

**LOYOLA UNIVERSITY NEW ORLEANS**  
**FLEXIBLE BENEFITS PLAN**  
(Including Flexible Spending Accounts)

**Summary Plan Description**

**Restated Effective January 1, 2009**

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# Loyola University New Orleans Flexible Benefits Plan

Loyola University New Orleans offers all eligible employees the opportunity to participate in the Loyola New Orleans Flexible Benefits Plan (the "Plan").

The Plan enables you to choose the benefits and level of coverage that best fit your needs. Available benefit options include medical (including prescription drug), dental, vision, optional term life insurance, optional AD&D, and long-term disability. In most cases, you pay your share of the cost for these benefits with pre-tax dollars. As a result, your taxable pay is reduced.

*Note: You may also choose to elect dependent life insurance coverage although, due to IRS rules, this benefit cannot be included in a flexible benefits plan and this coverage must be paid for on an after-tax basis. References to dependent life insurance are included in this booklet however, as many of the definitions and rules are the same as those for the benefits covered under the Flexible Benefits Plan.*

In addition, you may choose to participate in the Health Care Flexible Spending Account (HCFSA) and/or the Dependent Care Flexible Spending Account (DCFSA). These flexible spending accounts allow payment for many typical medical expenses and/or dependent or child care needs with tax-free money.

This booklet is the Summary Plan Description of the Flexible Benefits Plan for eligible employees. This summary is intended to provide an overview of the Flexible Benefits Plan in easy-to-read, simplified terms. It cannot cover every detail of the Plan. The Plan is operated according to the terms of a legal document called a Plan Document. In the event of a conflict between this summary and the Plan Document, the Plan Document will be followed.

The University intends to maintain this plan for eligible employees, but reserves the right to change or end the Plan at any time. These changes could affect the benefits provided or your contributions. This booklet is not a guarantee of employment or an employment contract.

## Eligibility

All full-time faculty and staff are eligible to participate in the plan. New employees are eligible to participate on the first day of the month following hire, provided the required enrollment form is returned within 30 days of that date. If you become eligible at any time other than the beginning of a plan year, your elections will be for the remainder of the calendar year.

For some flexible benefits, you have the option to enroll eligible dependents. For medical (including prescription drug), dental, vision, optional life and accidental death and dismemberment, and the HCFSA, the term eligible dependent means:

- Your lawful spouse (unless you are legally separated),
- Your unmarried, dependent children under age 21 (14 days to under age 21 for dependent life insurance) who reside with you for more than half of the year and who do not provide more than one-half of their own support.
- Your unmarried, dependent children under age 25 who are full time students in a licensed or accredited school and depend on you for primary financial support.
- Your stepchildren who reside in your home.
- Adopted children for whom the final court order has been secured, or who have been placed in your home for adoption purposes.
- Except for dependent life insurance and family accidental death and dismemberment insurance, any other children for whom you or your spouse have legal custody and for whom you provide principal support and maintenance.

- Your unmarried children who are unable to support themselves due to a mental or physical disability, are primarily dependent upon you for support, and who were disabled and enrolled in coverage before reaching the limiting age listed above. Proof of the handicap must be provided within 30 days of the date the child would have otherwise become ineligible for coverage.

Additional proof of Student or Handicapped status may be required from time to time.

**The definition of “eligible dependent” is different under the Dependent Care Flexible Spending Account (DCFSA). This definition is discussed in detail under the DCFSA section of this booklet.**

## **Enrollment**

You must enroll in the Plan and authorize the necessary contributions within 30 days of your eligibility date. If you do not complete the required enrollment form(s) within this timeframe, you will be treated as having elected a “default” plan that includes:

- Employee only University paid basic term life insurance coverage; and
- Long-term disability coverage.

You will not be able to change your plan options (or add dependents) until the next annual enrollment period, unless you experience a “change in status” as explained in a later section.

Your decision regarding dependent coverage can vary for different benefits. For example, you may choose “Employee Only” coverage under the medical plan and “Employee and Family” coverage under the dental plan. If you and your spouse are both eligible employees, only one of you may cover a dependent child. However, if you choose to cover your dependents they must be covered under the same option as you. For example, you cannot decline medical coverage for yourself but cover your dependent children.

If you are not actively at work on the day coverage would otherwise become effective, your benefits, other than medical (including prescription drug coverage), may be limited or delayed until after you return to work on a full-time basis. For more information regarding these limitations, please see the separate summary plan description for each coverage or contact the Human Resources Department.

Further, if you do not enroll yourself or your eligible dependents when initially eligible, and you later wish to enroll them during a subsequent annual enrollment period, you or your dependent will be considered a “late entrant.” Coverage may be delayed for certain benefits until satisfactory evidence of good health is provided or limited for a pre-existing condition. Please contact the Human Resources Department for more information regarding the benefits offered, creditable coverage and benefit limitations for late entrants.

## **Annual enrollment**

After your initial election, you make your personal choices for your flexible benefits during the annual enrollment period each year. The benefits you choose go into effect on January 1<sup>st</sup> following the annual enrollment period and generally remain in effect through December 31.

If you do not complete and return a new enrollment form during the annual enrollment period, your benefit options (i.e. medical [including prescription drug], dental, vision, life, AD&D, long-term disability and dependent life) will be the same as those that were in effect the prior year, and your compensation will be reduced by whatever amount is necessary to purchase those benefits for that year. Your spending account elections (HCFSAs and DCFSA) will be reduced to zero.

If you wish to participate in the flexible spending accounts, you will be required to make an election each year. You can use the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account worksheets to help estimate eligible expenses for the plan year and to determine how much to contribute to your accounts. Worksheets are shown in your Benefits Guide and can also be obtained from the Human Resources Department.

## When you can change your elections

Because of the tax advantages provided under this flexible benefits plan, the Internal Revenue Service restricts the coverage changes you may make during the plan year (January 1 through December 31). In general, your initial election or any election you make at annual enrollment is binding throughout the plan year. However, you may be permitted to make certain election changes during the plan year if you experience a “change in status.” Those events that qualify as “change in status” events and the types of election changes that will be permitted if you experience a change in status are set out in the following chart.

Permissible mid-year election changes include:

Change in Status Event	Medical, Dental, Vision and HCFSA	Life Insurance and AD&D	DCFSA
Marriage, birth or adoption*	<ul style="list-style-type: none"> <li>• See <i>HIPAA Special Enrollment Rights</i>.</li> <li>• You may enroll your new spouse or newly acquired dependent child to your existing dental or vision coverage.</li> <li>• You may increase your HCFSA election.</li> <li>• You may drop coverage if you are enrolled for coverage under your spouse's plan.</li> </ul>	<p>You may either increase or decrease your coverage.</p> <p>Evidence of insurability may be required to enroll or increase coverage.</p>	<p>You may increase/decrease your DCFSA election if the event affects your dependent care expenses and the change is consistent with the event.</p>
Death of dependent or divorce, legal separation or annulment	<ul style="list-style-type: none"> <li>• You must drop coverage for the affected dependent.</li> <li>• You may decrease your HCFSA election.</li> </ul>	<p>You may either increase or decrease your coverage.</p> <p>Evidence of insurability may be required to enroll or increase coverage.</p>	<p>You may increase/decrease your DCFSA election if the event affects your dependent care expenses and the change is consistent with the event.</p>
<p>Change in the employment status of the employee, spouse or dependent (e.g. change in work hours, change between salaried and hourly and leaves of absence.)</p> <p>The event must affect eligibility for coverage under this or another employer's plan and the election change must be consistent with the event.</p>	<ul style="list-style-type: none"> <li>• You may enroll for coverage if the change in employment status results in a loss of eligibility for other coverage.</li> <li>• You may drop coverage if the change in employment status results in eligibility for other coverage and you are enrolled in another health plan.</li> <li>• You may change your HCFSA election.</li> </ul>	<p>You may either increase or decrease your coverage.</p> <p>Evidence of insurability may be required to enroll or increase coverage.</p>	<p>You may increase or decrease your DCFSA election if the event affects your dependent care expenses and the change is consistent with the event.</p>
Dependent loses benefit eligibility (for example, marries, reaches limiting age, loses student status)	<ul style="list-style-type: none"> <li>• You must drop the affected dependent's coverage</li> <li>• You may increase your HCFSA election if the dependent remains eligible under the HCFSA.</li> <li>• You may decrease your HCFSA election if the dependent no longer qualifies under the HCFSA.</li> </ul>	<p>You may drop family AD&amp;D coverage if you no longer have any dependents.</p> <p>Not applicable to life insurance coverage.</p>	<p>You may decrease your DCFSA election if your dependent ceases to be qualifying individual for the DCFSA.</p>

