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*Loyola University Chicago offers benefits that are affordable, comprehensive, and competitive. The benefits at-a-glance table highlights three categories of benefits for eligible full-time Faculty and Staff members. These are labeled Core Benefits, Elective Benefits and Work-Life Benefits.*

**Core Benefits:** Choose from these benefits for health care and financial protection for yourself and your family.

**Elective Benefits:** Customize your benefits package and extend the protection available to you under the core benefits.

**Work-Life Benefits:** Consider these benefits for your personal development and special needs.

Benefits at a Glance Benefit Eligible Faculty and Staff		
Core Benefits	Elective Benefits	Work-Life Benefits
For managing your health and protecting you from the unexpected	For adding to your core benefits package	For your personal development and special needs
<ul style="list-style-type: none"> <li>▪ Medical, Wellness, and Prescription Drug Benefits</li> <li>▪ Dental</li> <li>▪ University-paid Basic Life Insurance for You</li> <li>▪ University-paid Short-Term Disability Benefits</li> <li>▪ University-paid Long-Term Disability Benefits</li> </ul>	<ul style="list-style-type: none"> <li>▪ Vision Care – You have two options for vision benefits</li> <li>▪ Flexible Spending Accounts</li> <li>▪ Supplemental Life and Accident Insurance for you</li> <li>▪ Supplemental Life and Accident Insurance for your dependents</li> <li>▪ Long-Term Care Insurance</li> <li>▪ Group Legal Plan</li> <li>▪ Transit Benefit</li> </ul>	<ul style="list-style-type: none"> <li>▪ Tuition Benefits</li> <li>▪ Adoption Assistance</li> <li>▪ Credit Union</li> <li>▪ University Holidays</li> <li>▪ Paid Time Off</li> <li>▪ Vacation; Sick</li> <li>▪ Personal Family Friendly Days</li> <li>▪ Retirement</li> </ul>

# Plan Participation

This booklet provides general information on all Loyola University benefit plans and is available at Loyola University's Human Resources Department, located on the 8<sup>th</sup> floor of Lewis Towers on the Water Tower Campus. You can also access this information by going to Loyola's website at <http://www.luc.edu/hr/index.shtml>. Additional information for selected benefits from the providers may be available through their websites. A reference table of phone numbers and websites for Loyola's benefit plan providers is found on the last page of this booklet.

## Eligibility

### For you as an Employee

You are eligible for benefits coverage through Loyola University Chicago if you are:

- A Full-Time University Lakeside Campus Faculty member, classified as 1.0 Full-Time Equivalent.
- A Full-Time Stritch School of Medicine (SSOM) Faculty member, classified as 1.0 Full-Time Equivalent.
- A Full-Time University Lakeside Campus Staff employee scheduled to work in one position classified as .80 Full Time Equivalent or greater
- A Part-Time University Lakeside Campus staff employee in a position identified as .53 Full Time Equivalent or greater, or scheduled to work at least 20 hours per week.
- A Part-Time SSOM Staff employee scheduled to work in a position classified as .50 Full-Time Equivalent or greater.

### For Your Dependents

You can elect coverage for yourself, your spouse, Legally Domiciled Adult (LDA), and any eligible dependent children that meet the following criteria.

Under Loyola's health, dental, and vision insurance, the Hyatt Legal Plan and Perspectives (EAP service), the following individuals may be included:

- Your Spouse/LDA
  - A Legally Domiciled Adult is:
    - Someone not legally married (does not have a spouse)
    - Someone who is living in the same primary residence for the past six months and intends to continue living in the same primary residence as the employee
    - Shares a close personal relationship (e.g., not a casual roommate or tenant) with the employee
    - Jointly responsible with the employee for basic living expenses
    - Someone who is 18 years of age or older
    - Not related by blood to the employee such that the relationship would bar marriage,
    - Not receiving benefits from any other employer (however, a LDA who is receiving medical but not dental benefits from his or her employer is eligible for dental, but not medical benefits from the University, **or**
  - Is a Federal tax dependent parent, adult sibling, or adult child (who is neither receiving benefits from an employer nor eligible for any group coverage) living in the same primary residence as the employee and is claimed as the employee's tax dependent.

An employee may either enroll a spouse or up to one LDA. The dependent children of the LDA may be covered if they are dependents of the employee by natural birth, adoption, or guardianship. If you choose to enroll a Legally Domiciled Adult, you must meet all of the

eligibility requirements and complete a Certification of Eligibility Form that is available for you from Human Resources.

- your unmarried children under the age of 23 who are primarily financially dependent on you for support (coverage will end on the last day of the month in which the child reaches age 23)
- your disabled children who depend on you for support and maintenance because of mental or physical handicap, regardless of age, if they were covered prior to reaching age 23
- children in your custody under an interim court order prior to finalization of adoption.  
*[children placed in your home for foster care are not eligible]*

## Levels of Coverage

For health, dental, and vision benefits, you have six choices of coverage levels:

- **Employee** - covers you, the employee, only
- **Employee plus Spouse** - covers you and your spouse
- **Employee plus Child(ren)** covers you and your eligible dependent children
- **Family** - covers you, your spouse, and your eligible children
- **Employee plus Legally Domiciled Adult (LDA)** - covers you, plus one LDA adult
- **Employee plus LDA/Child(ren)**: covers you, plus one LDA adult and any eligible dependent child(ren)

You must choose the same plan for you and your family. For example, you cannot choose the HMO Illinois plan for yourself and the PPO plan for your family.

## Paying for Benefits

**The cost for coverage depends on your elections and your employment status.** Contributions you make toward medical, dental, vision, and flexible spending accounts are automatically withheld on a pre-tax basis from your pay. The pre-tax contributions reduce your regular gross salary before Social Security (FICA), federal, and state taxes are deducted from your pay.

Any required employee contributions for benefit coverage will be automatically withheld on a pre-tax basis unless you elect otherwise. If you prefer to arrange after-tax deductions, please contact the Human Resources Department at 312-915-6175.

## Tax Implication for Covering LDA

The value of the cost for covering a non-dependent LDA is taxable income. Human Resources will add the value of the benefit to your bi-weekly or monthly pay and you will be taxed on that amount.

[We recommend you consult with your attorney or tax professional about specifics of your particular situation.]

## When Your Coverage Begins

In general, your benefits become effective on the first day of employment if your date of hire is on the first day of the month; otherwise, you are eligible the first day of the month following your date of hire. Additional waiting periods or exceptions are covered under each benefit description. Health insurance coverage of newborns begins at birth if the benefits department is notified of the birth within the **infant's first 31 days** of life.

## Changing Coverage

After your initial enrollment as a new hire, you may change your level of coverage and/or benefit options in the following situations:

### During Open Enrollment

In the fall of each year, during the Benefits Open Enrollment period, you have the opportunity to select benefits for the following calendar year. If you do not make a change to your benefits during the annual Benefits Open Enrollment period, your elections for the previous year will automatically continue for the next calendar year (with the exception of Flexible Spending Accounts).

### Flexible Spending Accounts (FSA)

Flexible Spending Accounts require re-enrolling every annual Open Enrollment period (to be effective January 1 of each calendar year).

### After a Qualifying Life Event

**Employees** may make changes to their benefits only during the Benefits Open Enrollment period, or if you experience a qualifying life event **within 31 days** from the date of the event. Qualifying life events are:

- Change in legal marital status (marriage, divorce, death of spouse, legal separation)
- Change in LDA eligibility criteria
- Change in number of eligible dependents (birth, placement for adoption, guardianship, or death)
- Employment status change for you, your spouse, or your dependent (termination or commencement of employment, full-time or part-time)
- Taking an unpaid leave of absence
- Dependent satisfies or ceases to satisfy eligibility requirement (attainment of age limit, marriage)
- Residence change by you, your spouse, or dependent (moving outside of an HMO service area)
- Change in cost or coverage due to spouse or dependent's open enrollment

### When Coverage Ends

Your insurance will end if:

- you no longer have active full-time status,
- your contributions are discontinued, or
- the Group Insurance Policy is terminated.

## Medical Plan PPO Highlights: Loyola University Option I PPO Plan

The following chart provides more details on the Loyola University **Option I PPO Plan**. Please Note: Non-PPO network benefits are based on a percentage of reasonable and customary charges.

<b>Loyola University Option I PPO Plan</b>			
<b>Plan Provision</b>	<b>LUHS/Gottlieb</b>	<b>PPO</b>	<b>Non-PPO<sup>(1)</sup></b>
Annual Deductible <sup>(2)</sup>	Individual: \$300 Family: 2 Individuals per Family Maximum	Individual: \$300 Family: 2 Individuals per Family Maximum	Individual: \$300 Family: 2 Individuals per Family Maximum
Annual Out-of-Pocket Maximum <sup>(3)</sup>	Individual: \$1,500 Family: 2 individuals out-of-pocket maximum	Individual: \$1,500 Family: 2 individuals out-of-pocket maximum	Individual: \$3,000 Family: 2 individuals out-of-pocket maximum
Lifetime Comprehensive Medical Maximum	\$2,000,000		
<b>Inpatient Hospital Services/Office Visits</b>			
<b>Inpatient Hospital Services<sup>(4)</sup></b>	100%	90% after hospital deductible	75% after hospital deductible
Hospital Deductible/Per Admission	None	\$250	\$400
Pre-Certification of Hospitalization <sup>(5)</sup>	None	Within two business days of an emergency hospitalization, before admission to any facility and for certain outpatient services; \$100 penalty for not pre-certifying as required.	
Skilled Nursing Facility, Coordinated Home Care and Hospice <sup>(4)</sup>	100%	90% after hospital deductible	75% after hospital deductible
Inpatient Physician Visits (including surgeons, anesthesiologists, radiologists, pathologists)	90% after deductible	80% after deductible	70% after deductible
Mental Health Services: Inpatient	80% after deductible; Maximum of 3 confinements up to a total of 60 days per lifetime	80% after deductible; Maximum of 3 confinements up to a total of 60 days per lifetime	70% after deductible; Maximum of 3 confinements up to a total of 60 days per lifetime
Mental Health Services: Out-patient	[Not applicable]. Provider services paid under the PPO or non-PPO level	80% after deductible; Maximum of 52 visits per year	70% after deductible; Maximum of 52 visits per year
Chemical Dependency (CD): Inpatient	80% after deductible; Maximum of 3 confinements up to a total of 60 days per lifetime	80% after deductible; Maximum of 3 confinements up to a total of 60 days per lifetime	70% after deductible; Maximum of 3 confinements up to a total of 60 days per lifetime
Chemical Dependency (CD): Out-patient	[Not applicable]. Provider services paid under the PPO or non-PPO level	80% after deductible; Maximum of 52 visits per year	70% after deductible; Maximum of 52 visits per year
Physician Charges for Maternity Care Including Delivery	90% after deductible	80% after deductible	70% after deductible
Office Visit for Illness or Injury	90% after deductible	80% after deductible	70% after deductible
Wellness Benefit	100% up to \$750 maximum per person, per year.		
Well Child Care Benefit <sup>(6)</sup>	100% up to 24 months of age.		

## Loyola University Option I PPO Plan

Plan Provision	LUHS/Gottlieb	PPO	Non-PPO
<b>Outpatient Services</b>			
Emergency Room <sup>(7)</sup>	\$75 emergency room co-pay, then 100% if it meets the definition of emergency. Emergency room co-pay is waived if admitted to the hospital.		
Outpatient Hospital Surgery	100%	90% after deductible	75% after deductible
Outpatient Physician Surgical Services	90% after deductible	80% after deductible	70% after deductible
Physician Diagnostic Testing <sup>(8)</sup> Hospital Diagnostic Testing	90%	80%	70%
Outpatient Hospital Services (radiation, chemotherapy, cardiac rehab, dialysis)	100%	90% after deductible	75% after deductible
<b>Other Services</b>			
Private Duty Nursing	80% up to a \$1,000 maximum per month		
Ambulance	80% after deductible		
Therapies – Physical/Speech/Occupational	90% after deductible; \$3,000 annual maximum per therapy per year	80% after deductible: \$3,000 annual maximum per therapy per year	70% after deductible; \$3,000 annual maximum per therapy per year
Durable Medical Equipment and External Prosthetic Appliances <sup>(10)</sup>	[Not applicable]. Provider services paid under the PPO or non-PPO level	80% after deductible	70% after deductible
Chiropractic <sup>(11)</sup>	90% after deductible <sup>(11)</sup>	80% after deductible	70% after deductible
Infertility Services <sup>(9)</sup>	90% after deductible for diagnosis, artificial insemination and fertility medications	80% after deductible for diagnosis, artificial insemination and fertility medications	70% after deductible for diagnosis, artificial insemination and fertility medications
Temporomandibular Joint Syndrome (TMJ)	[Not applicable]. Provider services paid under the PPO or non-PPO level	80% after deductible up to \$1,000 lifetime maximum	70% after deductible up to \$1,000 lifetime maximum

1. Non-PPO benefits are limited to the reasonable and customary charge. You pay the non-PPO network deductible and co-insurance plus any charges in excess of reasonable and customary amounts. Amounts over reasonable and customary do not apply to the plan's out-of-pocket maximum.
2. LUHS, PPO and non-PPO annual deductibles are not combined.
3. The LUHS and PPO out-of-pocket maximums are combined.
4. PPO inpatient hospital services are subject to the hospital deductible but are not subject to the annual deductible. Non-PPO inpatient hospital services are subject to the hospital deductible and to the annual deductible.
5. Pre-certification penalties are not included in the annual deductible or out-of-pocket expense limitation.
6. Well child care includes physical exams, diagnostic tests and immunizations up to 24 months of age. After 24 months coverage is under the wellness benefit.
7. Hospital Emergency Medical/Accident Care: Initial treatment in hospital of accidental injuries or sudden and unexpected medical conditions with severe life-threatening symptoms. If an inpatient admission occurs, MSA must be contacted within two business days or benefits will be reduced. ER \$75 co-pay is waived and inpatient deductible applies if admitted to hospital following ER care.
8. These expenses are not subject to the annual deductible.
9. Infertility expenses related to artificial insemination are covered up to a maximum of three attempts per lifetime. Any other infertility treatments are not covered.
10. Durable Medical Equipment and External Prosthetic Appliances (some examples: crutches, canes, walkers).
11. Not applicable if no provider at LUHS/Gottlieb. Provider services paid under the PPO or Non-PPO level.

## Medical Plan PPO Highlights: Loyola University Preferred PPO Plan

The following chart provides more details on the Loyola University Preferred PPO Plan. Non-PPO network benefits are based on a percentage of reasonable and customary charges.

<b>Loyola University Preferred PPO Plan</b>			
<b>Plan Provision</b>	<b>LUHS/Gottlieb</b>	<b>PPO</b>	<b>Non-PPO<sup>(1)</sup></b>
Annual Deductible <sup>(2)</sup>	Individual: <b>\$200</b> Family: 2 Individuals per Family Maximum	Individual: <b>\$600</b> Family: 2 Individuals per Family Maximum	Individual: <b>\$800</b> Family: 2 Individuals per Family Maximum
Annual Out-of-Pocket Maximum <sup>(3)</sup>	Individual: \$1,500 Family: 2 individuals out-of-pocket maximum	Individual: \$5,000 Family: 2 individuals out-of-pocket maximum	Individual: \$8,000 Family: 2 individuals out-of-pocket maximum
Lifetime Comprehensive Medical Maximum	\$2,000,000		
<b>Inpatient Hospital Services/Office Visits</b>			
Inpatient Hospital Services <sup>(4)</sup>	100%	70% after Hospital Deductible	50% after Hospital Deductible
Hospital Deductible/Per Admission	None	\$700	\$1,000
Pre-Certification of Hospitalization <sup>(5)</sup>	None	Within two business days of an emergency hospitalization, before admission to any facility and for certain outpatient services; \$100 penalty for not pre-certifying as required.	
Skilled Nursing Facility, Coordinated Home Care and Hospice <sup>(4)</sup>	100%	70% after hospital deductible	50% after hospital deductible
Inpatient Physician Visits (including surgeons, anesthesiologists, radiologists, pathologists)	90% after deductible	70% after deductible	60% after deductible
Mental Health Services: Inpatient	80% after deductible; maximum of 3 confinements up to a total of 60 days per lifetime	80% after deductible; maximum of 3 confinements up to a total of 60 days per lifetime	70% after deductible; maximum of 3 confinements up to a total of 60 days per lifetime
Mental Health Services: Out-patient	[Not applicable]. Provider services paid under the PPO or non-PPO level	80% after deductible; maximum of 52 visits per year	70% after deductible; maximum of 52 visits per year
Chemical Dependency (CD): Inpatient	80% after deductible; maximum of 3 confinements up to a total of 60 days per lifetime	80% after deductible; maximum of 3 confinements up to a total of 60 days per lifetime	70% after deductible; maximum of 3 confinements up to a total of 60 days per lifetime
Chemical Dependency (CD): Out-patient	[Not applicable]. Provider services paid under the PPO or non-PPO level	80% after deductible; maximum of 52 visits per year	70% after deductible; maximum of 52 visits per year
Physician Charges for Maternity Care Including Delivery	90% after deductible	70% after deductible	60% after deductible
Office Visit for Illness or Injury	90% after deductible	70% after deductible	60% after deductible
Wellness Benefit	100% up to \$750 maximum per person, per year.		
Well Child Care Benefit <sup>(6)</sup>	100% up to 24 months of age.		

