshed library of articles, self-guided assessments, links, calculators, information and resources in the following areas:

- Emotional well-being
- Family and care giving
- Health and wellness
- Daily living
- Working well
- Identify child care options
- Financial stress
- Marital/relationships
- Substances
- Job “burnout”
- Convenience services

To ACCESS PERSPECTIVES ONLINE

1. Go to www.perspectivesltd.com.
2. Click on the Online Services button on the navigation bar at the top of the page.
3. Follow the directions from there by using the username and password.
User Name: MCG501 Password: perspectives

Counselors are available between the hours of 8 AM and 6 PM CST and messages may be left 24 hours a day. The toll-free phone number is 800-456-6327.

USMLE Savings Program

McGaw offers a savings program for Housestaff to set aside funds to pay for the United States Medical Licensing Exam (USMLE). The money will be deducted from the Housestaff’s stipend check after taxes and maintained by McGaw in a non-interest bearing account. Housestaff may withdraw the full balance of the account by providing McGaw Payroll and Benefits with written notice at least seven business days before any stipend payment date. The requested amount will be included in the next stipend direct deposit. Housestaff may cancel this deduction at any time by notifying McGaw Payroll and Benefits in writing at mcgawpayroll@ey.com.

Alternatively, Housestaff may elect to have a portion of their stipend deposited directly into their own savings or other account. To elect this procedure, please complete a Direct Deposit Authorization form, and submit along with bank documentation stating the routing number and account number to: mcgawpayroll@ey.com. This program is designed only to assist Housestaff with savings for Step 3 of the USMLE. All paperwork associated with the registering and paying for the exam is the responsibility of the Housestaff member.

Forms to enroll in the USMLE Savings Program are available via email at mcgawpayroll@ey.com.

Time Off Work

McGaw offers Housestaff various paid and unpaid time off. It is important to remember that individual board requirements may not allow Housestaff to take all of the time off without having to make-up the time at the end of an academic year. For instance, if the board governing your program allows no more than 4 weeks not actively training during any year and you elect to take 15 vacation days (3 weeks) and 10 sick days (2 weeks), then one week will need to be made up at year-end before going to the next PGY level or before program completion.

Review your board requirements with your program coordinator in advance of time off so that you and your program coordinator are aware of the guidelines.

Paid time off opportunities include:

- 15 paid vacation days for PGY-1;
20 paid vacation days for PGY-2 and above
- 10 paid routine sick days
- 90 paid short-term disability (STD at 60%) days
- 6 weeks for birth of a child (combination of parental leave, sick and STD at 60%)
 - see FMLA on page 24
- 2 weeks paid parental leave

Unpaid time off opportunities include:

- Family Medical Leave Act
- Leave of absence

Short-Term Disability

House staff are automatically enrolled. No action required on your part/for your information only

Housestaff are allowed 10 routine sick days per academic year. These are paid at 100% of regular stipend. Housestaff must notify their program coordinator when taking a sick day. If a Housestaff member requires more than 10 sick days, then the Housestaff member will be eligible for short-term disability (STD). STD is paid at the rate of 60% of regular stipend. STD requires physician certification prior to or as quickly as possible following start of leave. Housestaff must personally arrange for STD with McGaw Payroll & Benefits. Failure to personally notify McGaw Payroll & Benefits will result in having to repay all overpaid funds. Additionally, the Housestaff member must personally update McGaw Payroll & Benefits with pending return to work date or need for additional time off.

Please contact McGaw Payroll & Benefits to complete the required documentation.

BIRTH OF A CHILD:

For a routine birth, a mother is entitled to six weeks off after delivery. For leave time, she will be paid two weeks parental leave, then use any remaining sick time for the year, up to 10 days; the balance of the six weeks will be made up with short-term disability benefits providing 60 percent of the usual stipend. If her physician does not release her to return to work after six weeks, she remains on short-term disability until her physician certifies that she is capable of returning to duty. If time off is necessary before delivery, again sick leave is used first and, if short-term disability coverage then is required, a physician's certification is necessary.

