

Loyola University Employee Benefits Plan

Summary of Material Modifications

Effective January 1, 2009

This document is a Summary of Material Modifications to the Loyola University Employee Benefits Plan and is intended to provide you with Plan Administration information and corrections to your Group Point of Service Contract effective January 1, 2009. This information together with your Group Point of Service Contract issued by BlueCross BlueShield Louisiana dated January 1, 2009 comprises your Summary Plan Description (SPD) as required by ERISA. This information should be kept with your Group Point of Service Contract.

Plan Administration Information

Plan Name:	Loyola University Employee Benefit Plan
Plan Number:	502
Plan Sponsor and Administrator:	Loyola University New Orleans 6363 St. Charles Avenue New Orleans, Louisiana 70118 504-864-7757
Employer Identification Number:	72-0408946
Plan Year:	January 1 through December 31
Agent for Service of Legal Process:	For disputes arising under the Plan, service of legal process may be made upon the Plan Administrator at the above address. For disputes arising under those portions of the Plan insured by BlueCross BlueShield of Louisiana, service of legal process may be made upon the insurance company.
Type of Plan:	Welfare plan providing medical and prescription drug benefits

Plan Funding:

The plan is funded partially through salary reduction by participating employees and partially through employer contributions. Disbursements are made by BlueCross BlueShield Louisiana according to the terms of the group insurance certificate.

Benefits under the medical plan are guaranteed through a contract of insurance issued by BlueCross Blue Shield Louisiana to the Company as follows:

BlueCross Blue Shield of Louisiana
P.O. Box 98024
Baton Rouge, Louisiana 70898-9024
Group Number: 76101-00L

Plan Amendment or Termination:

The Plan Sponsor intends to continue this plan indefinitely but reserves the right to terminate or modify the plan, in whole or in part, at any time, subject to the terms of the plan document and group insurance certificate. Such changes include, but are not limited to, changes in required contribution levels and adjustments to benefits provided.

Supplemental Information

The following provisions supplement and/or replace the information contained in Articles II F., VI C., X G., XI, XIV G., XVIX B., XXII, XXV and XXVII of your Group Point of Service Contract issued by BlueCross BlueShield Louisiana dated January 1, 2009.

Special Enrollment Rights under the Children’s Health Insurance Program Reauthorization Action of 2009 (CHIPRA)

The following information is added to Article II F. of your Group Point of Service Contract issued by BlueCross BlueShield Louisiana dated January 1, 2009.

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 is terminated as a result of loss of eligibility, 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 Medicaid or CHIP coverage terminates.

If you or an eligible dependent become eligible to have Medicaid or CHIP assist in the payment of your 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 benefit option. If you are already enrolled in the plan and your dependent loses eligibility for coverage under, or becomes eligible for premium assistance from, Medicaid or CHIP, you may enroll your dependent in your current option or you may change your election and enroll yourself and your dependent in a different option.

Preventive or Wellness Care – Immunizations – Network Benefits, Non-Network Benefits, and Dependent Out-of-Area Benefits

The following information supplements the information shown in Article VI C. of your Group Point of Service Contract issued by BlueCross BlueShield Louisiana dated January 1, 2009.

The plan will provide coverage for FDA approved immunizations recommended by the Member's Physician regardless of the state mandate status of the immunization or the patient's age upon immunization. To receive this benefit, the Physician should file the claim with the appropriate procedure code. The Deductible Amount will not apply to these immunizations.

Prescription Drug Benefits

The provision noted in Article X, item G.4. regarding step therapy does not apply. The provisions of Article XVIX, item B.13h regarding an exclusion for contraceptive drugs does not apply.

Other Covered Services, Supplies or Equipment

The provisions noted as items S. Dietician Visits and T. Autism Spectrum Disorders (ASD) are renamed items V. Dietician Visits and W. Autism Spectrum Disorders (ASD).

General Provisions – Legal Action

The provision noted as item G. Legal Action in Article XVI is renamed item H. Legal Action.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

The following information should replace the information contained in Article XXII, Continuation of Insurance.

As required by USERRA, if you (the employee) take a leave of absence in order to serve in the uniformed services, you may elect to continue group health care coverage for yourself (and your covered dependents, if any) for up to 24 months from the date your leave of absence begins.

Your USERRA continuation coverage will terminate earlier if one of the following events occurs:

- You fail to pay any premium within the required time;
- You lose your USERRA rights due to an dishonorable discharge or other conduct specified in USERRA
- You fail to report to work or to apply for reemployment following the completion of your service in the uniformed services within the time required by USERRA as described in the following chart:

If Your Period of Uniformed Service is:	You Must Report-to-Work/Submit an Application for Reemployment Not Later Than:
Less than 31 days (or if you are absent for purposes of an examination to determine your fitness to perform uniformed services)	The beginning of the first regularly scheduled work period on the day following the completion of your service after allowing for safe travel home and an 8 hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as possible.*
More than 30 days but less than 181 days	14 days after completion of your military service or if that is unreasonable or impossible through no fault of your own, as soon as possible.*
More than 180 days	90 days after completion of your service.*

*If you are hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service, the applicable time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. The maximum period for recovery generally is two years from completion of service.