Change in Status Event	Medical, Dental, Vision and HCFSAs	Life Insurance and AD&D	DCFSA
Loss of other employer-sponsored medical coverage by the employee, spouse or dependent or loss of eligibility for Medicaid coverage	See <i>HIPAA Special Enrollment Rights</i> .	N/A	N/A
Employee or dependent becomes eligible for Medicare or Medicaid or loses eligibility for Medicare	<ul style="list-style-type: none"> <li>You may drop coverage upon enrollment for Medicare or Medicaid.</li> <li>You may enroll for coverage if Medicare eligibility is lost.</li> </ul>	N/A	N/A
Court issues order regarding medical coverage of child (qualified medical child support order, or QMCSO)	<ul style="list-style-type: none"> <li>You may enroll yourself and/or enroll the child in the medical, prescription drug, dental and vision plan and increase your HCFSAs election if required to provide coverage.</li> <li>You may drop coverage or reduce your HCFSAs election if your former spouse is ordered to provide coverage and coverage is actually provided.</li> </ul>	N/A	N/A
Enrollment period for coverage under your spouse or dependent's plan occurs while your elections are in effect	<ul style="list-style-type: none"> <li>You may drop coverage if you are enrolled for coverage under another employer's plan.</li> <li>You may enroll for coverage under this plan if coverage under the other employer's plan was dropped during that plan's enrollment period.</li> <li>You may not change your HCFSAs election.</li> </ul>	You may make election changes that correspond with the coverage elections made under other employer's plan.	You may decrease your DCFSA election if your spouse elects coverage under a DCFSA offered by his/her employer.
You change dependent care providers	N/A	N/A	You may change your DCFSA election regardless of whether the new provider is a relative.
Significant increase in cost of dependent care	N/A	N/A	You may increase your DCFSA election <i>but only if the cost change is not imposed by a relative.</i>
Decreased need for dependent care	N/A	N/A	You may decrease your DCFSA election if your need for dependent care decreases (for example, child starts school).

*You cannot change your elections during the year if:*

- You decide you can't afford the deductions from your pay and want to stop them.
- You have an unforeseen expense and need the money for something else.
- You decide you don't like, or want to participate in, the plan during the year.
- You have medical or dependent care expenses that are larger or smaller than you anticipated.

*Note: Although dependent life insurance is not subject to the IRS rules listed above, the provisions for changing your dependent life elections during the Plan Year are the same as those shown for life insurance in the table above.*

## **HIPAA Special Enrollment Rights**

Generally you can only change your medical coverage during the annual enrollment period which occurs at the end of each year or when necessary due to a change in status as discussed above. This means that your election of a particular benefit option or your election to decline enrollment will remain in effect for the entire plan year.

However, you may also change your medical benefit option or enroll during the plan year if you qualify for a HIPAA special enrollment right.

There are four circumstances under which you will qualify for a HIPAA special enrollment right:

### **Acquisition of new dependent**

If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll yourself and your new dependent in any medical benefit option. If you are already enrolled in the plan when you acquire a new dependent, you may enroll your dependent in your current option or you may change your election and enroll yourself and your dependent in a different medical option.

To exercise this special enrollment right, you must enroll yourself and/or your dependents no more than 30 days after the date you acquire the new dependent.

If you don't enroll a new dependent within 30 days, you generally will not be permitted to enroll the dependent until the next annual enrollment period.

### **Loss of other coverage (excluding Medicaid)**

If you opted out or waived enrollment for yourself or for an eligible dependent because other health coverage (including COBRA coverage) was in effect, you may enroll yourself and your dependents in the plan if you or your dependents lose eligibility for that other health coverage or if employer contributions for that coverage are terminated.

For this purpose, "loss of eligibility" includes, but is not limited to:

- A loss of coverage that results from termination of employment, reduction in hours of employment; legal separation or divorce, death, or cessation of dependent status (e.g. reaching the maximum age to be eligible as a dependent under a plan).
- In the case of HMO coverage, a loss of benefits that results when an individual no longer resides, lives or works in an HMO service area and there is no other benefit package available to the individual;
- A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits under the other plan; and
- A situation in which a plan no longer offers any benefits to the class of individuals of which that individual is a part.

Loss of eligibility for other coverage does not include a loss due to the failure to pay premiums on a timely basis or termination of coverage for cause, such as fraud.

If you were not enrolled in the medical plan, you may enroll yourself and your eligible dependents in any medical benefit option. If you are already enrolled in the plan and one of your dependents loses other coverage (or employer contributions for the other coverage terminate), you may enroll your dependent in your current medical option or you may change your election and enroll yourself and your dependent in a different medical option.

To exercise this special enrollment right, you must enroll yourself and/or your dependents no more than 30 days after the date the other coverage ends (or employer contributions terminate).

### **Loss of Medicaid coverage (effective April 1, 2009)**

If you or an eligible dependent are enrolled for coverage under Medicaid or a state children's health insurance program (CHIP) and that coverage ends because of a loss of eligibility for it, you may enroll yourself and your eligible dependent for medical coverage under the plan, provided you do so no more than 60 days after the date the Medicaid or CHIP coverage ends.

If you were not enrolled in the plan, you may enroll yourself and your eligible dependents in any medical benefit option. If you are already enrolled in the plan and your dependent loses eligibility for coverage for coverage under Medicaid or CHIP, you may enroll your dependent in your current medical option or you may change your election and enroll yourself and your dependent in a different medical option.

### **Eligibility for Medicaid/CHIP premium assistance (effective April 1, 2009)**

If you or an eligible dependent become eligible to have Medicaid or CHIP assist in the payment of your medical coverage under the plan, you may enroll yourself and your eligible dependent for medical coverage under the plan, provided you do so no more than 60 days after you or your dependent is determined to be eligible for such assistance.

If you were not enrolled in the plan, you may enroll yourself and your eligible dependents in any medical benefit option. If you are already enrolled in the plan and your dependent becomes eligible for premium assistance from Medicaid or CHIP, you may enroll your dependent in your current medical option or you may change your election and enroll yourself and your dependent in a different medical option.

### **When changes become effective**

If you experience a change in status or a HIPAA special enrollment right and wish to make a change in your benefit elections, you must notify the Human Resources Department, complete and return the appropriate forms within 30 days of the event (60 days for Medicaid/CHIP events). All election changes must be permitted under the terms of the plan documents and insurance contracts. You will be notified of any change in the amount of your contributions at that time.

Election changes to medical (including prescription drug) coverage resulting from the birth, adoption or placement for adoption of a child or due to marriage will be effective on the date of birth, adoption, placement, or marriage.

Other election changes will become effective on the first day of the pay period that coincides with or next follows the date your new enrollment form (or other forms as applicable) is accepted by the Human Resources Department. Spending account election changes become effective on the first day of the pay period that begins coincident with or immediately following the first day of the calendar month after the date the new election form is accepted by the Human Resources Department.

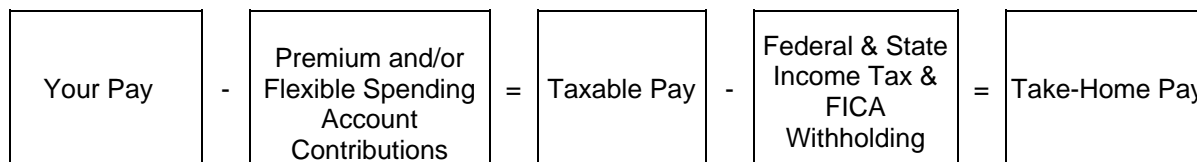
If you increase either of your flexible spending account elections during the plan year due to a change in status, the increased amount can only be used for expenses you incur after the change becomes effective.