If her physician releases her to return to training after six weeks but she wishes to extend the leave further, she may first use any remaining vacation time for the year and then request leave of absence without stipend (see Family and Medical Leave).

A housestaff member may choose to use vacation time instead of short-term disability for maternity leave if she wishes to receive 100 percent of her stipend, but the duration is limited to vacation time remaining for the year.

The Payroll/Benefits office must be notified in advance of an anticipated birth or adoption date, and the actual date conveyed promptly, so that benefits for the infant may be initiated. A "Request for Family and Medical Leave" form must be completed and approved by the Program Director. Request the Family Medical Leave (FML) form at mcgawpayroll@ey.com.

IF YOU ARE PREGNANT, YOU WILL NEED TO DO 2 THINGS WITH REGARD TO YOUR BENEFITS:

1. Call the BCBS Medical Services Advisory (MSA) at 1-800-635-1928 within 2 days of delivery.
2. Contact McGaw Payroll & Benefits to provide notification of pending short-term disability and projected dates of absence.

FOLLOWING THE BIRTH OF THE BABY, YOU WILL NEED TO:

1. Notify BCBSIL Medical Services Advisory (MSA) within two business days of delivery at 1-800-635-1928.
2. Email mcgawpayroll@ey.com to add the baby to your insurance (within 30 days of birth).
3. Email mcgawpayroll@ey.com to finalize the dates of your leave.

Family & Medical Leave Policy

McGaw Medical Center provides qualified Housestaff with leave pursuant to the federal Family and Medical Leave Act (FMLA) and applicable state laws which may provide more generous benefits. The FMLA does not supersede any state or local law which provides greater family or medical leave protection. Your rights under the federal FMLA are explained below.

ELIGIBILITY AND NOTICE REQUIREMENTS

Each Housestaff member may be entitled to unpaid leave, not to exceed 12 weeks in a rolling 12-month period (not to exceed 26 weeks for military caregiver leave). In order to qualify for FMLA a second time, housestaff must have participated in training for a minimum of 1,250 hours in the preceding 12-month period.

The rolling 12-month period is the 12-month period following the leave. For example, if a Housestaff member takes three weeks of leave beginning on May 1, on May 1 of the next year the Housestaff member will again have the three weeks of leave available.

Housestaff must notify their program coordinator at least 15 days (or if not possible, as soon as practicable) before any proposed leave is to begin. McGaw reserves the right to delay the start of any requested leave until appropriate notice is given. In the event of an emergency, notice must be provided to the program coordinator no later than three business days after the commencement of leave. All questions about FMLA leave should be addressed to McGaw Payroll and Benefits.

If a Housestaff member suffers a program-related injury that qualifies as a serious health condition, the leave provided under this policy will run concurrently with the leave required under the workers' compensation laws. The taking of leave under this policy will not be used against Housestaff in any educational or program decision, including in the determination of stipends or discipline; provided, however, that if such leave prevents a member of the Housestaff from fulfilling the requirements of the graduate medical education program in which that Housestaff member is enrolled, that Housestaff member shall not be advanced within the program. A Housestaff member on FMLA leave has no greater rights than if no leave had been taken.

AMOUNT OF LEAVE AVAILABLE

Housestaff are generally entitled to a total of 12 training weeks (26 training weeks for military caregiver leave) of unpaid leave during a rolling 12-month administrative year, regardless of the number of events giving rise to the leave

entitlement. Leave may be taken for any one or combination of the following reasons:

Birth or Placement of a Child

Unpaid leave may be taken by Housestaff on the birth or placement for adoption or foster care of a son or daughter. Leave must be taken all at once unless McGaw agrees to permit leave on an intermittent basis. The entitlement to leave for birth or placement for adoption or foster care ends 12 months after the birth or placement for adoption or foster care.