## Loyola University Preferred PPO Plan

Plan Provision	LUHS/Gottlieb	PPO	Non-PPO
<b>Outpatient Services</b>			
Emergency Room <sup>(7)</sup>	\$75 emergency room co-pay, then 100% if it meets the definition of emergency. Emergency room co-pay is waived if admitted to the hospital.		
Outpatient Hospital Surgery	100%	70% after deductible	50% after deductible
Outpatient Physician Surgical Services	90% after deductible	70% after deductible	60% after deductible
Physician Diagnostic Testing <sup>(8)</sup>	90%	70%	60%
Hospital Diagnostic Testing	90%	70%	50%
Outpatient Hospital Services (radiation, chemotherapy, cardiac rehab, dialysis)	100%	70% after deductible	50% after deductible
<b>Other Services</b>			
Private Duty Nursing	80% up to a \$1,000 maximum per month		
Ambulance	80% after deductible		
Therapies – Physical/Speech/Occupational	90% after deductible; \$3,000 annual maximum per therapy per year	70% after deductible; \$3,000 annual maximum per therapy per year	60% after deductible; \$3,000 annual maximum per therapy per year
Durable Medical Equipment and External Prosthetic Appliances <sup>(10)</sup>	[Not applicable]. Provider services paid under the PPO or non-PPO level	70% after deductible	60% after deductible
Chiropractic <sup>(11)</sup>	90% after deductible <sup>(11)</sup>	70% after deductible	60% after deductible
Infertility Services <sup>(9)</sup>	90% after deductible for diagnosis, artificial insemination and fertility medications	70% after deductible for diagnosis, artificial insemination and fertility medications	60% after deductible for diagnosis, artificial insemination and fertility medications
Temporomandibular Joint Syndrome (TMJ)	[Not applicable]. Provider services paid under the PPO or non-PPO level	70% after deductible up to \$1,000 lifetime maximum	60% after deductible up to \$1,000 lifetime maximum

1. Non-PPO benefits are limited to the reasonable and customary charge. You pay the non-PPO network deductible and co-insurance plus any charges in excess of reasonable and customary amounts. Amounts over reasonable and customary do not apply to the plan's out-of-pocket maximum.
2. LUHS, PPO and non-PPO annual deductibles are not combined.
3. Out-of-Pocket Maximum
4. Inpatient hospital services are not subject to the annual deductible, however, PPO and Non-PPO are subject to the deductible for hospitalization.
5. Pre-certification penalties are not included in the annual deductible or out-of-pocket expense limitation.
6. Well child care includes physical exams, diagnostic tests and immunizations up to 24 months of age. After 24 months coverage is under the wellness benefit.
7. Hospital Emergency Medical/Accident Care: Initial treatment in hospital of accidental injuries or sudden and unexpected medical conditions with severe life-threatening symptoms. If an inpatient admission occurs, MSA must be contacted within two business days or benefits will be reduced. ER \$75 co-pay is waived and inpatient deductible applies if admitted to hospital following ER care.
8. These expenses are not subject to the annual deductible.
9. Infertility expenses related to artificial insemination are covered up to a maximum of three attempts per lifetime. Any other infertility treatments are not covered.
10. Durable Medical Equipment and External Prosthetic Appliances (some examples: crutches, canes, walkers).
11. Not applicable if no provider at LUHS/Gottlieb. Provider services paid under the PPO or Non-PPO level.

## Prescription Drug Benefit (PPO)

### Retail

Under the prescription drug benefit, when you go to a pharmacy to purchase a prescribed medication, this is known as a retail purchase. The chart below lists the deductible and each of the out-of-pocket amounts. In all cases, your plan allows a maximum of a 34-day supply of the prescribed medication. The coinsurance payment levels are identical whether your prescriptions are purchased via retail or mail-order delivery.

Feature	Brand Name Prescription	Generic Name Prescription
Deductible: Individual Family	\$100 per person, calendar year 2 individuals per family, calendar year	
Co-Insurance	75%	90%
Out-of Pocket Maximum: Individual Family	\$2,000 per calendar year 2 individuals per family, calendar year	

### Mail Order Prescriptions

The mail order prescription program (home delivery plan) is available only for maintenance medications. Maintenance medications refer to long-term medications that are prescribed by the physician for treatment of chronic health conditions. This benefit saves time through the convenience of home delivery and discounted savings. If you have questions on costs or would like to obtain an order form to enroll in the mail order delivery plan, you may phone the **BlueCross BlueShield Prescription Drug Inquiry Unit at 1-800-423-1973**.

# Medical Plan Options

Loyola University Chicago provides a choice of three medical plans that will allow you to choose a plan that best fulfills the medical needs for you and your family. Loyola provides the following three health care options:

- **BlueCross BlueShield PPO – Option I**
- **BlueCross BlueShield PPO – Loyola Preferred**
- **HMO Illinois**

## BlueCross BlueShield Option I and Loyola Preferred

Loyola offers two PPO (Preferred Provider Organizations), Loyola Preferred PPO and Option I PPO. Blue Cross and Blue Shield of Illinois is the claims administrator.

### What is a PPO?

A PPO is a network of doctors, hospitals and other health care providers who agree to provide health care services at discounted rates.

Both PPO plans allow you to seek medical care with the provider of your choice; however, you receive a higher level of coverage if you choose a network provider. The highest level of benefits is payable when services are provided by Loyola Physicians at Loyola University Health Systems (LUHS).

## Accessing PPO Network & Loyola Physicians

The PPO does not require you to sign up with a particular hospital or physician when you enroll. You select the hospital and physician each time you need care. To determine if a particular hospital or physician is a part of the PPO network, call BlueCross and BlueShield Member Services at: **866-266-3674**. You may access a listing of PPO physicians in your area through the BC/BS website [www.bcbsil.com](http://www.bcbsil.com) or go directly to <http://bcbsil.com/providers/index.htm>

If you are enrolled in **Loyola Preferred** or wish to visit a Loyola physician, you are welcome to call the **Physicians Referral Center** for referral information on Loyola physicians at: **708-216-3896**.

## Your Annual Medical Deductible and Payment Levels

With PPO plans, you must satisfy an annual deductible per person before any benefits are paid by the plan. Once your annual deductible has been satisfied, you only pay a percentage (or co-insurance) of the remainder of the incurred expenses for that year. There are some expenses for which the deductible does not apply. For example, there is a separate deductible for prescription drug purchases.

The deductibles for the entire family will be satisfied when two members of the family have satisfied their individual deductibles. Once the deductible is met, the percentage you pay for services will vary between the Option I plan and the Loyola Preferred plan and the type of expense incurred. If you choose to use a non-PPO hospital or non-PPO physician, the benefit level is at a lesser amount, and you are responsible for paying any amount in excess of the scheduled fee.

## Per-Admission Inpatient Hospital Deductible

There is a per-admission deductible for every inpatient confinement **except at Loyola University Medical Center (LUMC)**. This deductible is applied every time you or a family member is admitted to a hospital.

Before you receive medical care from a hospital, Skilled Nursing Facility, or Coordinated Home Care, **except at LUMC**, you must contact the Blue Cross Medical Services Advisory program (MSA).

## Medical Services Advisory (MSA)

The Medical Services Advisory (MSA) program is a group of doctors and nurses who help you maximize your Plan benefits. Their job is to make sure you get the full value for your health care dollars. They will work with you and your private physician to help you understand your treatment options and decide the most effective treatment plan. These services are free to you.

**Hospital admissions:** except at LUMC, you must call the MSA **before** being admitted to qualify for maximum benefits.

**Emergency admissions:** if you or your family member is admitted to the hospital through an emergency room visit, you must contact the MSA within two business days.

**Pregnancy:** if you or your spouse is pregnant, contact the MSA before completion of the first trimester of pregnancy. If you or your spouse's maternity stay lasts more than two days for a normal delivery or four days for a cesarean section, be sure to contact the MSA again. You must also contact the MSA if the newborn's discharge date is extended beyond the mother's.

*If you do not call the MSA, a non-certification deductible of \$100 per occurrence is applied in addition to the per-admission deductible.* For more information about the MSA program, you may call the MSA telephone number on the reverse side of your Blue Cross identification card. The number is: 1-800-635-1928.

## PPO Member Services Available

### ***Blue Care Connection:***

**BlueCross BlueShield** of Illinois is offering to all PPO participants, ***Blue Care Connection***, which is an integrated care management online tool to give you access to your health Care Coordination, Utilization and Case Management, Disease Management, Health Expectations, and Wellness Programs. ***Blue Care Connection*** provides you with information, resources and online tools designed to help you maintain your health. Employees can set up a personal health record to keep track of and manage their family's health information within a secure location online. You can go online to check when your medical claims are paid and see the payment amounts, by visiting **Blue Access for Members** at [www.bcbsil.com](http://www.bcbsil.com) and click on the Personal Health Manager icon to get started.

## BlueCard Worldwide®

When you need health care outside the U.S. – always carry your BlueCross BlueShield identification card. If you need emergency medical care, go the nearest hospital. Call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177 if you are admitted. For detailed information, please visit the website at: <http://www.bluecares.com/bluecardworldwide/index.html>.

### While Traveling

If you need medical attention while traveling inside or outside of the United States, and you enrolled in the Loyola Medical Plan Option I PPO Plan or Preferred PPO Plan, your health care is covered through the BlueCard Worldwide Program. If you enrolled in the HMO Illinois option, you are covered only for life threatening emergencies while traveling.

### Link to Coverage and PPO Network Providers

Your BlueCross BlueShield Identification Card is your link to health care coverage and PPO providers while traveling. **When you are traveling, it is very important that you keep your BlueCross BlueShield Identification Card with you at all times.** If you do not have an Identification Card, contact the Human Resources Department to obtain an ID card before you travel.

### If you need Medical Care that exceeds 24 hours:

The World Access Service Corporation is the medical assistance company for the BlueCard Worldwide Program which allows you to use your BlueCross BlueShield health insurance I.D. card so that you can receive covered inpatient and outpatient care at participating hospitals. If you require inpatient hospital care, you must present your I.D. card at any participating hospital, and your claim will be handled that same as in the United States. The World Access Service Corporation at 1-800-673-1177 is available 24 hours a day and will help facilitate hospitalization at a participating hospital or schedule a doctor's appointment for you. When you call the World Access Service Center, they can arrange direct billing from the hospital to BlueCross BlueShield.

### If you need Medical Care for less than 24 hours:

You must pay for the treatment at the time of service and then file a medical claim to receive reimbursement.

The contact numbers are:

- **In the United States** to find a PPO Provider: World Access Service Corporation at **1-800-810-BLUE (2583)** available 24 hours a day, seven days a week.
- **Outside the United States:** You may call collect through the World Access Service Corporation at **1-804-673-1177** if you are admitted and this service is available 24 hours a day, seven days a week.

## Hospital Benefits

In-patient and Out-patient hospital care, in duly licensed facilities, as well as care received in certain specialized facilities such as a licensed ambulatory surgical center, are covered under your plan.

For a list of PPO hospitals, see the BlueCross BlueShield website [www.bcbsil.com](http://www.bcbsil.com).

## Emergency Room Care

Your plan covers emergency medical care for the initial treatment of a sudden and unexpected medical condition which has such severe life-threatening symptoms that the absence of immediate emergency medical attention could result in serious or permanent medical consequences. It also covers emergency accident care and related diagnostic services when initiated within 72 hours of the accidental injury. Emergency Room visits are subject to \$75/visit co-pay.

**A Medical Emergency** - is a situation so serious that it demands immediate medical attention and could put a person's life in danger or cause serious harm. Examples of serious, life-threatening medical emergencies are:

- **Severe chest pain or pressure**
- **Uncontrollable bleeding**
- **Loss of consciousness or confusion**
- **Difficulty breathing**
- **Severe or multiple injuries, including obvious fractures.**

If there is a life-threatening emergency, go to the nearest emergency room immediately for treatment or call 911. Then notify the PPO Network within 48 hours to receive benefits at Emergency Room level. If the PPO Network is not notified, benefits will be paid at Outpatient Hospital Services level based on service provider (LUHS, PPO or Non-PPO).

**A Non-Medical Emergency** – is a situation, which *usually* does not require immediate emergency room medical care for instances such as:

- **Colds, strep throat and flu**
- **Earaches**
- **Sprains**
- **Headaches**
- **Cuts not requiring stitches**

Emergency room and urgent care center charges are covered at Emergency Room level if they meet the definition of a medical emergency under the plan (see above). If they do not meet the definition of a medical emergency under the plan, they are covered at Outpatient Hospital Services level based on service provider (LUHS, PPO or non-PPO). [See Medical Care: Option I PPO Plan or Medical Care: Preferred PPO Plan for coverage levels.]

## Wellness Benefits for Routine Medical Care Services

Wellness means assuming responsibility for maintaining good health and incorporating good healthy habits and lifestyle choices to enhance your well-being and improve the quality of your life. Some examples of *routine services* are routine physical examinations, mammograms, and immunizations.

Each member of your family covered under the BlueCross BlueShield PPO plans may use up to \$750 per calendar year (not subject to the annual deductible) to cover the cost of routine services. The member is responsible for all routine charges incurred that are greater than the \$750 per calendar year limit. **Any charges over \$750 do not get applied towards your annual deductible.**

## Well Child Care

Under the PPO plans, immunizations, routine tests, and routine examinations for children up to age 24 months are covered at 100% with no maximum. Immunizations, routine exams and routine testing for individuals aged 25 months and above are subject to the \$750 maximum per year Wellness Benefit explained above.

## Other Covered Services

The PPO plans provide coverage for many other services when deemed medically necessary. In some cases, coverage provided is subject to a maximum benefit limitation. Please refer to your BlueCross BlueShield Summary Plan Description (SPD) or the PPO Option I and Loyola Preferred charts in this section of the Benefits Booklet. Listed below are some of the “other covered services,” payable at the appropriate co-insurance levels:

- Physical Therapy - \$3,000 maximum per calendar year
- Occupational Therapy - \$3,000 maximum per calendar year
- Speech Therapy - \$3,000 maximum per calendar year
- Private Duty Nursing - \$1,000 maximum per month
- Ambulance transportation when deemed medically necessary
- Chiropractic services
- Durable medical equipment and prosthetics (when deemed medically necessary). Rental price is covered up to purchase price.
- Oxygen and its administration
- Blood and blood components
- Coordinated Home Care initiated by a hospital to facilitate early patient discharge
- Hospice
- Temporomandibular Joint Dysfunction (TMJ) - \$1,000 lifetime maximum

## Out-of-Pocket Expense Limitation

Your BlueCross BlueShield Plan protects you from costly payments in cases of heavy medical expenses. Once you have paid the total Out-of-Pocket dollars for your plan, the plan will pay 100% of the cost of that individual's health care for the remainder of that calendar year. If two people in the family have paid the maximum out-of-pocket cost in one year, then the maximum is met for the entire family. (Per Admission and MSA deductibles are excluded.) Charges in excess of the scheduled maximum allowance do not apply to the out-of-pocket limitation.)