For certain benefit options (excluding medical), proof of good health may be required to make a coverage change due to a change in status. If this is the case, coverage changes requested will become effective on the later of the date of the status change or the date the proof of good health is approved. Please contact the Human Resources Department for more information regarding the benefit options offered and any limitations that may be imposed.

## The Cost of Your Coverage

Your contributions for most benefits are deducted from your paycheck on a before-tax basis.

Under the before-tax payment plan, the sequence works like this:



Your share of the cost of the benefits you elect and your flexible spending account contributions are paid before your taxable pay is calculated. As a result, your taxable pay is reduced. Lower taxable pay means lower taxes and higher take-home pay.

The cost for the following benefits is deducted on a *before-tax* basis:

- Medical (including prescription drug)
- Dental
- Vision
- Employee Additional Term Life Insurance
- Accidental Death and Dismemberment Insurance
- Long-term Disability Insurance\*
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account

*\*You may also choose each year whether to have your deductions for long-term disability coverage taken on a pre-tax or post tax basis. The Loyola University Benefits Guide provides more details on this issue.*

However, the IRS treats the “value” of any associate life insurance in excess of \$50,000 as taxable pay. This value is calculated according to an IRS table and will appear on the W-2 that the Company prepares for you at the end of the year.

As noted previously, due to IRS rules, dependent life insurance is paid on an after-tax basis and is therefore not technically included in the flexible benefits plan.

### Effect of pre-tax deductions on benefits

Even though participation in the Flexible Benefits Plan reduces your taxable income, your pay for determining other benefits, such as life insurance and retirement, will not be affected. For example, if your annual income is \$30,000 and you set aside money from your pay in the flexible spending accounts, your life insurance coverage will still be based on income of \$30,000. Your federal income taxes, however, will be calculated after deposits to the flexible spending accounts have been deducted.

And, since you don’t pay Social Security taxes on your before-tax contributions, they are not included in your earnings reported to the Social Security Administration. This means you will be paying less into the Social Security system and could translate into reduced Social Security benefits when you retire. However, this reduction is usually small. Of course, a byproduct of the decrease in Social Security (and federal and state) taxes is higher net pay, which enables you to save for your retirement through other methods.

You should also keep in mind that you cannot use the amount of your before-tax contributions for medical or dental benefits as part of your itemized deductions when preparing your annual tax return.

## Flexible Spending Accounts

The Loyola University New Orleans Flexible Spending Accounts provide you with a great way to save on your taxes. The Health Care Flexible Spending Account (HCFSA) and Dependent Care Flexible Spending Account (DCFSA) allow you to pay for typical medical expenses and/or dependent or child care needs with dollars that are deducted from your pay before taxes are calculated.

You use the HCFSA and DCFSA in much the same way you use your bank checking account - you put money into either account (or both) each pay period, and when you have an eligible expense, you're reimbursed from that account. Because your deposits and reimbursements are tax-free, using the HCFSA and/or DCFSA reduces your taxes and increases your take-home pay.

You can change the amount of your deposits each year during the annual open enrollment, or if you experience a "change in status." See the *When you can change your elections* section for more details.

The HCFSA provides a tax-free method of paying for qualified health care expenses that aren't covered by Loyola's medical (including prescription drug), dental or vision plans or *any* medical, prescription drug, dental and vision plans in which you may be enrolled.

The DCFSA provides tax-free payment for child care expenses or care for a disabled adult.

Planning is the key to maximizing your savings through the two spending accounts. Together or separately, they provide a tax-saving way to pay for certain health and dependent care expenses. You should consider your options carefully, perhaps with the help of a financial advisor.

According to Internal Revenue Service (IRS) regulations, you will forfeit any money left in your account that is not used for expenses incurred by the end of the plan year. This is called the "use it or lose it" rule, and it's the IRS's way of making sure the spending accounts are used as intended. Keep this rule in mind when considering how much to put into your flexible spending accounts.

## Health Care Flexible Spending Account (HCFSA)

You can use the HCFSA to pay unreimbursed health care expenses for yourself, your spouse and any other dependents as defined in Section 152 of the Code, without regard to the income limitations specified therein. Actual coverage under any of the Loyola University New Orleans plans is not required.

You should plan to use the HCFSA to pay for any medical, dental, vision or hearing care that you and your eligible dependents expect to receive during the plan year that won't be paid by the Loyola University New Orleans plans or by any other plan.

*In general*, the list of eligible expenses under the HSA are the same as those shown in IRS publication 502, "Medical and Dental Expenses" available from the local IRS office or the IRS web site at [www.irs.ustreas.gov](http://www.irs.ustreas.gov). Here are some examples of expenses for which you can be reimbursed:

- Deductibles and copayments for the Loyola University New Orleans medical, dental or vision plans or your spouse's group plan (provided you are not reimbursed for these amounts through coordination of benefits).
- Certain medical, dental and vision expenses not covered under any health plan.
- Hearing examinations and hearing aids.

Some examples of expenses that are *not* eligible for reimbursement from the HSA include:

- Health club memberships.
- Premiums for health insurance coverage under this or any other plan.
- Cosmetic surgery and similar procedures.

A detailed list of eligible and ineligible expenses is provided at the end of this section.

Certain over-the-counter (OTC) medications are eligible for reimbursement through the HCFSA. To be eligible for reimbursement, the OTC drug must be for “medical care” which means the drug or service is needed to treat a medical condition. However, many OTC medications can be used to promote general good health as well as to treat a medical condition. These are called “dual purpose” items. Special rules apply in order to receive reimbursement for dual-purpose items. See the section called *How To File A Claim*.

If you participate in this account, you'll designate a dollar amount that will be deducted from your paycheck in equal installments on a tax-free basis and deposited to your account. When you have an eligible health care expense, you are reimbursed from your account with those same tax-free dollars.

The maximum HCFSA deposit for any plan year (January 1<sup>st</sup> through December 31<sup>st</sup>) is \$5,000. The minimum deposit is \$120 per plan year.

## HCFSA Formula

The following formula shows the *estimated* tax advantages of using the HCFSA for one family.

1. Find your income tax bracket percentage, e.g. 10%, 15%, etc.
2. Add the FICA tax percentage (currently 7.65%)
3. Multiply the sum of 1 and 2 by your annual HAS election.

### Example

The Cleaver family consists of Ward and June and their children Wally and Theodore. Ward and June both work and have a combined income of \$50,000, which puts them in the 15% income tax bracket. The family has \$2,500 in health care expenses that are not covered by any medical, dental or vision plans.

Using the above formula, the Cleavers can estimate their tax savings as follows:

$$(15\% + 7.65\%) \times \$2,500 = \$566$$

**Ward and June have \$566 more in the bank simply because they used the HCFSA. The above figures are illustrative only, are based on estimated 2008 federal tax rates exclusive of exemptions and deductions and do not include any state tax. You may want to talk with your tax advisor for more information.**

## The HCFSA vs. the federal tax deduction

Expenses for which you have been reimbursed cannot be claimed as itemized deductions on your federal income tax return. But keep in mind your medical and dental expenses may be deducted from your federal income tax return only if they total more than 7.5% of your income. Since few people's medical expenses reach that high of a percentage, most find the HSA works to their advantage.

## Dependent Care Flexible Spending Account (DCFSA)

The cost of care for young children can be a major expense for many families. And for some families, the cost of care for an elderly or disabled adult takes up what's left of an already stretched budget.

If you're paying for care for your child or a dependent adult, you probably know what you'll pay each year – the costs are easy to predict. That makes it easy to determine how many tax-free dollars to put into your Dependent Care Flexible Spending Account (DCFSA).