Medical Leave

Eligible Housestaff may use FMLA leave for their own "serious health condition" or to care for a child, spouse, domestic partner or parent with a "serious health condition." A serious health condition generally involves inpatient care at a hospital, hospice or nursing home, or outpatient care which requires continuing treatment by a health care provider. To meet the definition of a serious health condition, the condition must generally exist for more than three calendar days. Medical leave may be taken all at once or in smaller increments as medically necessary.

Military Caregiver Leave

Unpaid leave may be taken by Housestaff to care for a military service member who has incurred a serious injury or illness in the line of active duty, if the military service member is the Housestaff's spouse, son, daughter, parent or next of kin. Military caregiver leave may be taken for up to a total of 26 training weeks during a single 12-month period. Housestaff who are eligible for military caregiver leave under the FMLA are limited to a combined total of 26 training weeks of leave for any FMLA-qualifying reason during the single 12-month period (only 12 of the 26 weeks total may be for a FMLA-qualifying reason other than to care for a covered service member).

MEDICAL CERTIFICATION

Housestaff who wish to take a medical leave of absence for their own serious health condition or that of an eligible family member must provide McGaw with a Health Care Provider Certification completed by the treating health care provider. This document must be provided to McGaw Payroll and Benefits no more than 15 calendar days after the earlier of the commencement of leave or the date on which the request for leave is made. Any requested clarification must be completed and returned to McGaw Payroll and Benefits within five calendar days after the request.

After receiving the Health Care Provider Certification, McGaw may require that a Housestaff see a health care

provider of McGaw's choosing in order to verify the information provided. McGaw will pay the cost of this examination. If the results of the second examination differ from the original certification, McGaw may require a third examination, again at its expense, by a health care provider which is mutually agreeable to McGaw and the Housestaff. Both McGaw and the Housestaff are obligated to cooperate in selecting a suitable health care provider. The results of this third examination will be final and binding on the Housestaff and McGaw as to the classification of the leave.

When a Housestaff takes leave because of his/her serious health condition, McGaw may require the submission of additional certifications periodically during the leave. Recertifications of the Health Care Provider Certification may be requested every 30 calendar days (or if longer, the stated duration of the leave) unless the facts and circumstances do not appear to support the original Certification or McGaw has information which casts doubt on the stated reason for leave. In such a case, a recertification of the serious health condition may be requested at an earlier point in time. McGaw will provide notice to the Housestaff of any recertifications which may be required.

INTERACTION BETWEEN FMLA AND OTHER PAID TIME OFF

Housestaff granted FMLA leave must first use any accrued sick days before taking unpaid leave. However, use of paid time off will not extend the length of the FMLA leave beyond 12 weeks. In addition, FMLA leave runs concurrently with all other types of leave, including workers' compensation and short and long-term disability. For example, for the birth of a child, house staff are entitled to 12 weeks of FMLA leave. McGaw Medical Center offers two weeks paid parental leave for all house staff. House staff giving birth will follow the two weeks parental leave with remaining sick days paid @100% of stipend and short-term disability paid @60% of stipend for the remainder of the six weeks following delivery date. Short-term disability is paid at 60 percent of the regular stipend. Any remaining leave up to the maximum 12 weeks will be unpaid. Vacation time may be used in lieu of unpaid time or to supplement short-term disability payments but will not extend the length of FMLA leave beyond 12 weeks.

BENEFITS DURING FAMILY AND MEDICAL LEAVE

During an approved FMLA leave, McGaw will continue to make available to Housestaff the same insurance benefits which are available to Housestaff not on leave. It is the Housestaff member's responsibility to continue to contribute his/her portion of any insurance premiums during leave. If the Housestaff member is paid during the leave period, the premium will be deducted from the pay available. However, during any unpaid period of leave, the Housestaff member is responsible for making the premium payment in a timely

fashion. The failure to make timely premium payments may result in the loss of benefits.

No Housestaff will lose any accrued seniority or benefits while on leave; however, additional seniority and benefits will not accrue during any unpaid family or medical leave.