## Plan Limitations

While these plans are designed to be comprehensive, certain expenses, services, supplies, and providers are excluded from coverage. A few, but not all, of the limitations are listed below. Please refer to your BlueCross Summary Plan Description or contact the Human Resources Benefit Office for more details.

These services are among those **not** covered:

- elective abortions
- hospitalization, services and supplies that are not medically necessary
- services or supplies for which Workers' Compensation benefits are available
- maintenance therapy of any kind
- hearing aids
- custodial care, personal comfort items
- investigational services and supplies
- routine medical services (except as listed in Wellness Benefit section)
- In Vitro Fertilization (IVF)
- Birth Control Pills not covered in PPO plan

## Terms and Conditions

Participants in the Loyola BlueCross BlueShield Plan may choose Option I or Loyola Preferred. These options pay health expenses to the hospital or physician you select. You may select any licensed hospital or board certified physician for you or your family's care. To receive the highest level of coverage there are certain guidelines you must follow. If you choose not to follow these guidelines, your benefits may be reduced. You will be responsible to pay the balance of costs not covered.

## BlueCross BlueShield of Illinois – Blue Extras<sup>SM</sup> Money Savings Discount Program

Through the Blue Extras discount program, all BlueCross and BlueShield of Illinois (BCBSIL) members are eligible to save money on value-added health care products and services that help support healthy lifestyles. These discounts are for health care products and services not usually covered by your health care benefit plan. There are no claims to file, no referrals or pre-authorizations, and no additional fees to participate – it's just one more benefit of being a BCBSIL member. To use Blue Extras, simply show your card to a participating provider to receive your discount. Discounts are offered for:

### Complementary Alternative Medicine:

[www.bcbsil.com/member](http://www.bcbsil.com/member) (866) 656-6069

Includes a variety of therapies that may help to improve your health, prevent illness and address existing symptoms and conditions. You're automatically eligible to receive up to 30 percent off standard fees through a network of more than 35,000.

### Jenny Craig

[www.jennycraig.com](http://www.jennycraig.com)

(800) 597-Jenny (800-597-5366)

Jenny Craig is a long-term food/body/mind solution that can help you manage your weight by teaching you how to create a healthy relationship with food and build an active lifestyle and develop a balanced approach to living.

## Curves

[www.curves.com](http://www.curves.com)

(800) CURVES-30 (800) 287-8373

Curves offers a 30-minute workout that combines strength training and sustained cardiovascular activity through resistance equipment.

## Davis Vision

[www.davisvision.com](http://www.davisvision.com)

(877) 393-8844

Save on eyeglasses (frames and lenses), as well as contact lenses, laser vision correction services, examinations and accessories through one of the nation's leading provider of routine vision care programs. For a list of Davis Vision providers near you, search the Provider Finder® at [www.bcbsil.com](http://www.bcbsil.com). The Davis Vision network consists of major national and regional retail locations, such as EyeMasters and Visionworks and independent ophthalmologists and optometrists.

## TruHearing

[www.truhearing.com](http://www.truhearing.com)

(866) 687-2020

Save on digital hearing aids through TruHearing. You can get a hearing test at no additional charge by a licensed hearing specialist when performed for the purpose of fitting a hearing aid. Enjoy a 45-day money back guarantee and a two-year warranty and a selection of hearing aid styles at various price levels.

# Health Maintenance Organization (HMO)

An HMO is a healthcare group that provides services and supplies exclusively through their HMO network of doctors, hospitals, and other healthcare facilities.

When you enroll in an HMO plan, you will be asked to select a Medical Group and a Primary Care Physician (PCP) from within the HMO network to coordinate all of your healthcare needs. Your chosen PCP must authorize and refer all services rendered under the plan you have chosen. **If you choose to receive care that has not been authorized by your PCP, no benefits will be payable for those services, except in some emergency medical situations. HMOs do not have a lifetime maximum medical coverage limit and services are paid according to the contract.**

As an HMO member you have the right to request a change to another Medical Group/PCP at any time during the benefit plan year. Whenever you wish to change your Medical Group, you are required to phone the Customer Service number for your HMO plan and speak directly to an HMO Representative regarding the change. All Medical Group changes will be effective the first of the month, regardless of when the call is made. If you wish to change your Primary Care Physician (PCP) within the same Medical Group, please contact the Medical Group directly (phone number is on the FRONT of your HMO ID card). The Medical Group will advise you of the effective date of the PCP change.

Loyola offers one HMO option, which is **HMO Illinois**. The HMO plan has no deductibles or coinsurance levels. There are some services that have co-payments, such as doctor's office visits, prescription drugs and emergency room visits. Please see the following grid that details the HMO Illinois plan.

When trying to select a PCP, you should visit the HMO Illinois website at [www.bcbsil.com](http://www.bcbsil.com), or work directly with the HMO Illinois Customer Service Department.

## **HMO Member Services Available:**

### ***Blue Access* for HMO Illinois Members @ [www.bcbsil.com](http://www.bcbsil.com)**

This secure member website is an easy way to manage your health care benefits and your health, provided by BlueCross BlueShield of Illinois (BCBSIL). The BCBSIL web site gives you immediate access to health care benefit information and easy-to-use tools. You will be able to take charge of your health in the ***Personal Health Manager*** to find practical information about specific conditions and self-management tools for common health problems, you will be able to take a health risk assessment, create a health record, and receive targeted wellness information. In addition, you will be able to check the status of Inpatient Claims, confirm your coverage and benefit coverage for your dependents, and can use the Provider Finder to locate a contracting doctor or hospital. It's easy to get immediate access - all you need are your group and identification numbers (found on your BCBSIL ID card).

## HMO Health Plan Highlights

Features	BlueCross BlueShield HMO Illinois
<b>Your Primary Care Physician (PCP)</b>	HMO Illinois' Physician network includes Loyola Primary Care Physicians. Use the HMO IL website to select a physician near you: <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-800-892-2803.
<b>Referrals</b>	All referrals requires your Primary Care Physician's approval
<b>In-Patient Hospital</b>	Payment Level: 100% After \$100 Co-Pay per Admission
<b>Out-Patient Hospital</b>	Payment level: 100%
<b>Physician Services Office Visits</b>	\$20 Co-pay
<b>Emergency Care</b>	\$75 Co-pay
<b>Standard Mental Health</b>	<b>Inpatient:</b> (\$100 co-pay per admission) Payment level: 100% (Maximum 20 days per calendar year for Non-Serious Mental Health; 45 Days for Serious Mental Health) <b>Outpatient:</b> Payment level: 100% after you pay \$20 per visit co-pay (Maximum 20 visits per calendar year for Non-Serious Mental Health; 60 Days for Serious Mental Health)
<b>Chemical Dependency (CD) Services</b>	Must call HMO Illinois Chemical Dependency Hotline at 800-346-3986 <i>or treatment will not be covered.</i> <b>Inpatient:</b> Payment level at 100% (maximum 20 days per year); \$100 co-pay per admission <b>Outpatient:</b> Payment level at 100% after you pay \$20 per visit co-pay (max 20 visits per year)
<b>Prescription Drug Benefit</b>	Co-pay levels: \$15 Generic \$35 Brand Name, Formulary \$45 Nonformulary
<b>Mail Order Prescription Drug Program (Optional)</b>	Available by contacting BC/BS at 1-800-423-1973 (3 month supply for 2x co-pay). Also available at participating retail providers.
<b>Vision Benefit (only through participating providers)</b>  <b>Note: You must use - Davis Vision provider – go on line to <a href="http://www.bcbsil.com">www.bcbsil.com</a> to view participating providers.</b>	<ul style="list-style-type: none"> <li>• Optical services <u>only</u> through participating providers.</li> <li>• Payment level: 100% for eye exam once in every 12 months (\$20 co-pay).</li> <li>• Discounts available on eyewear in addition to a \$75 allowance for the purchase of glasses or contacts every 24 months.</li> </ul>

# Dental Insurance Options

You may choose from two dental options:

- **Delta Dental** - a dental PPO plan
- **Guardian/First Commonwealth** - a managed-care dental plan

## Delta Dental

Loyola’s dental PPO plan is administered through Delta Dental. With this dental coverage you may select the dentist of your choice. To access the PPO Provider list call 1-800-323-1743 or go to their website at [www.deltadentalil.com](http://www.deltadentalil.com) to select a dental provider. There are different levels of coverage based on the PPO network. See the chart below.

	<b>Delta Dental PPO (In-network)</b>	<b>Delta Premier</b>	<b>Non-Network</b>
Explanation of Network	Employees receive highest level of benefits when selecting dental providers from this network.	- Benefit level slightly lower than Delta PPO - Employees are not responsible for charges exceeding “Usual and Customary”	Employees who use out-of-network dental providers are responsible for any charges exceeding “Usual and Customary”
Preventative & Diagnostic	100% deductible does not apply	90% deductible does not apply	90% deductible does not apply
Annual Deductible (*Two family members)	\$50*	\$75*	\$75*
Basic Services	80%	50%	50%
Major Services	60%	50%	50%
Annual Maximum Benefit Per Person	\$1,800	\$1,500	\$1,500
Orthodontic Lifetime Benefit for Children up to 19 Yrs	50% coverage up to a lifetime maximum of \$1,000	50% coverage up to a lifetime maximum of \$1,000	50% coverage up to a lifetime maximum of \$1,000

## Terms (Delta)

**Annual Deductible** for the whole family is satisfied when *three* (3) members of the family have satisfied their individual deductible.

**Preventative & Diagnostic Services** include bi-annual oral examination including full mouth and bite-wing x-rays, teeth cleaning and, for patients under age 19, topical fluoride application.

**Basic Services** include extractions, dental surgery, space maintainers, sealants treatment of gum disease, general anesthesia required in relation to dental surgery, endodontic and periodontic treatment.

**Major Services** include crowns, fixed bridge restorations, removable partial or complete dentures, and repairs to existing dentures. [Note: Implants and related services not covered]

## Pre-Determining Your Dental Cost

If your dentist recommends a course of treatment that will cost more than \$200.00, he or she should submit a treatment plan to Delta Dental before treatment begins. This treatment plan must include:

- a report describing the planned treatment
- copies of necessary x-rays, photographs, and models, and
- an estimate of the charges for the treatment

Delta Dental will review the information taking into consideration alternative courses of treatment and will notify you and your dentist of the benefits which will be provided for your treatment.

## Delta Dental's Health Enhanced Benefits Program

Delta Dental of Illinois offers a Health Enhanced Benefits Program that applies only to the Delta Dental PPO and Delta Dental Premier networks. The enhanced benefits are covered for Diabetics, Pregnant Women, and Persons with Periodontal Disease or a History of Periodontal Surgery, are shown below:

<b>Delta Dental Eligible Members</b>	<b>Treatment</b>	<b>Coverage Level</b>	<b>Frequency per Benefit Year</b>	<b>Applies to Annual Maximum</b>
<b>Diabetics</b>	Prophylaxis and Periodontal Maintenance Cleaning	Same % as the Group Contracted Benefit Level	4 x total	Yes
	-Or- Periodontal Maintenance Cleaning	Same % as the Group Contracted Benefit Level	4 x total	Yes
<b>Pregnant Women</b>	Prophylaxis	Same % as the Group Contracted Benefit Level	4 x total	Yes
<b>Persons with Periodontal Disease or a History of Periodontal Surgery (At-Risk Persons)</b>	Prophylaxis and Periodontal Maintenance Cleaning	Same % as the Group Contracted Benefit Level	4 x total	Yes
	-Or- Periodontal Maintenance Cleaning	Same % as the Group Contracted Benefit Level	4 x total	Yes
	Fluoride Varnish (no age limits)	Same % as the Group Contracted Benefit Level	2 x total (following Perio surgery)	Yes
<b>All Enrollees</b>	Oral CDx Brush Biopsy*	Same % as the Group Contracted Benefit Level	N/A	Yes

\*The OralCDx brush biopsy is standardly covered under oral surgery in Delta Dental of Illinois' plans.

For more information, you may visit Delta Dental of Illinois' website at [www.deltadentalil.com](http://www.deltadentalil.com) or you may phone Delta's customer service number at 1-800-323-1743.

## Guardian/First Commonwealth (DHMO)

Similar to an HMO plan, Guardian/First Commonwealth is a dental managed care plan (DHMO) with its own network of dentists. Under this plan it is not necessary for you and your family to use the same dentist, but **the dentist must be a member** of the **Guardian/First Commonwealth network**. There are no out-of-network benefits with this plan.

You must decide which dental providers you and your family will use at the time of enrollment. If you decide to change your dentist you must first call Guardian/First Commonwealth at 1-866-494-4542. The change process takes approximately 20 days. An up-to-date list of the names and locations of participating dental providers may be found at their website: [www.guardianlife.com](http://www.guardianlife.com).

Description	First Commonwealth DHMO
Preventive & Diagnostic	100%
Annual Deductible	None
Basic Services	85%
Major Services*	65%
Annual Maximum Benefit Per Person	None
Orthodontic Lifetime Benefit for Children and Adults	\$1,000 (savings off prevailing ortho. fee)

\*Major Services: Select Cosmetic Services are covered at 50%  
 [Note: Implants and related services not covered]

### Terms (DHMO)

**Annual Deductible** for the whole family is satisfied when 2 members of the family have satisfied their individual deductible.

**Preventative & Diagnostic Services** include bi-annual oral examination including full mouth and bite-wing x-rays, teeth cleaning and, for patients under age 19, topical fluoride application.

**Basic Services** include extractions, dental surgery, space maintainers, treatment of gum disease, general anesthesia required in relation to dental surgery, endodontic and periodontic treatment.

**Major Services** include crowns, fixed bridge restorations, removable partial or complete dentures, and repairs to existing dentures. [Note: Implants and related services not covered]

# University-Paid Basic Life Insurance

If you are in a benefits-eligible full-time position, Loyola University automatically provides you with Basic Term Life Insurance equal to 1½ times your annual salary with maximum up to \$500,000. Loyola University pays the entire cost of this coverage and your life insurance policies are administered through CIGNA insurance.

There are some tax consequences to employees with employer-funded insurance coverage over \$50,000. As mandated by the IRS, coverage amounts in excess of \$50,000 are subject to imputed income whereby the excess amount of the life insurance coverage is subject to federal income and Social Security (FICA) taxes. The taxable amount is included in your W-2 and is calculated using an IRS age-based table. If you wish to limit your life insurance coverage to a \$50,000 maximum, you will not be subject to the excess tax. To do this, you must complete a waiver form obtained from the Human Resources office. However, please understand that if you elect to limit your life insurance to \$50,000 and later wish to reinstate your coverage amount to the original 1½ times your salary, or increase any other life insurance coverage, you will need to complete an Evidence of Insurability form, which may include a physician's certification of good health (See *Evidence of Insurability* on the next page).

Beneficiaries for your Basic Life must be the same for Supplemental Life. For more information, please contact the Human Resources office.

# University-Paid Short Term Disability

Short Term Disability (STD) coverage is provided to all benefits-eligible full-time faculty and full-time staff. STD provides salary replacement during a medical leave due to a medical condition that prevents you from performing your regular work responsibilities for three or more work days. This benefit is provided at no cost to the employee.

## **Benefits-Eligible Full-Time Faculty and University Administrators:**

Full-time benefits-eligible Faculty and University Administrators who have completed six months of employment receive 100% of pre-disability earnings during the first 14 weeks of any illness or disability that prevents them from working. Weeks 15 through 26 are paid at 80% of pre-disability earnings.

## **Benefits-Eligible Staff:**

Full-time benefits-eligible exempt staff members who have completed six months of employment receive 100% of pre-disability earnings for up to 10 weeks of any illness or disability that prevents them from working. There is a 10-day elimination period.