You decide how much you want to deposit into your DCFSA – up to \$5,000 (\$2,500 if you are married and file separate tax returns) per plan year. The minimum deposit is \$120 per plan year. You should keep in mind that, under IRS rules, you may deposit a maximum of \$5,000 *per family*. For example, if you and your spouse are both eligible to participate in a DCFSA (from the same or separate employers) the most you and your spouse may contribute to all DCFSA plans combined is \$5,000.

## Eligible dependent care expenses

The rules for determining eligible expenses under the DCFSA are the same as the federal child care tax credit. In order to be eligible for reimbursement, a dependent care expense must meet the following requirements:

- The care must be necessary in order for you to work, or for you to work part-time, or attend school full-time.
- If you are married, the dependent care must be necessary for you and your spouse to work, or for you to work and your spouse to attend school full-time (unless your spouse is incapable of caring for himself or herself).
- If you are divorced or separated, a dependent care expense is eligible for reimbursement only if you are the custodial parent. You will be considered the custodial parent if you have custody of your child for a greater period during the year than the other parent. [Note: a non-custodial parent is not eligible for reimbursements under a DCFSA even if that parent is responsible for paying child care expenses or may claim the child's exemption on his or her federal income tax return for the year.]
- Your DCFSA reimbursements must not be greater than your annual earned income or your spouse's, whichever is lower. If your spouse is a full-time student or is mentally or physically incapacitated – and does not have a regular job – his or her financial status will be based on an assumed monthly income of \$250 if you have one eligible child, and \$500 if you have two or more eligible children.
- If your dependent is a *child* and you want to use the DCFSA to pay his or her care expenses:
  - He or she must be younger than age 13 and reside with you for more than one-half of the calendar year. (No age limit applies for a child who is physically or mentally incapable of caring for himself or herself.)
  - Care may be provided either inside or outside your home, but it may not be provided by anyone considered your dependent for income tax purposes, or one of your older children under age 19. Further, expenses outside your home for a disabled child age 13 and older are eligible only if the child regularly spends at least eight hours each day in your household.
  - If you use a facility that cares for more than six children, the facility must be licensed.
- If the dependent is an *adult* and you want to use the DCFSA to pay his or her care expenses:
  - He or she must be physically or mentally incapable of caring for himself or herself.
  - He or she must reside with you for more than one-half of the year.
  - He or she must be dependent upon you for more than one-half of his or her financial support.
  - Care may be provided either inside or outside your home. Expenses outside your home (such as a nursing home) are eligible only if the dependent regularly spends at least eight hours each day in your household.

You can use the DCFSA to pay for:

- Care in a child or adult care center that complies with state and local regulations.
- Nursery school or summer day camp.
- Dependent care duties performed by a housekeeper.
- Dependent care provided by a relative, as long as he or she is not one of your dependents.
- Baby-sitting inside or outside your home.

The following expenses are not eligible for reimbursement from your DSA:

- Baby-sitting that is not work-related.
- Overnight camp.
- Educational expenses. Generally, the IRS considers costs related to kindergarten and above to be primarily educational in nature. You can claim expenses for before school and after school care. Check with the Human Resources Department for a determination on sports or other day camps where the organization

providing the service is a licensed child care facility and/or the child's attendance allows both parents to work.

- Nursing home expenses for dependents who don't live with you.

For a complete list of eligible and ineligible expenses, see IRS Publication 503, "Child and Dependent Care Expenses", available from the local IRS office or the IRS web site at [www.irs.ustreas.gov](http://www.irs.ustreas.gov). The Human Resources department will also have a reference copy.

Federal income tax law requires that you identify the provider of dependent care on your federal return. When identifying the provider, you must include the provider's name, address and social security number or taxpayer identification number (TIN). (If your provider is a nonresident or resident alien who does not have and is not eligible to get a social security number, he or she must apply for an individual taxpayer identification number by filing a Form W-7). These same requirements apply whether you use the DCFSA or take advantage of the federal dependent care tax credit.

### Comparing tax advantages for dependent care

If you are a working parent, you should compare the tax advantage of the DCFSA to the federal child care tax credit. Current tax laws make it impractical to use a combination of the two, since the maximum allowable expense under the tax credit must be reduced dollar for dollar by the amount you are reimbursed through the DCFSA.

However, if you have more than one qualifying dependent, you may be able to utilize both because recent tax laws have increased the maximum dollar limit for the federal dependent care tax credit to \$3,000 for one child and to \$6,000 for two or more children. Because this tax law did not affect DCFSA's (the maximum you may contribute is \$5,000 per year or \$2,500 if you are married and file a separate return), you may be able to claim the amount of your eligible DCFSA expenses that exceed \$5,000 under the federal dependent care tax credit. You should consult your tax advisor for more information.

*In general*, if your adjusted gross household income (yours and your spouse's combined) is more than about \$40,000, you will pay less federal income tax and social security taxes by using the DCFSA.

The child care tax credit is a reduction in your federal income tax for child care expense incurred so you (or you and your spouse, if you are married) can work. The amount of child care credit varies with your income level and the number of children you have, as you can see in the following chart:

<b>Adjusted gross income (AGI) or, if married and filing jointly, combined AGI of:</b>	<b>Percentage of expenses allowed as a tax credit*:</b>
\$15,000 or less	35%
\$15,001 to \$17,000	34%
\$17,001 to \$19,000	33%
\$19,001 to \$21,000	32%
\$21,001 to \$23,000	31%
\$23,001 to \$25,000	30%
\$25,001 to \$27,000	29%
\$27,001 to \$29,000	28%
\$29,001 to \$31,000	27%
\$31,001 to \$33,000	26%
\$33,001 to \$35,000	25%
\$35,001 to \$37,000	24%
\$37,001 to \$39,000	23%
\$39,001 to \$41,000	22%
\$41,001 to \$43,000	21%
\$43,001 or more	20%

\* The maximum eligible child care expense you may use in calculating your federal tax credit is \$3,000 per year if you have one child and \$6,000 per year if you have two or more children.

The chart illustrates that the tax credit equals a percentage of your eligible child care costs. This percentage is 35% if the combined income of you and your spouse is \$15,000 or less, and gradually goes down to 20% if your combined income is more than \$43,000. So, the lower your income, the greater the percentage of child care costs you can deduct from your federal income tax using the federal tax credit.

## Special HCFSA And DCFSA Rules

While the HCFSA and DCFSA are good ways for you to reduce taxes you have to pay, you should be aware of these rules:

- Because of the tax advantages provided under these spending accounts, under IRS regulations the choices you make during an enrollment period are binding until December 31 of that plan year. In addition, you will not be able to change the amount of your HCFSA or DCFSA election during the year unless you have a "change in status" under IRS rules. Examples of permissible election changes are shown on pages 3 through 6 in the section called *When you can change your elections*.
- "Use it or lose it" is an important condition placed on the use of these accounts. The IRS requires that you must forfeit any money not used for covered expenses during the plan year. This means you should plan carefully and put aside money only for those expenses that you feel certain you will incur during the plan year. Expenses are "incurred" when the service is rendered, not when you pay for it.
- All claims for reimbursement must be submitted no later than 90 days following the end of the Plan Year in which the expenses were incurred. Claims submitted after this date are not eligible for reimbursement.
- The HCFSA and DCFSA are completely separate accounts. Account balances may not be transferred from one to the other.
- Your salary-related benefits, such as your pension benefits, are generally not affected by the flexible spending accounts. These benefits are based on your total, unreduced pay.
- You cannot use the HCFSA or DCFSA to be reimbursed for expenses you incur before you are a participant in the plan or after your participation ends, except as described in *When Coverage Ends* below. In addition, expenses from a given plan year must be paid with money deposited to your spending account during that year.