RETURNING FROM FAMILY OR MEDICAL LEAVE

Housestaff returning from FMLA leave should, where possible, give McGaw at least two weeks, but not less than two work days, written notice of their intent to return to active status in the graduate medical education program. Any Housestaff who returns from FMLA leave upon or before the expiration of leave will be reinstated to active status in the graduate medical education program with equivalent benefits, stipend and other terms and conditions. However, McGaw cannot guarantee reinstatement to Housestaff whose leave extends beyond 12 weeks (26 weeks for military caregiver leave) in any 12-month period, except to the extent necessary to comply with applicable state or federal law.

If a Housestaff is on leave because of his/her own serious health condition, McGaw will require the submission of a fitness-for-duty certificate to his/her program coordinator before returning to active status in the graduate medical education program, if the absence was for more than three work days. A fitness-for-duty certificate is a doctor's note stating that the Housestaff is now able to perform his/her job and may return to active participation in the graduate medical education program. If a Housestaff member fails to provide a fitness-for-duty certificate by the end of any medical leave, that person may not be eligible for reinstatement.

FAILURE TO MEET POLICY REQUIREMENTS

If a member of the Housestaff fails to meet the requirements of this policy, the request for leave may be denied or delayed until the requirements are met. If you have any questions regarding the operation or interpretation of this policy, please contact McGaw Payroll and Benefits.

Workers' Compensation: Injured on the Job?

Have you received a needlestick or other work-related injury? If so, please seek medical assistance immediately and notify your program director. Shortly thereafter, call McGaw Payroll & Benefits at 888-449-0016 or send an email to mcgawpayroll@ey.com to file a workers' compensation claim so your medical bills will be paid.

Failure to report your work-related injury in a timely manner to McGaw Payroll/Benefits will result in delay of payment for services received and could possibly result in a collection agency seeking payment directly from the injured Housestaff.

Even if you seek medical assistance from Corporate Health, you are still required to contact McGaw Payroll/Benefits to file a claim.

Professional Liability Insurance

Contact the legal department of the hospital at which your program is based for information pertaining to your Professional Liability Insurance.

NORTHWESTERN MEMORIAL HOSPITAL

Main phone: 312-926-2000

Dept of Insurance: 630-933-6799 or 312-926-5973

ANN & ROBERT H. LURIE CHILDREN'S HOSPITAL OF CHICAGO

Main phone: 312-227-4000

Risk Management: 312-227-4204

VA HOSPITAL

Main phone: 312-569-8387

Risk Management: 312-569-6909

SHIRLEY RYAN ABILITYLAB

Main phone: 312-238-1000

Office of General Counsel: 312-238-1537

COBRA Continuation Coverage

A federal law enacted in 1985 requires most group health plan sponsors to offer participants and their family members the opportunity for a temporary extension of health coverage at group rates in certain instances when coverage under these plans would otherwise end.

McGaw Housestaff who are covered under the McGaw group health plans at the time of the end of training at McGaw are eligible for COBRA continuation coverage. Their current insurance will be terminated at the end of the month in which they terminate. For example, if you terminate from McGaw on June 22, your insurance will cease on June 30.

You are eligible to elect to continue your current medical, prescription, dental and/or vision insurance. You may **not** continue life insurance, long-term disability or your FSA account, except that under very limited circumstances you may continue your healthcare FSA on an after-tax basis for the remainder of the year in which you terminate.

Following the end of your training, you will receive a letter from PayFlex informing you of the cost and the deadlines for applying for coverage. Failure to meet the deadlines means automatic cancellation of insurance and loss of rights under COBRA. Once you elect coverage, it is your responsibility to make sure that payments are made in a timely manner. Even if an invoice is lost in the mail and not received by you, you must contact PayFlex to arrange for payment by the deadline. There are no exceptions to this policy.

All questions or inquiries in regards to COBRA should be directed to PayFlex at 800-284-4885, including:

- How much does COBRA cost?
- How does COBRA work?
- What plans are included in COBRA?
- How to change your home address if you are a current COBRA participant?
- When are payments due?
- How do I sign-up?