## **Benefits-Eligible Professional Hourly Staff:**

Full-time benefits-eligible non-exempt and professional-hourly staff members who have completed six months of employment receive 100% of pre-disability earnings for up to 10 weeks of any illness or disability that prevents them from working. There is a 10-day elimination period.

# University-Paid Long Term Disability

Long Term Disability (LTD) coverage is provided to all full time benefits-eligible faculty and staff. LTD provides salary replacement during any extended leave due to a medical condition that prevents you from performing your regular work duties/responsibilities. This benefit is provided at no cost to the employee.

Upon approval by the Long Term Disability insurance carrier, CIGNA, the Long-Term Disability plan will pay 66-2/3% of your monthly/contracted salary, less other income benefits. The LTD plan allows for a maximum benefit of \$12,500 per month.

## **Benefits-Eligible Full-Time Faculty and University Administrators:**

Upon hire, full-time benefits-eligible Faculty and University Administrators are eligible for 66-2/3% pre-disability earnings after 180 consecutive calendar days of any illness or disability which prevents them from working. Length of benefit varies.

## **Benefits-Eligible Exempt Staff:**

Upon hire, full-time benefits-eligible exempt staff members are eligible for 66-2/3% of pre-disability earnings after 90 consecutive calendar days of any illness or disability which prevents them from working. Length of disability varies.

## **Benefits-Eligible Non-Exempt/Professional Hourly Staff:**

Upon hire, full-time benefits-eligible non-exempt and professional-hourly staff members are eligible for 66-2/3% of pre-disability earnings after 90 consecutive calendar days of any illness or disability which prevents them from working. Length of benefit varies.

- *Short-Term and Long-Term Disability insurance terminates on your last day worked. You may contact the Human Resources Office for more details on the Long Term Disability Plan.*
- Refer to the chart on the next page, showing STD and LTD benefits.

Short Term Disability (STD)		Long Term Disability (LTD)*	
All University <b>Full-Time Benefits-Eligible Faculty and University Administrators</b> who have completed 6 months of employment	All Other <b>University Full-Time Benefits-Eligible Staff Employees</b> who have completed 6 months of employment	All University <b>Full-Time Benefits-Eligible Faculty and University Administrators</b> upon Date of Hire	All Other University <b>Full-Time Benefits-Eligible Staff Employees</b> upon Date of Hire
Your absence from work lasting more than 3 days due to your own illness or non-work related injury.		The inability to perform the regular duties of your job.  During the Elimination Period, unlimited trial (or partial) workdays are allowed as long as you do not earn more than 80% of your pre-disability earnings,  Partial return to work is also allowed once your LTD benefits have begun.  After 2 years from the onset of your disabling condition, disability will be determined based on your inability to engage in any work for which you have practical training, education or experience.	
Benefits are payable from the 1 <sup>st</sup> day of absence (when the absence lasts more than 3 days).	Benefits are payable after 10 working days of absence.	Benefits are payable after 180 calendar days of disability beginning with the onset of the illness or injury causing disability.	Benefits are payable after 90 calendar days of disability beginning with the onset of the illness or injury causing disability.
Benefits are payable for up to 26 weeks for any one period of disability.	Benefits are payable for up to 10 weeks for any one period of disability.	Benefits are payable up to age 65 when disability begins before age 60; if disability begins at or after age 60, benefits are payable for a period of time of no less than 1 year but no longer than 5 years, based upon your age at the onset of disability	
100% of pre-disability earnings for the first 14 weeks, 80% thereafter.	100% of pre-disability earnings.	66 2/3% of monthly earnings, to a maximum of \$12,500	
If you begin a period of disability, return to work for less than 10 working days and are again unable to work due to the same illness or non-work related injury, your entire absence will be treated as a single period of disability.		If you begin a period of disability, then <u>return to work in a trial or partial capacity</u> , you will interrupt your Elimination Period if your earnings exceed 80% of your pre-disability earnings.	

**Eligibility**

*(This describes who is entitled to participate in and receive benefits from each plan.)*

**Definition of Disability**

*(This describes how each plan defines what a disability is.)*

**Elimination Period**

*(This described how long you must be disabled (unable to work) before benefits are paid.)*

**Benefit Duration**

*(This describes how long you may receive benefits for any one period of disability)*

**Benefit Amount**

*(This describes how much your benefit will be. STD benefits will be paid on the dates of your biweekly or monthly payroll cycle; LTD benefits will be paid on a monthly basis.)*

**Period of Disability**

*(This described how mixed periods of inability/ability to work will be treated for purposes of having to satisfy new Elimination Periods and meeting the maximum Benefit Duration period.)*

\*The LTD benefits are provided through an ERISA Plan. The benefits and definitions cited here are just for illustration. In the event of conflicting information, the actual terms of the LTD plan, as evidenced by the Plan

Document, shall govern. The University further reserves the right to terminate or modify the terms of its benefit programs at any time.

### **Additional Benefits through LTD**

***CIGNA Life Assistance*** is a comprehensive resource that offers consultation, information, and personalized community referrals on a range of topics such as elder and child care resources, information on healthy lifestyle choices, personal financial management and more. You may speak confidentially with a Life Assistance consultant by calling their toll-free number at 1-800-538-3543. This service is available 24 hours a day, 7 days a week, and 365 days a year. You may also find their website helpful because it provides hundreds of resources on an array of work and life issues. To access the services available on the web visit: [www.cignabehavioral.com/cgi](http://www.cignabehavioral.com/cgi).

***CIGNAssurance*** – brings an objective, comprehensive financial counseling service which is available to terminally ill employees or to survivors of employees who have passed away. To obtain more information about this benefit you may access their website at [www.cigna.com](http://www.cigna.com).

# Vision Plan Benefit Options

You may choose from two vision plan options:

- **VSP<sup>®</sup>** (Vision Service Plan) - Comprehensive eye care benefits provided by VSP network for routine services
- **AlwaysVision<sup>SM</sup>** - AlwaysVision network includes:
  - Loyola University Health System Ophthalmologists
  - Offers access to National eye care chains

## Vision Service Plan (VSP<sup>®</sup>)

Loyola’s Vision Service Plan (VSP) is a voluntary benefit that provides comprehensive eye-care benefits when you visit a VSP network doctor for routine services. This plan allows you to obtain eye care with the provider of your choice; however, you will receive the higher level of benefits if you choose a VSP network doctor. If you choose an out-of-network provider, you will pay the provider for services rendered; you then must file a reimbursement claim with VSP. [Identification cards are not issued by VSP. You only have to phone the VSP provider of your choice to make an appointment.]

Benefit	Frequency <sup>1</sup>	Co-pay	From VSP Doctor	Out of Network Benefits
<b>Exam</b>	Every Plan Year <sup>1</sup>	\$10	Covered in full	\$45
<b>Lenses</b>	Every Plan Year <sup>1</sup>	\$15	Single vision, lined bifocal, lined trifocal, lenticular and polycarbonate lenses for dependent children are covered in full <sup>2</sup>	Single vision up to \$35 Lined bifocal up to \$58 Lined trifocal up to \$75 Lenticular up to \$95
<b>Frames</b>	Every Other Plan Year <sup>1</sup>		A frame of your choice covered up to \$150 allowance <sup>3</sup>	Up to \$50
<b>Contact Lenses</b>	Every Plan Year <sup>1</sup>	100%	Covered up to \$150 <sup>4</sup>	Up to \$125

<sup>1</sup> Based on calendar year

You may choose prescription glasses or contacts. If you choose contacts, you will not be eligible to receive glasses (lenses and a frame) in the same service period. Your allowance of \$150 applies to the cost of your contact lens exam and your contact lenses. You will receive a 15 percent discount off the cost of your contact lens exam from a VSP doctor. Your contact lens exam is performed in addition to your routine eye exam to check for eye health risks associated with improper wearing and fitting of contacts.

### Value Added Discounts

Laser VisionCare<sup>SM</sup> – VSP has contracted with many of the nation’s finest laser surgery facilities and doctors, offering you a discount off PRK, LASIK and Custom LASIK surgeries. Visit [www.vsp.com](http://www.vsp.com) to learn more about this program.

Prescription glasses – Receive 20% savings when you purchase additional pairs of prescription glasses, including prescription sunglasses from any VSP doctor within 12 months of your last eye exam.

You will receive up to **30% savings** on lens extras such as scratch resistant and anti-reflective coatings and progressives.

<sup>2</sup>Lens options, which can enhance the appearance, durability, and function of your glasses, are available to you at VSP's preferred member pricing at an additional cost to the member.

<sup>3</sup>If you choose a frame valued at more than your allowance, you will receive 20% off on any out-of-pocket costs.

<sup>4</sup>Current soft contact lens wearers may qualify for a special contact lens program that includes a contact lens evaluation and initial supply of replacement lenses. Learn more from your VSP doctor or [vsp.com](http://vsp.com).

To find a VSP network doctor close to your home or work, call VSP Member Services at (800) 877-7195 or go to [www.vsp.com](http://www.vsp.com).

# AlwaysVision<sup>SM</sup>

The AlwaysVision<sup>SM</sup> plan is a voluntary benefit that provides comprehensive eye-care benefits when you visit participating providers for services. This plan allows you to obtain eye care with the service provider of your choice and includes Loyola University Health System (LUHS) Ophthalmologists. The chart below describes the plan.

**Vision Exam Benefit:** Each member is entitled to a comprehensive Vision Exam. An eye exam co-pay applies and is outlined in the grid below.

**Vision Materials Benefit:** Each member may purchase eyewear in the form of an eyeglass frame and lenses or contact lenses with this plan. Purchases are subject to benefit frequencies and co-pays. Contact lenses may be purchased in lieu of frames and eyeglass lenses. Plan features include:

- **Frame Benefit:** Members may choose any frame within a provider's collection, subject to the retail frame allowance listed below. If the cost is greater than the plan's benefits, the member is responsible for the difference.
- **Eyeglass Lens Benefit:** Members always receive new lenses of the highest quality and craftsmanship. Standard plastic (CR-39 Plastic Material) single vision, bifocal and trifocal lenses are generally covered in full and plan allowances are listed below for specialty lenses. If the cost is greater than the plan's benefits, the member is responsible for the difference.
- **Contact Lens Benefit:** Members electing contact lenses instead of glasses may choose to apply the contact lens retail allowance to any lenses in the provider's collection. If the cost is greater than the plan's benefits, the member is responsible for the difference. The contact lens allowance will apply to the retail cost of contact lenses and to any professional fitting fee charged by the provider.

## AlwaysVision<sup>SM</sup>

Benefit	ALWAYS VISION <sup>TM</sup>		
	Loyola Ophthalmologists	Other Participating Providers	Out-of-Network
<b>Exam</b> (every 12 months)	\$20 co-pay	\$10 co-pay	Up to \$45
<b>Materials</b>	\$15 co-pay	\$15 co-pay	See Below
<b>Standard Plastic Lenses</b>			
(every 12 months)			
Single	Covered by co-pay	Covered by co-pay	Up to \$35
Bifocal	Covered by co-pay	Covered by co-pay	Up to \$58
Trifocal	Covered by co-pay	Covered by co-pay	Up to \$75
Lenticular	\$80 allowance	\$80 allowance	Up to \$50
Progressive	\$50 allowance	\$50 allowance	Up to \$40
<b>Lens Options</b>			
Scratch resistant coating	N/A	N/A	N/A
Polycarbonate Lenses for Children	N/A	N/A	N/A
<b>Frames</b>	N/A	N/A	N/A
(every 24 months) Members choose from any frame at provider locations	Up to \$150 retail allowance	\$150 retail frame - covers a wide selection of frames. (\$94 retail frame at Wal-Mart & Sam's Club)	Up to \$50
<b>Contact Lenses</b>			
(every 12 months)			
(Includes, fit, follow-up and materials)			
Elective	Up to \$150 retail	Up to \$150 retail	Up to \$125 retail
Medically Necessary	Up to \$210 retail	Up to \$210 retail	Up to \$125 retail

## **AlwaysVision<sup>SM</sup>**

### **Selection of Providers:**

Members may access providers in our nationwide PPO network of 22,000 providers in over 18,000 locations. Options include access to Loyola's Department of Ophthalmology for Well Eye Exams and Contact Lenses (employees may phone Loyola's Medical Center – Central Scheduling at 708-216-8563 to make an appointment with a Loyola Ophthalmologists), independent Optometrists, plus regional and national retail chains (Pearle Vision, Target, Sears, JC Penney and Eyemasters). Members may choose different providers for vision exam and materials purchases. Out-of-network benefits are available, but members receive the best value in-network.

You may visit [www.AlwaysVision.com](http://www.AlwaysVision.com) or call 888-729-5433, Ext. 2013 for a list of participating providers. Most participating providers (excluding Wal-Mart) offer discounts on items purchased after using the insurance benefit

# Flexible Spending Accounts (FSA)

All full-time University benefits-eligible Faculty and Staff employees scheduled to work in a position classified as .80 FTE (Full-Time Equivalent or greater) are eligible to enroll in the FSA plan. All full-time Stritch School of Medicine (SSOM) benefits-eligible Faculty and Staff who are scheduled to work in a position classified as 1.0 FTE (Full-Time Equivalent) or greater are eligible to enroll in the FSA plan.

The University recognizes the need to provide a program that helps you pay for expenses not covered by your health plan and expenses related to dependent care. Flexible Spending Accounts (FSAs) for **Health Care Needs** and/or **Dependent Day Care Needs**, used properly, can help save you money on these expenses. By participating in either or both of these flex accounts you use **pre-tax dollars** to pay for certain out-of-pocket expenses not covered under your insurance plan. The dollars you save are from the following payroll taxes:

- Federal Income Tax
- State Income Tax
- Social Security (FICA) Tax

**Benefit Express** administers the FSA plan for Loyola University. Once enrolled, it is easy to access information and download forms through their website at [www.lovolaexpress.com](http://www.lovolaexpress.com). Claim forms may be **faxed to Benefit Express at 1-253-793-3766**. For additional information call **1-877-837-5017**. The mailing address is:

**Benefit Express  
Loyola FSA  
P.O. Box 189  
Arlington Heights, Illinois 60006**

## Enrollment

As a benefits-eligible new hire, you may participate in either or both the Health Care and Dependent Day Care Flexible Spending Accounts (FSA). You must enroll within your first 31 days of employment. If you do not enroll at this time, the next opportunity to enroll is during the annual Benefits Open Enrollment period, which is generally held in the fall.

Each year during the Benefits Open Enrollment period, you decide if you want to participate in one or both of the Flexible Spending Accounts for the following year. If you decide to enroll in the program, you also will have to decide how much to contribute to each account. You cannot stop, start, or change this decision during the calendar year unless you experience a change in your family status as defined by the IRS and the Plan. **Yearly enrollment is an IRS regulation.**

## FSA Debit Card - Benefit Express “My Card”

The Benefit Express “My Card” is a debit card that can simplify the process of paying for eligible medical and dependent care FSA expenses. You can use the card at qualifying merchant locations, pharmacies and doctors’ offices that accept MasterCard. It is your responsibility to ensure that your FSA MasterCard is used only for qualified medical and dependent care expenses, and for checking your account balances to make sure you have sufficient funds available. When you activate your card, it is loaded with the amount you have elected to contribute to your benefit program. As you use the card to pay for items eligible for reimbursement, corresponding deductions will be made from the card balance.

Special arrangements which have been made with merchants such as Walgreens and Wal\*Mart, allow you to make eligible over-the-counter drug purchases (such as cold medicine) that are automatically approved. In most cases, this means that you will not be required to submit receipts for substantiation, although we always recommend that you keep your receipts in case a situation arises in which a transaction is questioned. In other transactions outside of Walgreens and Wal\*Mart, you will be asked to provide copies of documentation. We recommend that you keep all receipts for the entire plan year in the event that supporting documentation is requested.

The FSA Debit Card allows you to pay for eligible expenses at the point of service. Additional benefits include:

- Immediate access to your FSA account – you avoid paying with cash or check.
- Immediate payment of the expense – you avoid waiting for the reimbursement check.