## When Coverage Ends

Your participation in the Flexible Benefits Plan will end on the last day of the month in which your employment ends or you otherwise cease to be an eligible employee. For more information regarding when coverage ends for each benefit option, please see the separate summary plan description for each coverage or contact the Human Resources Department. Reimbursement for Eligible Expenses incurred prior to termination for your Health Care and Dependent Care Flexible Spending Accounts will be provided for the remainder of the plan year under the following circumstances:

- If your employment terminates, you may qualify to continue your HCFSA under COBRA. See the *Continuation of Coverage Under COBRA* section below. By law, DCFSA's are not eligible for COBRA continuation coverage.
- As an alternative to COBRA, you may continue coverage under either or both of the FSA's for the remainder of the Plan Year by making monthly payments on an after tax basis until the earliest of the following:
  - The last day of the Plan Year.
  - The date you elect to terminate coverage.
  - The last day of the month in which your final contribution was made.

You will need to contact the Human Resources department to make arrangements for timely payment of your contributions.

- If you decide not to continue coverage, your coverage will end on the last day of the month for which a required contribution was made. You have 90 days from the end of the Plan Year following your termination to submit expenses, however,
  - For the HCFSA, you may only submit expenses incurred up to the date of your termination and may not claim any expenses after this date unless you continue making after-tax deposits to your spending account on the same schedule as active employees or continue your coverage under COBRA. Your COBRA rights are discussed in detail in a following section.
  - Reimbursement under the DCFSA will be provided for Eligible Expenses incurred during the Plan Year, even if they are incurred after your termination date.

### **If you go on unpaid FMLA Leave**

If you go on an approved unpaid leave under the Family and Medical Leave Act of 1993 (“FMLA”), your health coverage and your participation in the HCFSA may continue for the length of the leave, as long as you continue to make any required contributions on a timely basis. If you do not make these contributions, coverage will terminate on the last day of the month for which the last contributions were made.

You are not required to continue participation while you are on FMLA leave. If you choose not to continue to participate, you will have the following options when you return to work:

- Resume coverage at the level in effect immediately prior to the FMLA Leave and make up any contributions that were not made during the FMLA Leave, or
- Resume coverage at a level that is reduced on a pro rata basis for the period during the FMLA Leave for which no contributions were made with contributions due in the same monthly amount payable immediately prior to FMLA Leave.

Note that if your coverage lapsed while you were on FMLA Leave, any expenses incurred during the period of the lapse in coverage will not be eligible for reimbursement.

Similar rules apply to your participation in the DCFSA. However, you may be reimbursed for eligible dependent care expenses incurred while you were not participating to the extent that they do not exceed your DCFSA balance at the time your coverage lapsed. Loyola University New Orleans is not required to reimburse for qualifying expenses incurred while you were not participating.

### **Military leave of absence**

If you go on a leave protected by the Uniformed Services Employment and Re-employment Rights Act of 1994, you may continue health coverage for you and your dependents and your participation in the HCFSA for the remainder of the current plan year, provided you continue your timely contributions during the leave. If you do not make these contributions, participation will end on the last day of the month for which contributions were made. The USERRA continuation coverage is separate from COBRA continuation coverage.

Please contact the Human Resources Department for more information about how your participation in the Flexible Benefits Plan may be affected by a leave of absence.

### **Continuation of Coverage Under COBRA**

You and your qualified dependents may be offered COBRA continuation coverage when your coverage under the plan would otherwise end because of a life event known as a “qualifying event.” COBRA continuation coverage generally consists of the coverage under the plan that you and your family members had immediately before the qualifying event. This includes medical, dental and vision coverage as well as coverage under the Health Care Spending Account (HCSA) that is in effect at the time of your qualifying event.

Each qualified beneficiary who elects COBRA continuation coverage will have the same rights under the Plan as other similarly situated individuals covered by the Plan who did not have a qualifying event. This includes the right to add dependents if they qualify for a HIPAA special enrollment period. If the plan changes, continuation coverage changes accordingly. During annual enrollment, each qualified beneficiary will have the same options under COBRA coverage as active employees covered under the Plan.

## When COBRA continuation coverage is available

The specific qualifying events that trigger the right to elect COBRA continuation coverage are listed below. After a qualifying event, COBRA continuation coverage will be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

If you are an employee:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee:

- Your spouse dies,
- Your spouse's hours of employment are reduced,
- Your spouse's employment ends for any reason other than his or her gross misconduct,
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both), or
- You become divorced or legally separated from your spouse.

An employee's dependent child will become a qualified beneficiary if he or she loses coverage under the Plan because any of the following qualifying events occurs:

- The parent-employee dies,
- The parent-employee's hours of employment are reduced,
- The parent-employee's employment ends for any reason other than his or her gross misconduct,
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B or both),
- The parents become legally divorced or separated, or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

*Special Rule for Retirees:* Sometimes, the filing of a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If such a proceeding is filed with respect to your employer and, as a result of that filing, a retired employee loses coverage under the plan, or if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed, the bankruptcy will be a qualifying event and the retired employee will be a qualified beneficiary with respect to the bankruptcy.

The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan. In that event, the retiree will be entitled to coverage for life and the spouse and covered dependents of the retiree will be entitled to coverage for the life of the retiree. If the retiree dies while continued coverage is in effect, the other qualified beneficiaries will be entitled to continue coverage for up to 36 months from the date of the retiree's death. If the retiree is not living at the time of the qualifying event but the retiree's spouse has coverage, the surviving spouse is entitled to continued coverage for life.

Qualified beneficiaries will be offered COBRA continuation coverage only after the Human Resources Department has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the associate, commencement of a proceeding in bankruptcy with respect to the employer, or the associate's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Human Resources Department will notify the COBRA administrator of the qualifying event.

## **You must give notice of some qualifying events**

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Human Resources Department in writing within 60 days after the qualifying event occurs. This notice should be sent to the Human Resources Department at the address specified in the section *How to contact the Human Resources Department*. A notice mailed to the Human Resources Department will be considered provided on the date of mailing.

The notice must include the employee's name, the name of the spouse and/or dependent child, the nature of the qualifying event (e.g. divorce, legal separation or a child's loss of dependent status) and the date the qualifying event occurred (date of divorce or legal separation or the date the dependent child reached the plan's limiting age, married or lost full-time student status).

***If notice is not provided during this 60-day notice period, the spouse or dependent child who loses coverage will not be offered the opportunity to elect COBRA continuation coverage.***

## **Duration of COBRA Coverage**

COBRA continuation coverage is a temporary continuation of coverage. The duration of the coverage depends on the nature of the qualifying event that causes the loss of coverage:

- Continued coverage under the HCFSA may continue only for the duration of the plan year in which the qualifying event occurred, regardless of whether another qualifying event, disability or Medicare entitlement occurs.
- When the loss of coverage is on account of the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage for the employee's spouse and/or dependent child may last for up to a total of 36 months.
- When the loss of coverage is on account of the employee's termination of employment or reduction of hours of employment, COBRA continuation coverage for the employee and his or her spouse and dependent children generally may last for up to a total of 18 months.

A special rule applies if the employee becomes entitled to Medicare benefits less than 18 months before the end of employment or reduction in hours. In that situation, the employee is still entitled to up to 18 months of COBRA continuation coverage under the general rule described above. However, COBRA continuation coverage for qualified beneficiaries other than the employee may last up to 36 months after the date of the employee's Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement. Thus, their COBRA continuation coverage may continue for up to 28 months after the date of the qualifying event (36 months minus 8 months).

If the employee becomes entitled to Medicare more than 18 months prior to the end of employment or reduction hours, the general rules apply.

## ***Extension of the 18-Month Period of Continuation Coverage***

There are two ways in which the 18-month period of COBRA continuation coverage can be extended.

***Disability extension.*** If the Social Security Administration (SSA) determines that you or a family member covered under the plan is disabled and the COBRA administrator receives timely notice of that determination, you and your other family members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months of COBRA coverage. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the initial 18-month period of COBRA continuation coverage. In order for the extension to be available, you must notify the COBRA administrator in writing of the disability determination during the first 18 months of COBRA continuation coverage and no more than 60 days after the latest of: (i) the date of the SSA determination, (ii) the date of the qualifying event or (iii) the date coverage would end on account of the qualifying event.