FREQUENTLY ASKED QUESTIONS

Does McGaw pay for my coverage during the days following the end of training while I am deciding if I want COBRA?

No. Your insurance is terminated as indicated above. If you elect COBRA within the 60-day deadline, the insurance is effective retroactive back to the date of lost coverage.

Can I add my newborn to COBRA?

Yes. Contact PayFlex at 800-284-4885 within 30 days (your window for “Change in Status”) to inform them of your newborn. If you are currently paying for COBRA at the single rate, you will owe additional funds to increase to the family rate.

I never received an invoice from PayFlex and now they’ve canceled my insurance. Can I still have coverage if I pay late?

No. It is your responsibility to ensure that payment is made in a timely manner and to notify PayFlex of any change in address. If a couple weeks have passed into the new month and no invoice is received, you should contact PayFlex immediately to make arrangements for payment.

**COBRA PREMIUM ADDRESS:
PAYFLEX SYSTEMS USA, INC.
P.O. BOX 953374
ST. LOUIS, MO 63195-3374**

Your Stipend Check Stub/Direct Deposit/Forms W-4 and IL-W-4

McGaw housestaff are paid twice each month, on the 15th and the last day of the month.

YOUR STIPEND CHECK

The top section of your stipend check is a live check. Your check detail is provided on the stub below.

DIRECT DEPOSIT

Direct Deposit ensures that your stipend is automatically deposited in your bank account each and every payday. No more trips to the bank to deposit your check and no lost checks. Lost checks may take 1-2 payroll cycles to be reissued.

Paper check stubs are not issued. Electronic check stubs are available on-line at:

<https://workforcenow.adp.com>
Registration Code: McGawNU-GME

If you do not remember your user name and password please click on “forgot user id/password” and follow the prompts.

To sign-up for Direct Deposit, email or fax a completed Direct Deposit Authorization Form to McGaw with a voided check. Request the form at: mcgawpayroll@ey.com.

If you close your bank account for any reason you must notify McGaw Payroll & Benefits immediately. Your bank may hold the Direct Deposit for up to ten days before returning it to the payroll provider. In other words, it may take 1-2 payroll cycles to rectify the problem and reissue your stipend check, due to your account closure.

If at anytime you wish to change banks or accounts, notify McGaw Payroll & Benefits approximately 2 weeks prior to the anticipated switch. You will be asked to provide a new Direct Deposit Authorization Form and email indicating you wish to stop Direct Deposit on your current account.

FORMS W-4 AND IL-W-4

Your stipend check stub indicates the amount being withheld for federal and state taxes as well as deductions for elected benefits.

McGaw Payroll & Benefits cannot provide assistance completing forms W-4, IL-W-4 or IN W-4 (if applicable). Contact your tax advisor for assistance completing the forms or for questions regarding your withheld tax.

If you wish to change your taxable marital status or number of exemptions, submit a new W-4 (federal and/or state) via fax or mail. Request forms via email at: mcgawpayroll@ey.com. Forms must be completed in entirety with date and signature or will not be considered valid.

FREQUENTLY ASKED QUESTIONS

How long does it take before the Direct Deposit starts working?

It depends on when in the payroll cycle the information is received. If the information is received at least 7 business days prior to check date, your payroll should be direct deposited on that check date.

The stipend check never arrived at my house. Can I get a replacement?

If after 10 days your stipend check has not been received (not Direct Deposit, but an actual stipend check), we will ask that you sign an affidavit indicating you will not cash the check if it eventually does arrive. We will then place a stop payment on the check and reissue you a check on the next payroll period.

I can't find my last stipend check stub. Can you mail another one?

Stipend check stubs are available online at <https://workforcenow.adp.com>.

2017 W2s will also be available online at the web address provided above (<https://workforcenow.adp.com>).

Registration Code: McGawNU-GME