The ease of use at the point of sale reduces burden of having to pay money out-of-pocket, and eliminating the wait for a reimbursement have proven to be extremely convenient for plan participants. Also, please remember that there is a replacement fee of \$10 for all lost FSA Debit cards.

## How Much to Contribute

There are maximum allowable contributions that limit the salary dollars you may set aside. The Health Care FSA yearly maximum election is \$5,000.00; the Dependent Day Care yearly maximum election is \$5,000.00 (yearly minimum election is \$240). In addition, under the guidelines of this program, the IRS Code specifies that:

- Any money not used for allowable expenses within the calendar year is forfeited and will not be refunded.
- Requests for reimbursement of dollars expended within the benefit calendar year must be submitted to *Benefit Express* along with the required documentation, **prior to March 31**, of the following year.
- Expenses reimbursed through these accounts cannot be claimed as deductions or credits when you file your income tax returns.

To avoid forfeiture of your yearly elections, consider carefully the dollar amount to set aside. Review your out-of-pocket expenses for the previous 2 or 3 years. Identify how this might change in the current year and elect amounts that will cover realistic expenses. Because this program offers tax savings under IRS Section 125, your unused pre-tax salary reductions cannot be returned to you or rolled-over into future plans years. IRS regulations require that all funds be used or forfeited in the plan year the salary reduction was made.

## Dependent Day Care Account

The Dependent Day Care Account is designed to pay for the care of children or adults who qualify so that you can work. Eligible expenses include:

- In-home care
- Care at another's home
- Nursery or preschool tuition
- After-school care
- Dependent care centers
- Summer day camp as long as that cost compares reasonably with other alternatives

You will need to provide detailed information about your dependent care provider including: name, address and Social Security Number or Tax Identification Number. Without this information you cannot be reimbursed.

Your Dependent Day Care Account has a few important *limitations*:

- Care for your dependent (who must reside in your home for at least 8 hours a day) must be necessary in order for you and your spouse (if married) to work.
- Eligible dependents are defined as children under age 13, or a spouse or legal dependent of any age who is physically or mentally incapable of self-care.
- Dependent Care, such as private baby-sitting, may not be provided by someone who can be claimed as your dependent for tax purposes, such as an older son or daughter.
- If dependent care services are provided at a day care center, the center must comply with applicable state and local laws and licensing requirements.

**Maximum contribution** - the total amount of money that can be set aside on a pre-tax basis for dependent care cannot exceed \$5,000 per household per tax year.

## Health Care Account

### Eligible Expenses and Limitations

Many different health care expenses are eligible for reimbursement from your Health Care Reimbursement Account. Eligible health care expenses are expenses incurred by you and your dependents for “medical care” as defined by IRS code. Generally, this means an item for which you could have claimed a medical care expense deduction on an itemized federal income tax return, for which you have not otherwise been reimbursed or could be reimbursed, from insurance or some other source. You, your spouse, or an eligible dependent must incur these expenses. Only those expenses incurred while you are a participant in the Flexible Spending Accounts plan are eligible for reimbursement. You may claim reimbursement for your health care deductibles, co-payments, expenses not covered by other plans, routine physical or dental examinations, infertility treatments, braces and other orthodontia, birth control items, vision expenses, and hearing expenses. To assist you, please review the following chart showing some of the common eligible and ineligible expenses.

## Flexible Spending Account – Health Care

Eligible Expenses*			
<p><b>Medical</b></p> <p>Abdominal support Acupuncture Ambulance hire Air Conditioner for allergy relief (if prescribed by doctor, cannot be central a/c) Anesthesia Artificial limbs/prosthesis Alcoholism treatment Back support Birth control pills (Rx only) Braces Braille books/magazines Chiropractic services Co-payments for insurance Crutches Deductibles Dermatological fees</p>	<p>Diathermy Doctor office visits Fertilization services Gynecological exams Hospital bills Immunizations Insulin Lab exams Medical clinic visits Neurologist fees Nurse’s fees Obstetrician fees Orthopedic Shoes Osteopath Over-the-counter drugs** Oxygen Pediatrician fees Physical Therapist Physician fees Podiatrist fees</p>	<p>Prescription Drugs Psychiatric care Psychological fees Psychotherapist fees Sex Therapy Special diets Surgeon fees Therapeutic care (for drug and alcohol abuse) Transplants Wheelchair</p> <p><b>Dental Expenses</b></p> <p>Bridges Co-pay for insurance Crowns Dentures Exams and X-rays Fillings Insurance deductible Orthodontia</p>	<p><b>Hearing Expenses</b></p> <p>Exams Hearing devices and aids Special communication equipment for the deaf</p> <p><b>Vision Care</b></p> <p>Contact lenses Exams Frames Laser eye surgery Lenses Oculist services Optician services Optometrist services</p>

\*This list does not cover all eligible expenses. Consult Benefit Express for questions or concerns.

\*\*The Internal Revenue Service (IRS) ruled in IRS Revenue Ruling 2003-102 that over-the-counter drugs are available for reimbursement under the FSA Plan provided they are purchased for personal use or for use by a spouse or dependent and the over-the-counter drug must alleviate or treat personal injury or sickness.

Limitations***		
<p>Bottled water Cosmetics, toiletries, toothpaste, etc. Cosmetic surgery Custodial care in an institution Funeral and burial expenses Health club fees Household and domestic help Marriage or family counseling</p>	<p>Maternity clothes, diaper services, etc. Membership fees or costs associated with weight loss or smoking cessation programs if not prescribed by a doctor Nursing for newborns Operation expenses from illegal procedures</p>	<p>Premiums for benefits Special schools Uniforms Vacations or travel taken for general health purpose Vitamins taken for general health purposes</p>

\*\*\*The above list summarizes several ineligible expenses. For a complete listing consult Benefit Express.

## Restrictions for Changing Your Flexible Spending Account(s)

You may elect to enter, exit, or change your FSA election only if you experience one of the following events:

- Change in legal marital status (marriage, divorce, death of a spouse)
- Change in number of tax dependents (birth of a child)
- Employment status change for you, your spouse or dependent
- Dependent satisfies, or ceases to satisfy, eligibility requirements

- Resident change by you, your spouse or dependent
- Change in cost of covered Day Care

A status change can be made only if it is consistent with the change in family or employment status, if the Human Resources Department is notified within 31 days of the change.

**IRS requires** anyone contributing to a Dependent Day Care Flexible Spending Account to complete Form 2441. The form can be found on the Benefits website.

## Reimbursement Process

You may begin submitting requests for reimbursement to **Benefit Express**, along with the required documentation of expenses incurred, after the date you became an eligible participant in the plan. You may choose to receive your reimbursement check through the U.S. **mail directed to your home**, or you may sign up for **automatic Direct Deposit** to your savings or checking account. The request for Direct Deposit can be accessed through **Benefit Express** by visiting the Website at [www.loyolaexpress.com](http://www.loyolaexpress.com).

You are required to use the *FSA Reimbursement Request Form* for submitting all eligible expenses to **Benefit Express**. Benefit Express forms can be printed from their website along with directions for completion the form. When submitting it, please furnish documentation of expenses incurred either through an itemized statement from the provider, your explanation of benefits form, or ask your doctor, dentist, or pharmacist to complete and sign in the section titled Provider's Signature on the form. The form allows you to list several expenses at once. There is a minimum of \$20.00 in expenses before the reimbursement will be processed. Remember to sign the form and attach your supporting documentation. The easiest way to submit the form for reimbursement is by fax at 253-793-3766. Whether faxed or mailed, you should always keep a copy of all information submitted for your records

## Remember....

(1) Reducing your taxable income may affect your future Social Security Benefits. (2) The IRS will not allow you to take the Dependent Care Tax Credit for expenses reimbursed through your FSA account, and (3) Depending on your personal situation, the Dependent Care Tax Credit may be more advantageous than the Pre-Tax Flexible Spending Account. Consult your tax advisor.

### Flexible Spending Accounts – A Pre-Tax Savings

	Without FSA	With FSA
Annual Pay	\$35,000	\$35,000
Pre-Tax Health FSA	0	2,500
Pre-Tax Dependent FSA	0	5,000
<b>Taxable Income</b>	<b>\$35,000</b>	<b>\$27,500</b>
Federal Income Tax	5,250	4,125
State Income Tax	1,050	825
Social Security	2,678	2,104
Medical Expenses	2,500	0
Dependent Expenses	5,000	0
<b>Spendable Income</b>	<b>\$18,522</b>	<b>\$20,446</b>
<b>Estimated Savings = \$1,924</b>		

*Actual savings will vary based on your individual tax situation.*

# Flexible Spending Accounts

## How to Enroll On-Line:

You have a convenient way to enroll in the Flexible Spending account On-Line from any personal computer with internet access. Using the internet to enroll is easy and safe! Our secured website is set up to automatically take you through each of the following steps:

### Step 1: Log on to [www.loyolaexpress.com](http://www.loyolaexpress.com).

- The website will prompt you to enter your **LOYOLA USERNAME** and your **LOYOLA PASSWORD**.

### Step 2: Click the Enrollment link on the welcome page.

- You will be prompted to make your Medical Care and Dependent Day Care Flexible Spending Account elections.
- You will enter an annual amount and the system will calculate your per pay deduction. If you do not wish to participate in either of the accounts, enter 0 and press the NEXT button.
- Remember, your election is valid for the entire year (January 1 through December 31). You may not change this election unless you experience an IRS Qualifying Life Event. You must make your change or your election within 31 days of experiencing a Qualifying Life Event. You must notify Loyola Benefits Department right away.

### Step 3: Review Your Enrollment Status.

- When you have completed enrollment, the system will present you with an Enrollment Status screen.
- Verify that **all** information is updated correctly.

### Step 4: Once you have reviewed your Confirmation Screen, you are finished.

- If you need to change any information, go through the enrollment process again (changing only the desired item).

Questions – Please call Benefit Express at 877-837-5017. Customer Service Representatives are available to assist you - Monday through Friday between the hours of 7:30 a.m. and 6:00 p.m.

# Supplemental Life and Personal Accident Insurance

## Supplemental Life Insurance

If you are benefits-eligible and interested in additional term life insurance coverage for employee only, you may purchase Supplemental Life Insurance. This coverage may be purchased in amounts equal to 1, 2, 3, 4, or 5 times your annual salary, up to a maximum of \$500,000. The cost for this coverage is based on your age. The premium you pay for this coverage automatically changes when your salary or age changes. Please realize that the amount of coverage you select may be subject to Evidence of Insurability rules [Refer to the *Evidence of Insurability* section on the next page.] Legally Domiciled Adult (LDA) not eligible to enroll in supplemental life insurance.

In compliance with the Age Discrimination in Employment Act (ADEA), Basic and Supplemental Life Insurance coverage will be reduced when the employee reaches age 65. The amounts of coverage decrease as follows:

Age	Insurance Volume Is Reduced by:
65	35%
70	55%
75	70%
80	80%
85	85%

## Spousal Life Insurance

If you are benefits-eligible, you may purchase life insurance coverage for your spouse in \$5,000 increments up to \$50,000; thereafter, \$10,000 increments up to a maximum of \$100,000. However, the maximum coverage for your spouse without Evidence of Insurability is \$25,000, only for a new hire. [Refer to the *Evidence of Insurability* section below.] Legally Domiciled Adult (LDA), not eligible to enroll in Spousal Life insurance.

## Child Life Insurance

If you are benefits-eligible, you may also purchase a flat \$5,000.00 plan that covers your dependent children until age 23.

Newborns and newly adopted children may be covered by Dependent Life Insurance if you apply within 31 days following their arrival. Newborns are insured from birth; however, the maximum benefit is limited to \$1,000 until the child reaches the age of six months.

**Limitation:** An employee is not eligible for life insurance as both an employee and a spouse (e.g., if employee's spouse is also an employee of Loyola University) or dependent at the same time.

## Calculating the Cost of Your Coverage

Follow these steps:

<b>Step 1 – Employee Supplemental Life</b>	$\$ \text{_____} \text{ Your Yearly Salary}$  $\times \text{_____} \text{ 1, 2, 3, 4, or 5 (salary multiples)}$  $= \$ \text{_____} \text{ Amount of Coverage you want}$
<b>Step 2</b>	Round the Amount of Coverage to the next higher \$10,000 increment e.g., \$214,300 becomes \$220,000
<b>Step 3</b>	$\$ \text{_____} \text{ Your Coverage Amount} \div 1,000 = \text{Employee Units } \text{_____}$
<b>Step 4</b>	$\text{Employee Units} \times \$ \text{ Employee Cost } */\text{Per Unit} = \$ \text{_____}$
<b>Step 5 – Spousal Life*</b>	$\text{Spouse Coverage } \$ \text{ Cost} = \$ \text{_____} (+)$
<b>Step 6 – Child Life*</b>	$\$5,000 \text{ Children @ } \$0.37 \text{ Cost} = \$ \text{_____} (+)$
<b>Total Monthly Cost:</b>	$= \$ \text{_____}$

\*Refer to Loyola's 2009 Monthly Rate Sheet for Cost

## Evidence of Insurability

Evidence of Insurability is the process by which an insurance carrier makes the determination that an employee or spouse is insurable at or above a certain dollar amount by requiring proof of good health. Evidence of Insurability will be required for any combination of the employee's Basic and Supplemental Life insurance that is greater than 3.5 times your annual salary, or if the combination of Basic and Supplemental is greater than \$600,000. New hires only are allowed to elect supplemental life up to 2 times their annual salary without Evidence of Insurability within the first 31 days of employment. Human Resources can provide you with an Evidence of Insurability form with instructions for you to complete and submit to CIGNA.

<b>Evidence of Insurability</b>	
<b>Basic Life Insurance</b> 1.5 times your annual salary	Evidence of Insurability <u>does not</u> apply
<b>If combination of Basic and Supplemental</b> is greater than 3.5 times your salary, or greater than \$600,000	Evidence of Insurability applies
<b>If Spousal Dependent Life</b> is greater than \$25,000	Evidence of Insurability applies
<b>Any change to Supplemental Life or Spouse Life</b> if not elected within the first 31 days of employment	Evidence of Insurability applies

## Beneficiary

Life insurance benefits are paid to the beneficiary on file when a life insurance claim is processed. You are automatically the beneficiary of any life insurance you choose for your spouse and children. Your benefit selection form allows you to designate both a primary and secondary beneficiary for your own insurance plan. You may change your beneficiary at any time during the calendar year. Below is some suggested wording for identifying that beneficiary.

<b>Suggested Wording for Beneficiary Designation</b>	
<b>Type of Beneficiary</b>	<b>Wording to Be Used</b>
To your estate	Estate
One beneficiary	Mary J. Smith, wife
Two beneficiaries (equal shares)	James Jones, brother, and Mary Scott, friend, in equal shares or the survivor, if any.
Two beneficiaries (unequal shares)	John J. Wills, father, as to two-thirds and Mark I. Wills, brother, as to one-third or the survivor, if any.
One primary and one contingent	Jane Doe, wife, if living; otherwise Tom Doe, son.

## Accidental Death & Dismemberment (AD&D) [Personal Accident]

This plan provides protection for all benefit-eligible faculty and staff if you, your spouse, or your dependent children (up to age 23) die or are dismembered as a result of an accident. The plan provides full coverage 24 hours a day, 365 days a year. You may purchase one of four coverage amounts for you and/or your family:

- \$50,000
- \$100,000
- \$200,000
- \$300,000

If you choose coverage for yourself, your beneficiary will receive 100% of this coverage if you should die in an accident. If you are dismembered in an accident, you will receive a percentage of your benefit amount. If you choose coverage for your family, the chart below shows your family's death benefit amounts. Your spouse is eligible until age 70. [Legally Domiciled Adult (LDA), not eligible.]