The notice must be sent to the COBRA Administrator at the address specified in the section *How to contact the COBRA administrator*. It must include the employee's name, the name of the disabled individual as well as copy of the Social Security Administration disability determination.

A notice mailed to the COBRA administrator will be considered provided on the date of mailing.

***If notice is not provided within the above timeframes, the 18-month maximum coverage period will not be extended.***

The disability extension is available only for as long as the family member remains disabled. The COBRA administrator must be notified if the Social Security Administration makes a final determination that the individual is no longer disabled. Continuation coverage will end on the first day of the month that begins more than 30 days after the date of the determination.

*Second qualifying event.* If your family experiences a second qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months of COBRA coverage. This extension may be available if the employee or former employee dies, is divorced or legally separated, or if a child no longer qualifies as a dependent child under the terms of the Plan, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. Coverage will be extended only if you or your family members provide notice of the second qualifying event to the COBRA administrator no more than 60 days after the event occurs.

This notice should be sent to the COBRA administrator at the address specified in the section *How to contact the COBRA administrator*. The notice must include the employee's name, the name of the spouse and/or dependent child, the nature of the second qualifying event (e.g. divorce, legal separation or a child's loss of dependent status) and the date the qualifying event occurred (date of divorce or legal separation or the date the dependent child reached the plan's limiting age, married or lost full-time student status).

A notice mailed to the COBRA administrator will be considered provided on the date of mailing.

***If notice is not provided during this 60-day notice period, COBRA continuation coverage will not be extended beyond the initial 18-month period.***

### **Electing COBRA continuation coverage**

Once the Human Resources Department receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. You and/or your spouse and dependent children will have 60 days in which to elect COBRA continuation coverage. This 60-day election period begins on the later of:

- The date coverage would end because of the qualifying event, or
- The date the COBRA administrator provides notice of the right to elect COBRA.

A COBRA election mailed to the COBRA administrator will be considered made on the date of mailing.

***If COBRA continuation coverage is not elected during the 60-day election period, the right to elect continuation coverage will be lost.***

You and/or your spouse and dependent children may elect COBRA continuation coverage for all qualifying family members. However, each qualified beneficiary has an independent right to elect continuation coverage.

Thus, both you and your spouse may elect continuation coverage, or only one of you may do so. You may also elect to continue coverage on behalf of your dependent children only.

## **Paying for COBRA continuation coverage**

You must pay the full cost of COBRA continuation coverage. Your first payment must be made within 45 days of the date that the COBRA election was made. If payment is not received within this 45-day period, the COBRA administrator will terminate coverage retroactively to the beginning of the coverage period.

After the initial premium payment is made, all other premiums are due on the first day of the month to which such premium will apply, subject to a 30-day grace period. ***A premium payment that is mailed will be considered made on the date of mailing.*** If the full amount of the premium is not paid by the due date or within the 30-day grace period, COBRA continuation coverage will be canceled retroactively to the first day of the month with no possibility of reinstatement.

The amount of the premium for COBRA continuation coverage will not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. In the case of an extension of COBRA continuation coverage due to a disability, the amount of the premium will increase to 150 percent of the cost of coverage.

## **When COBRA continuation coverage ends**

A qualified beneficiary's COBRA continuation coverage will end before the expiration of the maximum coverage period if any of the following events occurs:

- The premium for coverage is not paid in a timely manner,
- After electing COBRA continuation coverage, the qualified beneficiary becomes covered under another group health plan that does not contain an exclusion or limitation with respect to any pre-existing condition that the individual may have,
- After electing COBRA continuation coverage, the qualified beneficiary enrolls for Medicare,
- If coverage is extended on account of disability, the Social Security Administration makes a determination that the individual is no longer disabled, or
- Loyola University no longer provides group health coverage to any of its employees.

## **If you have questions**

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the Human Resources Department or COBRA administrator as indicated below. For more information about your rights under ERISA including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and telephone numbers of Regional and District EBSA Offices are available through the EBSA's website.)

## **Keep the Human Resources Department informed of address changes**

In order to protect your family's rights, you should keep the Human Resources department informed of any changes in the addresses of family members. If you have a qualifying event, you should also keep a copy of any notices you send to the Human Resources department for your records.

## **How to contact the Human Resources Department**

All initial COBRA qualifying event notices should be mailed to the Human Resources Department at the following address:

Loyola University New Orleans  
6363 St. Charles Avenue  
Campus Box 16  
New Orleans, LA 70118-6143

You can also call the Human Resources department at (504) 864-7757 if you have any other questions about COBRA continuation coverage.

## **How to contact the COBRA administrator**

All correspondence, other than the initial qualifying event notice should be mailed to the COBRA administrator at the following address:

Ceridian COBRA Services Center  
P.O. Box 534066  
St. Petersburg, Florida 33747-4066

You may also call the COBRA administrator at 1-800-877-7994 for any questions about your COBRA coverage.

## **How To File A Claim**

Information about filing claims for benefits other than the Flexible Spending Accounts is located in the summary plan description for each coverage option.

As a participant in the Flexible Spending Account(s), you will receive a supply of claim forms. The Human Resources Web-site can also provide you with forms to use when requesting reimbursement from your HCFSA and DCFSA. HCFSA and DCFSA claims should be submitted directly to Ceridian for processing. Mail your claim form to: FSA Claim Administration, P.O. Box 534451, St. Petersburg, FL 33747-4451 or fax your claim form to Ceridian FSA Administration Services at 1-866-717-3820.

Please be sure to follow the instructions on the claim form completely before submitting your claim to ensure your reimbursement is not delayed. You can submit receipts for eligible expenses as often as you like, however, reimbursements are provided weekly. Reimbursements are subject to the following:

- If your claim exceeds the balance in your DCFSA, you will be reimbursed for only what is in your account. The remainder of the claim will be held until your account balance is great enough to pay it.
- Claims submitted for the HCFSA will be reimbursed provided the expenses do not exceed the annual amount you have elected to deposit.
- All claims for reimbursement of OTC drugs will require a completed and signed claim form that includes the patient name for each medication. You must also include a receipt (not handwritten) that clearly shows the name of the drug/supply, the date purchased and the amount paid. Claims for dual-purpose items (see Appendix I) will require an additional physician's statement that indicates a medical diagnosis, a statement that the OTC drug is recommended to treat the condition, and, where applicable, a statement that the treatment is not cosmetic. If you are unsure whether an item is dual purpose, obtain a note from your physician.
- All HCFSA claims, other than claims for OTC medications, must first be submitted to the appropriate medical, dental or vision plans. When you submit your claim for reimbursement under the HCFSA, include a copy of the plan's Explanation of Benefits form (EOB) for the expenses.
- Expenses from a given plan year must be reimbursed with money deposited in your Flexible Spending Accounts that year. However, you may submit expenses for reimbursement until 90 days following the plan year in which they were incurred. After 90 days following the end of the plan year, your account is closed and you will lose any money remaining in it. Remember, an expense is incurred on the date the service is provided, not the date you received or paid the bill.

- If you pay for the ongoing care of orthodontia, your expenses will be reimbursed if payment for current year services are made by you during the current plan year, even if full treatment will not be performed until a future date within that current plan year.

## **Claims questions**

If any portion of a claim is not paid, or if you don't understand or agree with the handling of a claim, there are several things you can do to resolve the problem. Most of your questions can be answered quickly and efficiently by either calling or writing Ceridian, or the Human Resources department.

## **Initial claims determinations**

Ceridian will decide claims within a reasonable period of time, but not later than 30 days after a claim is received. This time period may be extended for an additional 15 days when necessary due to matters beyond Ceridian's control or if your claim is incomplete. You will be advised in writing of the need for an extension during the initial 30-day period and a determination will be made no more than 45 days after the date the claim was submitted. If the extension is needed because your claim is incomplete, the notice will specifically describe the information needed to complete the claim and you will be allowed 45 days from receipt of the notice to provide the information. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.