USERRA and COBRA

USERRA and COBRA coverage run concurrently, which means that they begin at the same time. However, COBRA coverage can continue for up to 18 months (and for longer periods under certain circumstances) while as noted above, USERRA coverage can continue for up to 24 months. In addition, COBRA coverage is subject to early termination for additional reasons that do not apply to USERRA coverage. For more information about COBRA continuation coverage see below and your Point of Service Certificate of Group Coverage issued by BlueCross BlueShield Louisiana dated January 1, 2009.

Payment of Premiums

If you elect to continue health coverage under USERRA, you will be required to pay 102% of the full premium for the coverage elected (the same rate as COBRA). However, if your uniformed service period is less than 31 days, you are not required to pay more than the amount that you pay for such coverage as an active employee.

Whom to Contact

If you leave employment to enter military service, you should contact your Human Resources Representative to determine whether you also have health care coverage continuation rights under USERRA.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

The following provisions supplement the information in Article XXII.

Notices/Premium Payments

For the following 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.

For purposes of our plan, any other reference to “Group” in this section of Article XX of the certificate should reference our COBRA Administrator, Ceridian. Therefore, all notices and premium payments other than as described above should be sent to Ceridian at the following address:

Ceridian COBRA Services Center
P.O. Box 534066
St. Petersburg, Florida 33747-4066
Telephone 1-800-877-7994

Notices/Payments will be considered mailed on the date of mailing (postmark).

If You Have Questions

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the Ceridian as indicated above.

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. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.).

Keep Loyola 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 Benefits Department and Ceridian for your records.

How to Contact the Human Resources Department

Human Resources Department
Loyola University New Orleans
6363 St. Charles Avenue, Campus Box 16
New Orleans, LA 70118-6143
(504) 864-7757

You can also call Ceridian at (800) 877-7994 if you have any other questions about COBRA continuation coverage.

Appeals Process

The provisions of Article XXV shown in your certificate entitled Appeal Process If The Member Is Not An ERISA Member does not apply

Initial Claims Determinations

The following provisions are added to Article XXVII of the certificate.

Initial Claims Determinations

The timeframes for making the initial decision regarding a claim and the procedures for notifying you about that decision depend on the type of claim.

Urgent care claims. You will be notified whether your urgent care claim has been approved or denied as soon as possible, but in no event later than 72 hours after the claim is received. If more information is needed in order for a determination to be made, you will be advised of the specific information necessary to complete the claim within 24 hours after receipt of the claim. You will be allowed at least 48 hours to provide the necessary information.

You will be notified of the determination within 48 hours after the earlier of: (1) the plan's receipt of the requested information or (2) the end of the period you were given in which to provide the information. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.

Pre-service claims. You will be notified whether your pre-service claim has been approved or denied within a reasonable period of time appropriate to the medical circumstances involved, but in no event more than 15 days after the claim is received. The 15-day period may be extended an additional 15 days if the extension is necessary due to matters beyond the control of the plan and you are notified of the extension before the initial 15-day period expires. If the extension is required because you failed to submit information necessary to decide the claim, the extension notice will specifically describe the information needed to complete the claim. You will be given at least 45 days from the time you receive the notice to provide the requested information. The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to the notice. If you provide the requested information within the specified timeframe, your claim will be decided within the time specified in the extension notice. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.

Previously-approved treatments

- If the insurance company previously approved an ongoing course of treatment that was to be provided over a period of time or that involved a specified number of treatments and you wish to extend the course of treatment beyond that which had been approved, you may request an extension. If the claim involves urgent care, you will be notified whether the extension has been approved or denied no more than 24 hours after your request for the extension is received, provided that you make such request at least 24 hours before the end of the previously approved period of time or before you received all of the previously approved treatments. If the request for an extension is made less than 24 hours before the expiration of the prescribed period of time or number of treatments, the request will be treated as a new urgent care claim and decided under the general timeframe applicable to urgent care claims. If the claim does not involve urgent care, the extension request will be treated as a new pre-service claim and will be decided within the timeframe applicable to pre-service claims as described above.
- If the insurance company previously approved an ongoing course of treatment that was to be provided over a period of time or that involved a specified number of treatments, any decision by the plan to reduce or terminate that course of treatment (other than by plan amendment or termination) before the end of such period of time or before all approved treatments have been received will be considered a benefit denial. You will be notified sufficiently in advance of such reduction or termination to allow you to appeal and obtain a determination on the appeal before the benefit is reduced or terminated.

Post-service claims. The insurance company will decide a post-service claim within a reasonable period of time, but not later than 30 days after the claim is received. This time period may be extended for an additional 15 days when necessary due to matters beyond the control of the plan 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. The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to such notice. If you provide the requested information within the specified timeframe, your claim will be decided within the time specified in the extension notice. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.