Accidental Death and Dismemberment Insurance (AD&D) [Personal Accident]	
If you cover your ...	The death benefit amount paid would be ...
Spouse only	50% of your benefit for spouse up to a maximum of \$150,000
Child(ren) only	20% of your benefit up to a maximum of \$30,000 per child
Spouse and Child(ren)	40% of your benefit for your spouse up to a maximum of \$150,000 and 10% of your benefit per child

## Accidental Death & Dismemberment (AD&D) [Personal Accident]

### Additional Benefits through AD&D

**CIGNA Secure Travel** – This 24-hour network of emergency medical and legal resources offers valuable protection for you and your family when you travel more than 100 miles from home. With just one call, covered employees and their families have access to qualified multilingual professionals trained to manage any medical emergency. These services, provided exclusively by Worldwide Assistance Services, Inc., can be accessed by phoning their toll-free number 1-888-226-4567 (U.S. or Canada). If you are traveling outside the U.S., you may call collect at 202-331-7635.

## Continuation of Life Insurance

*Life insurance* ends on your last day worked. Dependent life insurance coverage terminates either when your coverage ends or when the individual ceases to be your eligible dependent. For life insurance purposes, a dependent child, eligible for life insurance benefits is covered up to age 23. You may have portability options to port your life insurance, provided you are not sick or injured. The portability permits a portion of the existing (group) coverage to be continued, through the carrier, CIGNA, if the employee leaves the employer and contacts CIGNA within 31 days of your last day worked.

Or, you have the option to convert your group life insurance to an individual whole life policy, an Individual Life Insurance Policy, through the carrier, CIGNA. The conversion option is mandated by state law and gives the individual the right to replace the group term life insurance coverage with an individual (permanent) policy offered by the insurer, CIGNA. You must act within 31 days of your

termination date to continue coverage under either option. If you decide to continue your life insurance coverage, contact NEBCO, a third party administrator, at 1-800-423-1282 for life conversions and rates.

## Elective Termination of Life Insurance

The employee has the option to terminate their life insurance election(s), such as Employee Supplemental Life, Dependent Spouse Life, Child Life, and AD&D, typically during the annual Benefits Open Enrollment period. If you choose to re-elect your life insurance, this can only be done during a Benefits Open Enrollment period. Loyola's life insurance carrier will request that you complete their Evidence of Insurability form. Your life insurance (term life) ends on the last day worked (refer to *Continuation of Life Insurance* referenced above).

## Long Term Care Insurance

All full time faculty, staff, and regular part-time employees scheduled to work twenty (20) or more hours per week are eligible to enroll in this plan. Your spouse, parents, grandparents, parents-in-law, and grandparents-in-law are also eligible to participate in Loyola's Long Term Care insurance at group rates. If you choose to enroll your parents or grandparents or those of your spouse, the enrollment form is mailed directly to CNA.

Long Term Care is a voluntary option provided to you through CNA. Long term care is the type of help you may need when you are not able to perform some Activities of Daily Living (ADLs) by yourself due to an illness, disability, or severe cognitive impairment (such as Alzheimer's) or similar irreversible dementia.

Activities of daily living are bathing, dressing, toileting, mobility, continence, and eating. You might receive care at home, in a nursing home or an assisted living facility, or from community-based health care that allow you to stay in your own home. Your group health plan will pay little, if anything, toward long term care. This Long Term Care plan pays for care in a nursing home or an assisted living facility, or for community-based health care.

## Cost of Coverage

Premium rates are based on a choice of four fixed daily benefits and your age at the time of enrollment. When you select one of the "basic daily benefit" option levels of \$100, \$150, \$200, or \$250, this is the amount of daily benefits you may receive. For nursing home care, you will be reimbursed the daily benefit you select for each day you are confined to a nursing facility after you have satisfied the waiting period (60/15 Service Days). Your lifetime maximum benefit amount for any covered service (nursing facility care, community-based care) is based on the plan selected. After your application is approved by CNA, you will be advised of your monthly premium.

## The Long Term Care Plan is a "Portable Plan"

You may continue your coverage under this plan at the **same premium rate** even after you retire or leave Loyola. You are advised to contact CNA's Customer Service one month prior to leaving employment or retirement to set up direct billing to your home. CNA's Customer Service Department: 1-800-528-4582.

## The Long Term Care Insurance Plan Comparison

FEATURES AND BENEFITS	OPTION #1	OPTION #2	OPTION #3	OPTION #4
<p><b>Nursing Home Benefit</b> CNA will pay up to 100% of the benefit that you select for each day that you are confined in a long-term care facility.</p>	<i>\$100</i>	<i>\$150</i>	<i>\$200</i>	<i>\$250</i>
<p><b>Community-Based Care Benefit</b> CNA will pay up to 75% of your community based care benefit for each day you receive care in your home, an assisted living facility, an adult day care center or an adult foster care center.</p>	<i>\$75</i>	<i>\$112.50</i>	<i>\$150</i>	<i>\$187.50</i>
<p><b>Lifetime Maximum Amount (5 Year Plan)</b> Is a pool of money the insured can use for all eligible expenses. The lifetime maximum amount will automatically increase when your daily benefit for nursing home increases.</p>	<i>\$182,500</i>	<i>\$273,750</i>	<i>\$365,000</i>	<i>\$456,250</i>
<p><b>Waiting Period</b> For any combination of nursing home care and community based care, the waiting period is 60/15 Service Days. Once per Lifetime</p>	√	√	√	√
<p><b>Home Medical Technology</b> Covers a variety of assistive devices and pays up to \$1,000 per year.</p>	√	√	√	√
<p><b>Caregiver Training Benefit</b> CNA will pay up to 3 times the community based care benefit that you select for training of an informal caregiver in your home.</p>	√	√	√	√
<p><b>Hospice Benefits</b> CNA will pay benefits for terminally ill claimants. The payment will equal either the nursing home benefit or the community based care benefit you select depending on where the care is received.</p>	√	√	√	√
<p><b>Return of Premium at Death</b> Refunds premiums paid if the insured person dies before age 75. If death occurs prior to age 65, 75% of premiums refunded, less benefits received. After age 65, the amount refunded declines by 10% each year</p>	√	√	√	√
<p><b>Temporary Bed Holding Benefit</b> If you are required to leave a long-term care facility for a short period of time, CNA will continue to pay the facility to hold your bed up to 21 days per year.</p>	√	√	√	√
<p><b>Inflation Protection Feature</b> You will periodically be given opportunities to increase your benefit amount and lifetime maximum on a guarantee issue basis.</p>	√	√	√	√
<p><b>Worldwide Coverage</b> Provided coverage for those living outside the United States</p>	√	√	√	√

# Long Term Care Insurance

## (CNA)

To enroll in CNA's Group Long-Term Care insurance plan, you must go to their website where you can find your premium – and review your rate(s). You will be able to download the proper forms to complete and mail to CNA; the mailing address is located on the forms. You will not be able to enroll on-line. Please follow these basic steps:

- Step 1:** Log on to [www.ltcbenefits.com](http://www.ltcbenefits.com).
- Step 2:** Enter your Password: Loyola
- Step 3:** Click on the “Enroll Now” Button
- Step 4:** Click on “Find My Premium” - to review your rate
- Step 5:** Download and print the proper form:
- Employee Form
  - Spouses of Employees
  - Parents; Grandparents;  
Parents-in-law, Grandparents-in-law

You can *print* a copy of the Long-Term Care brochure.

- Step 6:** \*Mail the form to CNA (the mailing address is located at the bottom of the “Applying is Easy” form)

**TO REQUEST A LONG TERM CARE KIT, CALL CNA AT 1-800-528-4582**

## Group Legal Plan

The Hyatt Group Legal Services Plan provides you, as a benefit-eligible member, your spouse and eligible dependents, access to a network of attorneys who can provide a wide range of professional legal services including:

<ul style="list-style-type: none"><li>• <i>Wills and Codicils</i></li><li>• <i>Living Wills</i></li><li>• <i>Powers of Attorney</i></li><li>• <i>Living Trusts</i></li><li>• <i>Court Appearances</i></li><li>• <i>Civil Litigation Defense</i></li><li>• <i>Consumer Protection</i></li><li>• <i>Restoration of Driver's License (except DUI)</i></li><li>• <i>Juvenile Court Defense</i></li></ul>	<ul style="list-style-type: none"><li>• <i>Mortgages</i></li><li>• <i>Deeds</i></li><li>• <i>Notes</i></li><li>• <i>Demand Letters</i></li><li>• <i>Affidavits</i></li><li>• <i>Review of Personal Legal Documents</i></li><li>• <i>Pre-marital Agreement</i></li><li>• <i>Uncontested Adoption or Guardianship</i></li><li>• <i>Name Change</i></li></ul>	<ul style="list-style-type: none"><li>• <i>Debt Collection Defense</i></li><li>• <i>Re-payment Schedule Negotiation with Creditors</i></li><li>• <i>Personal Bankruptcy</i></li><li>• <i>Pre-bankruptcy Planning</i></li><li>• <i>Sale, Purchase or Refinancing of Your Primary Residence</i></li><li>• <i>Tenant Problems (when you are the tenant)</i></li><li>• <i>Eviction Defense</i></li></ul>
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The Hyatt Legal Plan allows access to a nationwide network of participating attorneys. Plan Attorneys have met stringent selection criteria and have an average of more than 16 years of legal experience.

Plan Attorney assistance includes:

- Consultation on the telephone
- In-person consultation
- Document preparation
- Representation in many frequently necessary legal matters

You have the flexibility to use a non-Plan Attorney and be reimbursed for the covered services according to a set fee schedule. If you use a non-Plan Attorney, you will be responsible for paying the difference between the Plan payment and the out-of-network attorney's charge for the service. *There are limitations to this plan. Covered legal services do not include representation in litigation matters.*

Legal advice is just a phone call away. When you face a situation that you think has legal implications, simply pick up the phone. A knowledgeable Client Service Representative will be available to assist you in locating a Plan Attorney near your home or workplace. Plan Attorneys are generally available to meet with you on weekdays, evenings, and Saturdays.

**Certain areas are not covered by the plan and there is no obligation to provide legal service benefits in any matter deemed frivolous, harassing or in contravention of the rules of ethical conduct by governing attorneys.** More information and a listing of available attorneys can be found on the Plan website: [www.legalplans.com](http://www.legalplans.com) or at **800-821-6400** 8:00 a.m. – 8:00 p.m., Eastern Time Monday through Friday.

This benefit is portable. If you leave the University you need to contact Hyatt Legal Services/MetLife one month in advance. Hyatt will give you details on plan continuation.

# Transit Benefit Program

1. **Chicago Card Plus, Chicago Card and the CTA Transit Card** – allows you to make pre-tax contributions to your card for purposes of travel on Chicago Transit Authority buses and subways. There is a one-time \$5 cost for the purchase of the *Chicago Card Plus* and the *Chicago Card*. Each month, the amount you have deducted through payroll for CTA will be automatically added to your Chicago Card Plus, Chicago Card, and CTA Card. You may elect any amount up to \$120 for 2009 for the pre-tax allowance. Your initial card will be mailed to your home.

➤ **Chicago Card Plus** (*Reloadable*)

- Allow for unlimited travel on the CTA for 30 days from the first day of use; the cards are reloaded automatically and have a 4-year expiration date. You may choose different monthly dollar amounts of \$30, \$45, \$60, and \$80.
- The Chicago Card Plus also offers a 30-day Pass for \$86 and has a cycle that begins on a 30-day usage and ends 30 days later regardless of what day you begin using the card.

➤ **Chicago Card** (*Monthly-Reloadable*)

- Cost limited to \$86/month.
- Reload monthly option
- Chicago Card cycle begins on the first of the month
- The Chicago Card expires on the last day of each calendar month regardless what day you begin using the card.

➤ **CTA Transit Card** (*Non-Reloadable*)

- Pay per use – cannot add more money to the card
- 13-month expiration date
- Available in dollar amounts of: \$30, \$35, \$50 and \$70
- A \$86/30-day card (cycle begins on the first day of use)

2. **RTA Transit Voucher** – You will be able to purchase a voucher up to the maximum allowed (with January contributions for your February transit media) to be used towards the purchase of train passes through the Regional Transportation Authority. The voucher may be used to purchase Metra fare media, including monthly passes, weekly passes, 10-ride passes, and Pace link-ups.

- RTA Vouchers will be available for pick-up before the first of the month from the Human Resources Office at WTC or LSC. Deductions for your voucher will be withdrawn from your check the month prior to use.
- RTA Vouchers may be used to purchase Metra, South Shore Railroad fares, or CTA or Pace transit cards from any authorized agent.

### 3. **How the Program Works:**

- Enroll in Transit via the Internet at: [www.LoyolaExpress.com](http://www.LoyolaExpress.com). Using the internet to enroll is easy and safe. Our secured website is set up to automatically take you through easy enrollment steps with instructions on line. After you log on, the website will prompt you to enter **your LOYOLA USERNAME and your LOYOLA PASSWORD**. You may phone *Benefit Express* – Customer Service at (877) 837-5017 if you have questions or enrollment problems.
- **You may log on at any time to view or change your elections.** To *change* your election(s) on-line, the cut-off date is the 15<sup>th</sup> of each month. Your new change will be effective with the following full month's payroll deduction(s) taken for the subsequent month's transit fare media. [Example: Changes made by October 15 would affect November payroll deductions used to purchase December transit media.]

- Note that currency will not be returned if the ticket fare is less than the voucher amount and vending machines will not return change.
- You may check your account balance on your Chicago Card Plus, suspend your participation in the program, or report a lost card by calling 1-888-YOUR CTA or by visiting their website [www.chicago-card.com](http://www.chicago-card.com).
- A minimum of three consecutive months is required before withdrawal. If you choose to withdraw from the program please use the form on the above website.

Questions – Please call Benefit Express at 877-837-5017. Customer Service Representatives are available to assist you - Monday through Friday between the hours of 7:30 a.m. and 6:00 p.m.

# Tuition Benefits

Requirements	Benefits for Full-Time Faculty and Staff	Benefits for Spouse/LDA and Dependent Children
<p><b><u>Full-Time Benefits Eligible Employees Only</u></b></p> <p><b><u>Service:</u></b> All employees hired on or after August 1, 2005, are eligible at the start of the first complete academic term that begins after completing one (1) year of continuous full-time employment.</p> <p><b><u>Admissions &amp; Academic Eligibility:</u></b> Admission into any academic program is never guaranteed and competition may be intense for a limited number of available openings.</p> <p><b><u>Deadlines &amp; Forms:</u></b> Strict compliance with all academic, financial and financial aid, and human resource policies and requirements is required. Failure to comply with stated deadlines and requirements will result in forfeiture of the tuition benefit for current or future terms.</p>	<p><b><u>Undergraduate Programs:</u></b> (Not Taxed)** The Benefit pays 100% of tuition for eligible employees taking most under-graduate or eligible certificate courses. At no time will the tuition benefit apply to more than three courses per semester (9 semester hours) or two courses per quarter (8 quarter hours).</p> <p><b><u>Graduate &amp; Professional Programs:</u></b> (Taxed)*** The Benefit pays 100% of tuition for most graduate and professional programs (except law and medicine). At no time will the graduate tuition benefit apply to more than two courses per semester (8 semester hours) or two per quarter (8 quarter hours).</p> <p>These are specialized courses of study and involve a special time commitment from the faculty and staff member in the advancement of their career and reflect a significant investment by the university in the faculty or staff member.</p>	<p><b><u>Undergraduate Programs:</u></b> The Benefit pays 100% of undergraduate tuition <u>after the co-pay</u> (including Rome Center &amp; FACHEX tuition) for the spouse/LDA and dependent children of full time benefits eligible employees.</p> <p>The benefit covers tuition only and does not include student activity or instructional fees, room and board, or other expenses.</p> <p><b><u>Co-Pays:</u>*</b> If dependent child or spouse/LDA is enrolled in 12 or more credit hours (full-time), the student contributes <b>\$585 per term</b> towards tuition.</p> <p>If dependent child or spouse/LDA is enrolled in 11 or fewer credit hours (part-time), the student contributes <b>\$295 per term</b> towards tuition.</p> <p><i>Note:</i> The Co-Pays may increase each July 1<sup>st</sup></p>

*\*The co-pay replaces all credit hour fees in the previous policy. Co-pays subject to change each July 1.*

- **Loyola University’s definition of dependent child and spouse/LDA** follows the guidelines established by the Internal Revenue Service, with a maximum age of 24 for the dependent child. For a “non-dependent” tuition is taxable income under the IRS guidelines.
- **\*\*Undergraduate Tuition Benefits** not subject to income tax.
- **\*\*\*Graduate Tuition Benefit** in excess of \$5,250 per calendar year is:
  - Subject to federal and state income tax and social security
  - Additional payroll tax will be withheld each academic term

## Taxability of Graduate Tuition

Under Section 127 of Internal Revenue Code, employers may provide each employee with up to \$5,250 of **GRADUATE** tuition benefit per year on a tax-free basis. The annual \$5,250 limit applies to all coursework taken by an employee enrolled in a **GRADUATE** program, regardless of the level (graduate or undergraduate) of the course. The IRS may still allow you to deduct “qualified educational expenses”

on your individual annual tax return. The IRS regulations and their explanation on tax treatment of educational expenses can be found at the IRS web site: <http://www.irs.gov/pub/irs-pdf/p970.pdf>. The University cannot provide tax advice so you should consult a tax advisor for possible deductibility of any **GRADUATE** tuition benefits.