## **If your claim is denied**

If Ceridian denies your claim for a benefit in whole or in part, you will receive a written notice that will provide:

- The specific reason or reasons for the denial.
- Reference to specific plan provisions on which the determination was based.
- A description of any additional material or information necessary to complete the claim and an explanation of why such material or information is necessary.
- A description of the steps you must follow (including applicable time limits) if you want to appeal the denial of your claim, including:
  - Your right to submit written comments and have them considered,
  - Your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and
  - Your right to bring a civil action under Section 502 of ERISA if your claim is denied on appeal.
- If Ceridian relied on an internal rule, guideline, protocol, or other similar criterion in denying your claim:
  - A description of the specific rule, guideline, protocol or criterion relied on, or
  - A statement that a copy of such a rule, guideline, protocol or criterion will be provided free of charge upon request.

## **Review of denied claims**

You may appeal the denial of your claim to the plan administrator. This appeal must be made in writing to the plan administrator within 180 days after you receive the written notice from the claims administrator that your claim has been denied in whole or in part. If you do not file your appeal within this time period, you will lose the right to appeal the denial.

Your written appeal should set out the reasons you believe that the claim should not have been denied and should also include any additional supporting information, documents or comments that you consider appropriate. At your request, you will be provided, free of charge, with reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The plan administrator will review and decide your appeal within a reasonable period of time but no longer than 60 days after it is submitted.

The review will take into account all comments, documents, records, and other information relating to the claim that you submit without regard to whether such information was submitted or considered in the initial benefit determination. The review will not give deference to the initial denial. In addition, the individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that individual's subordinate.

The plan administrator may consult with a health professional in deciding your appeal, except that any health professional consulted in connection with your appeal will not have been involved in the original benefit determination or be a subordinate of the health professional who was involved.

You will be notified in writing if the decision on appeal upholds the initial denial of your claim. The notification will provide:

- The specific reason or reasons for the denial.
- Reference to specific plan provisions on which the determination was based.
- A description of your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
- If the plan administrator relied on an internal rule, guideline, protocol, or other similar criterion in denying your claim:
  - A description of the specific rule, guideline, protocol or criterion relied on, or
  - A statement that a copy of such a rule, guideline, protocol or criterion will be provided free of charge upon request.
- A statement of your right to bring a civil action under Section 502 of ERISA.

The decision of the plan administrator is final and binding on all individuals dealing with or claiming benefits under the plan.

### **Designation of authorized representative**

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. This authorization must be in writing and signed by you.

## HCFSA Eligible Expenses

The following are some examples of eligible expenses under the health care reimbursement account. These expenses have been specifically approved by the IRS or courts. This list includes some expenses which may already be covered to some extent under the Loyola University New Orleans health plans.

- Acupuncture
- Alcoholism or drug addiction treatment
- Ambulance service
- Artificial limbs
- Prescription birth control pills and devices
- Braces
- Braille – books and magazines
- Certain over the counter medications (see attached Appendix I)
- Chiropractors' fees
- Christian Science practitioners' fees
- Contact lenses and solutions
- Crutches
- Deductibles and copayments (the portion of expenses that you pay) under the Loyola University New Orleans medical, plan or your spouse's group plan (provided you are not reimbursed for these amounts through coordination of benefits)
- Dental/orthodontic fees (except cosmetic procedures)
- Developmentally disabled persons' cost for special home
- Diagnostic X-ray and laboratory fees
- Disabled persons' special schools
- Doctors' fees, including a medical doctor (M.D.), doctor of osteopathy (D.O.), and podiatrist (D.P.M.)
- Drugs (insulin and prescription drugs only) and medical supplies
- Expenses in excess of coverage limits, such as hospital private room charges above the semiprivate rate, or charges in excess of usual and customary limits
- Eyeglasses, including exam fee
- Fertility treatment
- Guide dogs
- Hearing care and aids
- Hospital bills
- Immunizations
- Insulin
- Laetrile
- Lamaze classes
- Medical information plan
- Nurses' fees (including nurses' board and Social Security tax where paid by taxpayer)
- Nursing homes
- Obstetrical expenses
- Oxygen
- Prosthesis
- Psychoanalysis and Psychologists' fees
- Radial keratotomy, laser eye surgery and other procedures to correct vision
- Routine physical exams
- Smoking cessation programs, prescription medications, Nicotine patches, nicotine gum and over-the-counter smoking cessation drugs to alleviate withdrawal
- Special equipment (such as a hand control installed in a car for use by a disabled person)
- Surgical and sterilization fees(except cosmetic surgery)
- Therapy treatments (medical)
- Tuition at special school for disabled
- Vitamins by prescription
- Weight reduction programs undertaken at a physician's direction to treat an existing disease
- Wheelchair

## Examples of Expenses NOT Eligible for Reimbursement

- Any illegal treatment
- Auto insurance providing medical coverage for persons injured in or by the taxpayer's automobile
- Chauffeur services
- Contributions to other medical plans
- Contributions to state disability funds
- Cosmetic surgery (and other similar procedures)
- Cost of illegal drugs
- Cost of special foods taken as a substitute for regular diet, where the special diet is not medically necessary or taxpayer cannot justify cost in excess of cost of a normal diet
- Cost of toiletries, cosmetics and sundry items (such as soap, toothbrushes, etc.)
- Diaper service
- Distilled water purchased to avoid drinking fluoridated city water
- Expenses of divorce where doctor or psychiatrist recommends divorce
- Fees for exercise, athletic or health club membership
- Installation of power steering in automobile
- Insurance against loss of income, loss of life, limb, or sight
- Marriage counseling
- Maternity clothes
- Mechanical exercise device not specifically prescribed by doctor
- Mobile telephone used for personal calls, as well as calls to doctor
- Non-medical expenses, such as electronic air filters, whirlpools, or exercise equipment, unless prescribed by a physician for treatment of a specified medical condition
- Nursing services for a normal, healthy baby
- Pajamas purchased to wear in hospital
- Payments for Church of Scientology auditing and processing
- Payments for domestic help, companion, baby-sitter, etc., who primarily renders services of a non-medical nature (may be allowed under DSA)
- Physical treatments unrelated to a specific health problem (such as massage for general well-being)
- Premiums for health insurance
- Psychoanalysis undertaken to satisfy curriculum requirements of student
- Religious cult deprogramming
- Tattoos and ear piercing
- Union dues for sick benefits for members
- Vacuum cleaner purchased by individual with dust allergy
- Weight reduction programs, whether or not undertaken at a physician's direction if the purpose is to maintain general good health
- Wigs (where not medically necessary for mental health)

## Plan Information

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA).

<b>Plan name and number:</b>	Loyola University Employee Benefit Plan (PN502)
<b>Plan sponsor and administrator:</b>	Loyola University New Orleans 6363 St. Charles Ave. Box 16 New Orleans, LA, 70118 504-864-7272
<b>Employer identification number:</b>	72-0408946
<b>Type of plan:</b>	This is an employee welfare benefit plan which provides medical (including prescription drug), dental, vision, life and accidental death and dismemberment, employee assistance program, long term disability, and Health Care Flexible Spending Account. The plan also includes a Dependent Care Flexible Spending Account under IRS rules. Complete rules regarding eligibility, benefits, and all other related plan information are contained in separate documents. This document describes the terms of the Flexible Benefits Plan and the Flexible Spending Accounts.
<b>Type of administration:</b>	Third Party: Ceridian Benefits Services FSA Operations 3201 34 <sup>th</sup> Street South St. Petersburg, FL 33711 1-877-799-8820
<b>Agent for service of legal process:</b>	Loyola University New Orleans 6363 St. Charles Ave. Campus Box 16 New Orleans, LA, 70118
<b>Plan year ends:</b>	December 31
<b>Benefits provided by and disbursements from the plan made by:</b>	Health care and dependent care flexible spending accounts are funded solely by participating employees through salary reduction and are not insured by the University. Disbursements are made by the claims administrator in accordance with the terms of the plan documents.
<b>Termination or amendment of plan:</b>	Loyola University New Orleans reserves the right to terminate or amend the plan completely or partially at any time, subject to the terms and provisions of the underlying plan document.

## Statement of ERISA Rights

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

### Receive information about your plan and benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

### Continue group health plan coverage

In addition, if you are participant in a group health plan, you have the right to:

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for information concerning your COBRA continuation coverage rights.
- Receive a copy of the Plan's procedures regarding qualified medical child support orders without charge.

### Prudent actions by plan fiduciaries

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

### Enforce your rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## **Assistance with your questions**

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

**Date of issue of this Summary Plan Description:** January 1, 2009

## Appendix I

### Eligible and Ineligible Over-the-Counter Medicines

Type of Expense	Examples	Ruling
<b>Allergy Medicine:</b> <ul style="list-style-type: none"> <li>• Pills</li> <li>• Drops</li> <li>• Sprays</li> </ul>	Actifed, Advil, Afrin, Alavert, Benadryl, Cholor-Trimeton, Claritin, Tavist, Tylenol, Sudafed, Vicks, Diphedryl, Store Brands	Eligible
<b>Asthma</b>	Bronkaid, Inhalers, Inhaler Refills, Store Brands	Eligible
<b>Cold Relief:</b> <ul style="list-style-type: none"> <li>• Pills</li> <li>• Sprays</li> <li>• Lozenges</li> <li>• Rubs</li> </ul>	Actifed, Dimetapp, Drixoral, Robitussin, Sudafed, Triaminic, Advil, Comtrex, Theraflu, Tylenol Flu, Chloraseptic, Store Brands	Eligible
<b>Cold Sore Relief</b>	Novitra, Abreva, Store Brands	Eligible
<b>Diabetic Treatment</b>	Insulin, Glucose Tablets	Eligible
<b>Eye and Ear Treatment:</b> <ul style="list-style-type: none"> <li>• Drops</li> </ul>	Visine, Ocu Hist, Swim-ear, Store Brands	Eligible
<b>Foot Treatments:</b> <ul style="list-style-type: none"> <li>• Athletes Foot</li> <li>• Anti Fungal Solutions</li> <li>• Bunions/Spurs</li> </ul>	Micatin, Fungi Care, Lotrimin, Store Brands	Eligible
<b>Hemorrhoid Relief</b>	Hemorid, Anusol, Preparation H, Nupercainal, Tucks, Store Brands	Eligible
<b>Jock Itch</b>	Tinactin, Micatin, Lotrimin AF, Lamisil AT, Cruex, Store Brands	Eligible
<b>Lice Treatment</b>	LiceFree, Rid, Pronto, Store Brands	Eligible
<b>Pain Relievers:</b> <ul style="list-style-type: none"> <li>• Arthritis</li> <li>• Back Pain</li> <li>• Headaches</li> <li>• Menstrual</li> <li>• Urinary Pain Relief</li> </ul>	Aspirin, Ibuprofen, Advil, Midol, Motrin, Bayer, Doan's, Aleve, Excedrin, Pamprin, Premsyn PMS, Azo, Prodiem, Tylenol, Store Brands	Eligible
<b>Pedialyte</b>		Eligible
<b>Prenatal Vitamins</b>		Eligible
<b>Sleeping Aids</b>	Allune, Natrol, Nytol, Unisom, Store Brands	Eligible
<b>Smoking Cessation:</b> <ul style="list-style-type: none"> <li>• Devices</li> <li>• Patches</li> <li>• Gum &amp; Lozenges</li> </ul>	Endit, Lite'n up, Smoke Away, Venturi, Nicorette, NicoDerm CQ, Nicotrol, Store Brands	Eligible

Type of Expense	Examples	Ruling
<b>Stomach Remedies:</b> <ul style="list-style-type: none"> <li>• Antacid</li> <li>• Acid Reducers</li> <li>• Anti Diarrhea</li> <li>• Laxatives</li> <li>• Gas Relief</li> <li>• Lactose Intolerant Pills</li> <li>• Motion Sickness Pills</li> </ul>	Axid AR, Pepcid, Prilosec, Tagamet, Zantac, Tums, Rolaids, Alka-Seltzer, Maalox, Mylanta, Pepto-Bismol, Phillips, Gaviscon, Gas-X, Store Brands, Lactaid pills, Bonine, Dramamine, Emetrol, Store Brands	Eligible
<b>Toothache</b>	Orajel, Zilactin, Red Cross, Orabase, Den Tek, Dents, Store Brands	Eligible
<b>Topical Products:</b> <ul style="list-style-type: none"> <li>• Ointments</li> <li>• Creams</li> <li>• Antiseptics</li> <li>• Sprays</li> <li>• NOT cosmetics</li> </ul>	BenGay, Arth-Rx, Dr. Holt's, Flexall, IcyHot, Jointflex, Joint-Ritis, PR5, Mentholatum, Stopain, Hydrogen Peroxide, Bactine, Neosporin, Polysporin, Iodine, Desitin Diaper Rash, Balmax, Benadryl Anti-itch cream, Dermarest, Itch-X, Store Brands	Eligible
<b>Wart Treatment</b>	Compound W, Dr.Scholl's, Pedifix, Wart-off, Store Brands	Eligible
<b>Yeast Infection</b>	Monistat, Vagistate 3, Vaginex, Mycelex3	Eligible
<b>Alertness Aid</b>	NoDoz	Ineligible
<b>Cosmetics:</b> <ul style="list-style-type: none"> <li>• Face Creams</li> <li>• Lotions</li> <li>• Make-up</li> <li>• Nail Care</li> <li>• Teeth Whitening</li> </ul>	Olay, Aveeno, Jergens, St. Ives, L'Oreal, Neutrogena, Almay, CoverGirl, Maybelline, Cutex, Revlon, Sally Hansen, Store Brands	Ineligible
<b>Illegally Procured</b>	Marijuana	Ineligible
<b>Sun Block</b>	Coppertone, Hawaiian Tropics, Bull Frog	Ineligible
<b>Toiletries:</b> <ul style="list-style-type: none"> <li>• Toothpaste</li> <li>• Mouthwash</li> <li>• Shampoo</li> <li>• Conditioner</li> <li>• Soap</li> <li>• Deodorant/Antiperspirant</li> <li>• Shaving Cream</li> <li>• Powder</li> </ul>	Colgate, Crest, Aquafresh, Sensodyne, Scope, Listerine, Dial, Caress, Coast, Dove, L'Oreal, Pantene, Thermasilk, Denorex, Head & Shoulders, Baby Powder, Shower to Shower, Gillette, Barbasol, Skintimate, Arrid, Ban, Degree, Mitchum	Ineligible

Type of Expense	Examples	Ruling
<b>Acne Medicine:</b> <ul style="list-style-type: none"> <li>• Soaps</li> <li>• Creams</li> <li>• Pills</li> </ul>	Stridex, Clean and Clear, Neutrogena, LomaLux, Clearasil, Store Brands	Dual Purpose.
<b>Dietary supplements, herbal, homeopathic or naturopathic remedies, minerals, nutrients, vitamins, amino acids, hormones, enzymes</b>	Ensure, Acidophilus, Coenzyme, Q-10, DHEA, Fish Oils, Glucosamine and Chondroitin, L-Carnitine, Lecithin, Melatonin, MSM, Omega-3, SAM-e, Shark Cartilage, Echinacea, Flax Seed Oil, Garlic, Ginkgo Biloba, Herbs, Lutein, Menopause Supplements, Calcium, Chromium Picolinate, Iron, Lysine, Magnesium, Potassium, Selenium, Zinc, A's, B's, D's, E's, Antioxidants, C's, Children's, Folic Acid, Multi-Vitamins, Niacin, Prenatal or Senior Vitamins	Ineligible as a cosmetic procedure/expense for general health.
<b>Fiber Supplements</b>	Citrucel, Metamucil, Fiber Con, Store Brands	To become eligible, claim must be supported by a doctor's statement.
<b>Hair Growth Treatment</b>	Nu Hair, Rogaine, Store Brands	
<b>Weight-loss</b>	Puralin, Cidermax, Patentlean, Dexatrim, Store Brands	