Detailed information on the tuition benefit, its **restrictions and requirements** are on the University Home Page at [www.luc.edu/hr/policy\\_tuition.shtml](http://www.luc.edu/hr/policy_tuition.shtml).

## Adoption Assistance Program

Supporting families, Loyola's adoption assistance benefit is provided to you at no cost. This program will reimburse you at 90% for covered expenses up to a maximum of \$5,000 (or \$6,000 if the child has special needs). All regular full and part-time employees are eligible for this benefit. Expenses will only be paid for the adoption of children under the age of 18 or who are physically or mentally incapable of caring for themselves. Children may be related or non-related to the employee.

**Covered expenses** (which must be reasonable and necessary) include:

- Agency fees
- Maternity costs for the child
- Transportation costs
- Legal fees
- Temporary foster care
- Counseling fees
- Court costs
- Placement fees

**Limitations:** Benefits are not payable for the adoption of stepchildren or for pre-natal or maternity costs of the birth mother of the adoptive child. Benefits are payable at the time the child is placed in the home, pending legal adoption. Benefits will not be paid on a retroactive basis, only expenses occurring after the original start date of the program will be considered.

**Tax considerations:** the adoption assistance benefit is not subject to federal or Illinois state tax withholding, but is subject to FICA withholding tax.

## Loyola University Employee's Federal Credit Union

**Joining:** Membership is open to all faculty and staff of Loyola University Chicago, Loyola University Medical Center, and Madden Mental Health Center, and their immediate family. A savings account may be opened with a minimum balance of \$25.00. You may authorize payroll deduction for direct deposit into your Credit Union account(s). Membership forms may be obtained in the campus HR office or by contacting the Credit Union at (708) 216-4500.

### Services:

<ul style="list-style-type: none"><li>• Direct Payroll Deposit</li><li>• Savings Account</li><li>• Free Checking</li><li>• ATM Debit Card</li><li>• CD</li><li>• IRA</li><li>• Special Savings Clubs</li></ul>	<ul style="list-style-type: none"><li>• Loan options:<ul style="list-style-type: none"><li>- Signature</li><li>- New/used car</li><li>- Boat</li><li>- Motorcycle</li><li>- Home Improvement</li><li>- Computer</li></ul></li></ul>	<ul style="list-style-type: none"><li>• Discount Tickets:<ul style="list-style-type: none"><li>- Local movie theaters</li><li>- Great America</li></ul></li><li>• Summer Salary Plan</li><li>• Visa Credit Card</li></ul>
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# University Scheduled Holidays

Generally, the University's holiday calendar includes 10-12 paid holidays. See Campus specific holiday schedules:

- Lakeside Campuses: at [http://www.luc.edu/hr/holiday\\_calendar.shtml](http://www.luc.edu/hr/holiday_calendar.shtml).
- Medical Center Campus (SSOM): at <http://portal.luhs.org>, click on **Employee Resources** on the left of the page, and then click on [Holidays & Paydays](#).

## Paid Time Off:

### Vacation, Sick, and Personal Time (Staff Positions Only)

*Summary of Time-Off Policies for Full Time Employees as of January 1, 2009*

Employee Group	Years of Service	Annual Vacation Accrual	Annual Personal/Family Friendly Days	Annual Holidays	Annual Sick Days
<b>Technical, Clerical, Service, Maintenance (Job Classifications 09, 29, 39, 10, 20, 30, 11, 12)</b>	Less than 5 years	2 weeks	4 days	10 days	10 days
	5 but less than 10 years	3 weeks	4 days	10 days	10 days
	10 but less than 20 years	4 weeks	4 days	10 days	10 days
	20 or more years	5 weeks	4 days	10 days	10 days
<b>Directors, Managers, Supervisors, Professionals, Specialists, Advanced Technical, Nursing Classification (Job Classifications 04, 24, 34, 44, 54, 06, 16, 26, 36, 46, 56, 07, 17, 27, 37, 47, 08, 28, 38, 48, 58, 68, 13)</b>	Less than 10 years	3 weeks	4 days	10 days	10 days
	10 but less than 20 years	4 weeks	4 days	10 days	10 days
	20 or more years	5 weeks	4 days	10 days	10 days
<b>Administrative Director &amp; Above (Job Classifications 02, 03, 0698, 23)</b>	Less than 20 years*	4 weeks	4 days	10 days	10 days
	20 or more years	5 weeks	4 days	10 days	10 days
<b>Vice President and Above (Job Classification 01)</b>	Less than 5 years	4 weeks	4 days	10 days	10 days
	5 or more years	5 weeks	4 days	10 days	10 days

\* Change for those with less than 5 years of service.

**Vacation:** The maximum accrual allowed for vacation will continue to be two times your annual vacation accrual up to 10 weeks. Note: Newly hired staff employees are eligible to use vacation accruals after 6 months of employment.

**Sick Leave:** In general, staff employees earn up to 10 days per year of paid sick time. The amount of leave and/or short term disability benefits vary according to the employee's classification. Sick Leave Banks are limited to 30 days. If you have more than 30 sick days as of December 31, 2008, you will continue to have those days until you use them. You will not be able to accrue more sick days until your bank goes below 30 days. Details are at [www.luc.edu/hr/policy\\_sickleave.shtml](http://www.luc.edu/hr/policy_sickleave.shtml).

**Personal Family Friendly Days:** Each Benefits-eligible, Full-Time Staff employee (working 12 months) will receive four (4) Personal/Family Friendly days each year to be used for personal business. Newly hired staff employees are eligible after 90 days of employment. Part-Time Staff, scheduled to work 20 or more hours per week will receive two (2) days. To encourage you to use these days during the calendar year, they do not carry over from one year to the next. Personal/Family Friendly Days will not be paid out at termination or retirement.

**Funeral Leave:** Respecting a staff member's grief, the University allows 3 consecutive paid days off to a staff member (after 30 days of employment) experiencing a death in the immediate family, or 1 day if the death is in the extended family.

**Jury Duty:** the University supports the judicial system by paying full salary to those employees (after 30 days of employment) who serve on jury duty when the employee has informed his/her department of the call to serve. The Bailiff's receipt should be returned to the supervisor.

# Retirement Benefits

## Loyola University Chicago's 403(b) Defined Contribution Retirement Plan

Benefits-eligible faculty and staff are eligible for participation in the Loyola University 403(b) Defined Contribution Retirement Plan (DCRP). Loyola's DCRP provides a contribution equal to 8% of salary. The contribution increases to 9% on earnings in excess of the Social Security Taxable Wage Base. Participation is effective the first of the month following your employment in an eligible position. For example, if you begin eligible employment on June 1, you are eligible for retirement contributions on July 1. All participants are immediately 100% vested in the University's contributions.

Participants have the choice to direct Loyola's contribution to one of three service providers:

- AIG Retirement (VALIC)
- Fidelity Investments
- TIAA-CREF

The retirement program has an automatic enrollment feature. Once you are eligible to enroll in the retirement plan, the University will send its contribution to Teachers Insurance and Annuity Association (TIAA-CREF). If you do not call the Loyola Retirement Center (LRC) to choose a different service provider and select an investment fund, your money will remain with TIAA-CREF. TIAA will invest your funds in a default money market account if you do not self-direct your DCRP contributions. The default account may not reflect your choice of vendor and rate of savings.

An important step in planning for retirement is to start early. Even though you are not required to make voluntary contributions to the retirement plan, we encourage you to do so, because it will make a big difference in the amount of money you receive during your retirement years. Keep in mind that the University's retirement program is a Defined Contribution Plan, which means your retirement income will be based on the amount of money you and the University contribute to the plan, your investment options, and the compounding of your investment returns.

You may direct the University's contributions and your pre-taxed contributions to any of our three service providers, AIG Retirement (VALIC), Fidelity or TIAA-CREF, by calling the Loyola Retirement Center. The Loyola Retirement Center is staffed by TIAA consultants, who are available from 7:00 a.m. to 9:00 p.m. weekdays, and 8:00 a.m. to 5:00 p.m. on Saturdays, by phoning (1)773-508-2770.

### The Loyola Retirement Center

Answers to your retirement plan questions  
are just a phone call away.

Call the Loyola Retirement Center, administered by  
Teachers Insurance and Annuity Association (TIAA).

**773 508-2770**  
**(on campus dial 8-2770)**

**Monday to Friday 7:00 a.m. to 9:00 p.m. and**  
**Saturdays from 8:00 a.m. to 5:00 p.m. CT.**

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The Loyola Retirement Center will assist you with setting up and maintaining your retirement accounts. You may transfer funds between vendors or re-allocate funds at any time simply by telephoning the Loyola Retirement Center. You also have the option to meet with a retirement representative on a one-on-one basis at any time by calling the phone numbers listed below to set up an appointment.

- **AIG Retirement (VALIC)**      (312) 214-8870 or visit their website at: [www.valic.com](http://www.valic.com)
- **Fidelity Investments**      1-800-642-7131 or visit their website at: [www.fidelity.com](http://www.fidelity.com)
- **TIAA-CREF**      1-800-842-2005 or visit their website at: [www.tiaa-cref.org](http://www.tiaa-cref.org)

## Loyola University Employees' Retirement Plan (LUERP)

For Staff employees hired on or before March 1, 2003, you may have been a participant with frozen defined retirement benefits under the Loyola University Employees' Retirement Plan (LUERP). Please contact Donna Piha at 312-915-7925 for information.

## 2009 Limits for Benefit Plans

Each plan year the U.S. government-IRS adjusts limits for pension plans and other benefit programs to reflect price and wage inflation and changes in the law. The benefit changes for 2009 are shown below.

<b>Retirement Plans*</b>		
<b>403(b) Defined Contribution Retirement Plan</b>		
	<b>2009</b>	<b>2008</b>
<b>Annual Compensation</b>		
<b>Basic Limit</b>	<b>\$245,000</b>	<b>\$230,000</b>
<b>Limits on Benefits and Contributions:</b>		
<b>403(b) plans, elective deferrals</b>	<b>\$16,500</b>	<b>\$15,500</b>
<b>Catch-Up Contributions:</b>		
<b>403(b)</b>	<b>\$5,500</b>	<b>\$5,000</b>
<b>Transit Pass Benefit</b>		
<b>Chicago Card Plus, Chicago Card, The CTA Transit Card and RTA Transit Voucher</b>	<b>\$120</b>	<b>\$115</b>

\*As published by IRS

Dated: 10/17/2008

## Important Information

### *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*

The University's Group Medical plans do not have a provision that excludes pre-existing medical conditions.

### *Special Enrollment Rights*

If you or your dependents initially declined to enroll in one of the University's medical Plans because of other health insurance coverage, you may in the future be able to enroll you and your eligible dependents in one of the medical plans offered by the University, provided that you request and complete enrollment within 31 days after your other coverage ends. Whether you declined coverage or a participant in the plan, you may be able to enroll yourself and/or your dependents if you acquire a new dependent as a result of marriage, birth, adoption, placement for adoption, if you or your dependents lose eligibility for other coverage. However, you must request enrollment within 31 days the marriage, birth, adoption, placement for adoption, or loss of coverage.

### *Pre-Enrollment Disclosure Notice*

**Pre-existing Condition Limitation:** None of the HMOs and PPOs coverage options offered by Loyola University Chicago as group health plans contain a pre-existing condition limitation.

### *Newborn's and Mother's Protection Act*

The Newborns' Act affects the amount of time you and your newborn child are covered for a hospital stay following childbirth. The minimum stay for mothers and newborn children is 48 hours following a normal delivery and 96 hours following a cesarean section. Providers are not required to obtain authorization from the Plans or the Claims Administrator for prescribing a length of stay not in excess of the above periods.

### *Women's Health and Cancer Act*

If you have had, or are going to have, a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). The Act requires the University's Plan to cover the following medical services in connection with coverage for a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and physical complications for all stages of mastectomy, including lymph edemas.

The University's Plans comply with these requirements. Medical services will be provided subject to the same deductible and coinsurance that applies to other medical and surgical benefits provided under the Plans.

## Privacy Notice

The following is the Notice of Privacy Practices for health plan beneficiaries of Loyola University Chicago Health Plans. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The effective date of this Notice of Loyola University Chicago Health, Dental, Vision and FSA Plans Information Privacy Practices (the "Notice") is April 14, 2003.

Loyola University Health, Dental, Vision and FSA Plans (the "Plan") provides health benefits to eligible employees of Loyola University Chicago (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits.

For ease of reference, in the remainder of this Notice, the words “you,” “your,” and “yours” refers to any individual with respect to whom the Plan receives, creates or maintains Protected Health Information, including employees, retirees and COBRA qualified beneficiaries, if any, and their respective dependents.

The Plan is required by law to take reasonable steps to protect your Protected Health Information from inappropriate use or disclosure.

Your “Protected Health Information” (PHI) is information about your physical or mental health condition, the provision of health care to you, or payment for health care provided to you, but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you.

The Plan is required by law to provide notice to you of the Plan’s duties and privacy practices with respect to your PHI, and is doing so through this Notice. This Notice describes the different ways in which the Plan uses and discloses PHI. It is not feasible in this Notice to describe in detail all of the specific uses and disclosures the Plan may make of PHI, so this Notice describes all of the categories of uses and disclosures of PHI that the Plan may make and, for most of those categories, gives examples of those uses and disclosures.

The Plan is required to abide by the terms of this Notice until it is replaced. The Plan may change its privacy practices at any time and, if any such change requires a change to the terms of this Notice, the Plan will revise and re-distribute this Notice. Accordingly, the Plan can change the terms of this Notice at any time. The Plan has the right to make any such change effective for your entire PHI that the Plan creates, receives or maintains, even if the Plan received or created that PHI before the effective date of the change.

The Plan is distributing this Notice, and will distribute any revisions, only to participating employees, retirees and COBRA qualified beneficiaries, if any. If you have coverage under the Plan as a dependent of an employee, retiree or COBRA qualified beneficiary, you can get a copy of the Notice by requesting it from the contact named at the end of this Notice.

Please note that this Notice applies only to your PHI that the Plan maintains. It does not affect your doctor’s or other health care provider’s privacy practices with respect to your PHI that they maintain.

### **Receipt of Your PHI by the Company and Business Associates**

The Plan may disclose your PHI to, and allow use and disclosure of your PHI by, the Company and Business Associates without obtaining your authorization.

**Plan Sponsor:** The Company is the Plan Sponsor and Plan Administrator. The Plan may disclose to the Company, in summary form, claims history and other information so that the Company may solicit premium bids for health benefits, or to modify, amend or terminate the Plan. This summary information omits your name and Social Security Number and certain other identifying information. The Plan may also disclose information about your participation and enrollment status in the Plan to the Company and receive similar information from the Company. If the Company agrees in writing that it will protect the information against inappropriate use or disclosure, the Plan also may disclose to the Company a limited data set that includes your PHI, but omits certain direct identifiers, as described later in this Notice. The Plan may disclose your PHI to the Company for plan administration functions performed by the Company on behalf of the Plan, if the Company certifies to the Plan that it will protect your PHI against inappropriate use and disclosure.

**Business Associates:** The Plan and the Company hire third parties, such as a third party administrator (the “Claims Administrator”), to help the Plan provide health benefits. These third parties are known as the Plan’s “Business Associates.” The Plan may disclose your PHI to Business Associates, like the Claims Administrator, who are hired by the Plan or the Company to assist or carry out the terms of the

Plan. In addition, these Business Associates may receive PHI from third parties or create PHI about you in the course of carrying out the terms of the Plan. The Plan and the Company must require all Business Associates to agree in writing that they will protect your PHI against inappropriate use or disclosure, and will require their subcontractors and agents to do so, too.

For purposes of this Notice, all actions of the Company and the Business Associates that are taken on behalf of the Plan are considered actions of the Plan. For example, health information maintained in the files of the Claims Administrator is considered maintained by the Plan. So, when this Notice refers to the Plan taking various actions with respect to health information, those actions may be taken by the Company or a Business Associate on behalf of the Plan.

### **How the Plan May Use or Disclose Your PHI**

The Plan may use and disclose your PHI for the following purposes without obtaining your authorization. **Your Health Care Treatment:** The Plan may disclose your PHI for treatment (as defined in applicable federal rules) activities of a health care provider.

*Example:* If your doctor requested information from the Plan about previous claims under the Plan to assist in treating you, the Plan could disclose your PHI for that purpose.

*Example:* The Plan might disclose information about your prior prescriptions to a pharmacist for the pharmacist's reference in determining whether a new prescription may be harmful to you.

**Making or Obtaining Payment for Health Care or Coverage:** The Plan may use or disclose your PHI for payment (as defined in applicable federal rules) activities, including making payment to or collecting payment from third parties, such as health care providers and other health plans.

*Example:* The Plan will receive bills from physicians for medical care provided to you that will contain your PHI. The Plan will use this PHI, and create PHI about you, in the course of determining whether to pay, and paying, benefits with respect to such a bill.

*Example:* The Plan may consider and discuss your medical history with a health care provider to determine whether a particular treatment for which Plan benefits are or will be claimed is medically necessary as defined in the Plan.

The Plan's use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others.

- Obtaining payments required for coverage under the Plan
- Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication
- Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation, and determination of cost sharing amounts)
- Claims management, collection activities, obtaining payment under a stop-loss insurance policy, and related health care data processing
- Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges
- Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services

The Plan also may disclose your PHI for purposes of assisting other health plans (including other health plans sponsored by the Company), health care providers, and health care clearinghouses with their payment activities, including activities like those listed above with respect to the Plan.

**Health Care Operations:** The Plan may use and disclose your PHI for health care operations (as defined in applicable federal rules) which includes a variety of facilitating activities.

*Example:* If claims you submit to the Plan indicate that you have diabetes or another chronic condition, the Plan may use and disclose your PHI to refer you to a disease management program.

*Example:* If claims you submit to the Plan indicate that the stop-loss coverage that the Company has purchased in connection with the Plan may be triggered, the Plan may use or disclose your PHI to inform the stop-loss carrier of the potential claim and to make any claim that ultimately applies.

The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following purposes.

- Quality assessment and improvement activities
- Disease management, case management and care coordination
- Activities designed to improve health or reduce health care costs
- Contacting health care providers and patients with information about treatment alternatives
- Accreditation, certification, licensing or credentialing activities
- Fraud and abuse detection and compliance programs

The Plan also may use or disclose your PHI for purposes of assisting other health plans (including other plans sponsored by the Company), health care providers and health care clearinghouses with their health care operations activities that are like those listed above, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship.

- The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others.
- Underwriting, premium rating and performing related functions to create, renew or replace insurance related to the Plan
- Planning and development, such as cost-management analyses
- Conducting or arranging for medical review, legal services, and auditing functions
- Business management and general administrative activities, including implementation of, and compliance with, applicable laws, and creating de-identified health information or a limited data set

The Plan also may use or disclose your PHI for purposes of assisting other health plans for which the Company is the plan sponsor, and any insurers and/or HMOs with respect to those plans, with their health care operations activities similar to both categories listed above.

**Limited Data Set:** The Plan may disclose a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security Number and certain other identifying information.

**Legally Required:** The Plan will use or disclose your PHI to the extent required to do so by applicable law. This may include disclosing your PHI in compliance with a court order, or a subpoena or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records.

**Health or Safety:** When consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others.

**Law Enforcement:** The Plan may disclose your PHI to a law enforcement official if the Plan believes in good faith that your PHI constitutes evidence of criminal conduct that occurred on the premises of the Plan. The Plan also may disclose your PHI for limited law enforcement purposes.

**Lawsuits and Disputes:** In addition to disclosures required by law in response to court orders, the Plan may disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request or other lawful process or to obtain an order protecting the information to be disclosed.

**Workers' Compensation:** The Plan may use and disclose your PHI when authorized by and to the extent necessary to comply with laws related to workers' compensation or other similar programs.

**Emergency Situation:** The Plan may disclose your PHI to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your agreement to the Plan to do this.

**Personal Representatives:** The Plan will disclose your PHI to your personal representatives appointed by you or designated by applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you.

**Public Health:** To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product's quality, safety or effectiveness to a person subject to FDA jurisdiction.

**Health Oversight Activities:** The Plan may disclose your PHI to a public health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions.

**Coroner, Medical Examiner, or Funeral Director:** The Plan may disclose your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director's duties.

**Organ Donation:** The Plan may use or disclose your PHI to assist entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.

**Specified Government Functions:** In specified circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

#### Authorization to Use or Disclose Your PHI

Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time, by sending notice of your revocation to the contact person named at the end of this Notice. To the extent that the Plan has taken action in reliance on your authorization (entered into an agreement to provide your PHI to a third party, for example) you cannot revoke your authorization.

#### The Plan May Contact You

The Plan may contact you for various reasons, usually in connection with claims and payments and usually by mail.

<p>You should note that the Plan may contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.</p>
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#### Your Rights With Respect to Your PHI

**Confidential Communication by Alternative Means:** If you feel that disclosure of your PHI could endanger you, the Plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the Plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the contact person named at the end of this Notice. You do not need to state the specific reason that you feel disclosure of your PHI might endanger you in making the request, but you do need to state whether that is the case. Your request also must specify how or where you wish to be contacted. The Plan will notify you if it agrees to your request for confidential communication. You should not assume that the Plan has accepted your request until the Plan confirms its agreement to that request in writing.

**Request Restriction on Certain Uses and Disclosures:** You may request the Plan to restrict the uses and disclosures it makes of your PHI. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement. To request a restriction, please submit your written request to the contact person identified at the end of this Notice. In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing.

**Paper Copy of This Notice:** You have a right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously, or have agreed to receive this Notice electronically. To obtain a paper copy please call or write the contact person named at the end of this Notice.

**Right to Access Your PHI:** You have a right to access your PHI in the Plan's enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the contact person named at the end of this Notice. The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request.

**Right to Amend:** You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to the contact person named at the end of this Notice. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan's records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan's records, and a description of how you may complain to Plan or the Secretary of Health and Human Services.

**Accounting:** You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize, or that occurred prior to April 14, 2003, are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the contact person named at the end of this Notice. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

**Personal Representatives:** You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

## Complaints

If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the contact person named at the end of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

## Contact Information

The Plan has designated Thomas M. Kelly, Vice President, Human Resources, as its contact person for all issues regarding the Plan's privacy practices and your privacy rights. You can reach this contact person at: 820 North Michigan, 8<sup>th</sup> floor, Chicago, Illinois 60611. All HIPAA related documentation and release forms can be found on Loyola's Human Resources website, <http://www.luc.edu/hr/privacy.shtml>.

## COBRA Notice

This notice contains important information about the right to COBRA continuation coverage. COBRA coverage is a temporary extension of coverage that applies in certain situations when a loss of health coverage would otherwise occur. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985.

This notice generally explains COBRA continuation coverage, when it may become available and what to do to protect the right to receive it. If you have any questions about this notice or the Plan in general, you can contact:

Loyola University Chicago  
Human Resources – 8<sup>th</sup> Floor  
820 North Michigan Avenue  
Chicago, Illinois 60611  
Phone (312) 915-6175  
Fax (312) 915-7612  
Email HR-WTC@luc.edu

Loyola has contracted with Benefit Express (“the COBRA Administrator”) to perform many of the administrative tasks required by federal law. This Initial Notice of COBRA Rights indicates when you should contact the COBRA Administrator, rather than Loyola, for information or assistance. In the event you are direct to contact the COBRA Administrator, address all inquiries to:

Benefit Express  
COBRA-Loyola University Chicago  
P.O. Box 189  
Arlington Heights, IL 60006  
Phone (847)637-1516  
Fax (253)793-3766

The group health benefits to which this notice applies are provided under the following plan(s):

- The Loyola University Chicago Health Insurance Plan
- The Loyola University Chicago Dental Insurance Plan
- The Loyola University Chicago Health Care Flexible Spending Account Plan
- Vision Service Plan
- AlwaysVision

Each of these plans is referred to in this notice as the “Plan,” so you should read this notice as if it applied separately to each Plan. The word “participant” refers to any employee or former employee of Loyola who is or was covered under health benefits provided by the Plan.

Under the Plan, participants can elect coverage under the following health benefits:

### **MEDICAL**

- BlueCross BlueShield PPO - Option I
- BlueCross BlueShield PPO - Loyola Preferred
- HMO Illinois
- Vision Service Plan
- AlwaysVision

### **DENTAL**

- Traditional Dental Plan - Delta Dental
- Managed Care Dental Plan - First Commonwealth DMO

### **FLEXIBLE SPENDING ACCOUNTS**

- Health Care Flexible Spending Account Plan

### **What is COBRA continuation coverage?**

COBRA continuation coverage is a continuation of group health plan coverage that may become available when coverage would otherwise end because of a life event known as a “qualifying event.”

#### ***Qualified Beneficiaries***

A participant, the participant’s spouse (as defined in federal law)/Legally Domiciled Adult (LDA), and the participant’s dependent children can be qualified beneficiaries who are entitled to elect COBRA coverage if they lose coverage under the Plan because of a qualifying event. After a qualifying event has occurred (and, if applicable, proper notice of the qualifying event has been given), COBRA coverage must be offered to each of these “qualified beneficiaries” that would lose Plan coverage as a result of that qualifying event.

#### ***To a Participant***

If you are a participant, you will be entitled to elect COBRA if you have a loss of coverage under the Plan because one of the following events occurs:

- Your hours of employment with Loyola are reduced to a level that renders you ineligible for benefits.
- Your employment with Loyola ends for any reason other than your gross misconduct.

#### ***To a Participant’s Spouse/Legally Domiciled Adult (LDA)***

If you are the spouse/LDA of a participant, you will be entitled to elect COBRA if you have a loss of coverage under the Plan because any of the following events occurs:

- Your spouse/LDA dies.
- Your spouse’s/LDA’s hours of employment with Loyola are reduced.
- Your spouse’s/LDA’s employment with Loyola ends for any reason other than his or her gross misconduct.
- You become divorced or legally separated from your spouse/LDA, but only if notice of the divorce or legal separation is given to as specified later in this Notice in the section entitled “In Some Cases Qualified Beneficiaries Are Required to Give Notice.”

#### ***To a Participant’s Dependent Child***

If you are the dependent child of a participant, you will be entitled to elect COBRA if you have a loss of coverage under the Plan because any of the following events occurs:

- The participant that is your parent dies.
- The participant that is your parent has a reduction in hours of employment with Loyola.
- The participant that is your parent terminates employment with Loyola for any reason other than his or her gross misconduct.
- The participant that is your parent becomes divorced or legally separated, but only if notice of the divorce or legal separation is given as specified later in this Notice in the section entitled “In Some Cases Qualified Beneficiaries Are Required to Give Notice.”

- You stop being eligible for coverage under the Plan as a “dependent child” of the participant, but only if notice of the event making you ineligible is given as specified later in this notice in the section entitled “In Some Cases Qualified Beneficiaries Are Required to Give Notice.”

### **When Will COBRA Become Available?**

In order for COBRA coverage to become available, a qualified beneficiary (as described above) must have a loss of coverage due to certain events (listed below). When one of these events causes a qualified beneficiary to lose coverage under the Plan it is referred to as a “qualifying event.”

### **Are Qualified Beneficiaries Required to Give Notice of a Qualifying Event?**

The type of qualifying event determines whether a qualified beneficiary is required to give notice of the qualifying event.

#### **In Some Cases Qualified Beneficiaries Are Required to Give Notice**

If a qualifying event is a participant’s divorce or legal separation, or a dependent child’s losing eligibility for coverage under the Plan, COBRA will not be offered (or available) unless written notice of these events is provided to Loyola University

The notice must be given within 60 days after the later of the event (the divorce or legal separation, or the event causing the dependent child’s ineligibility) or the date the Plan says coverage will end because of the event. If notice is not provided within the 60-day period, COBRA coverage will not be available as a result of that event. Also, any claims paid by the Plan after the date coverage should have ended must be refunded to the Plan.

#### **In Other Cases, No Notice is Required**

If a qualifying event is a participant’s termination of employment, reduction in hours of employment or death, you are not required to give notice of the event in order for COBRA coverage to be offered. COBRA coverage will be offered to the qualified beneficiaries with respect to these events even if no notice is provided.

### **How Is COBRA Elected?**

When it is determined that a qualified beneficiary should be offered COBRA, the offer is made by sending an election notice. The election period ends 60 days after the date of the election notice or, if later, the date the Plan terms call for the qualified beneficiary to lose coverage because of the qualifying event. The postmark date on the envelope in which the election of COBRA coverage is sent will be deemed the date the election was made.

If your COBRA coverage election is not made before the end of the 60-day election period as described above, you will lose the right to obtain COBRA coverage and your health coverage under the Plan will end.

### ***Independent Election Rights***

Each qualified beneficiary losing coverage due to a qualifying event (and for whom any required notice has been provided) will have an independent right to elect COBRA coverage, meaning that each may elect COBRA coverage even if other family members do not.

### ***Effect of Other Coverage or Medicare***

Qualified beneficiaries who are entitled to elect COBRA may do so even if covered by another group health plan or Medicare prior to the election date. COBRA coverage will terminate automatically if, after electing COBRA, a qualified beneficiary first becomes entitled to Medicare benefits or becomes covered under another group health plan (but only after the qualified beneficiary is no longer subject to any

exclusion or limitation applicable under that coverage that applies to a preexisting condition of the qualified beneficiary).

## **How Long Can COBRA Coverage Be Available?**

### ***Limited Availability of Health Care FSA***

COBRA coverage under the Health Care FSA will terminate at the end of the plan year in progress at the time of the qualifying event. You will not be able to make an election for the next plan year. All of the usual rules for the Health Care FSA regarding submitting claims, forfeiting unused balances, etc. will apply during the COBRA period.

If a qualified beneficiary elects COBRA under the Health Care FSA, the COBRA coverage will apply to all of the qualified beneficiaries who lost Health Care FSA coverage due to the same qualifying event as the electing qualified beneficiary, unless the election form specifies otherwise. Each qualified beneficiary has separate election rights, and each could elect separate COBRA coverage under the Health Care FSA to cover that beneficiary only, with a separate Health Care FSA annual limit and a separate premium.

If the qualifying event was a participant's termination of employment or reduction in hours of employment, the maximum COBRA coverage period for health benefits other than the Health Care FSA generally is 18 months.

### ***Events Potentially Extending an 18-Month Maximum COBRA Coverage Period***

The 18-month maximum COBRA coverage period that usually applies when a termination of employment or reduction in hours qualifying event occurs can be extended in three situations.

#### *Medicare Entitlement Before Termination of Employment or Reduction in Hour*

If a participant becomes entitled to Medicare during the 18 months before a qualifying event consisting of the participant's terminating employment or reducing hours, an extended maximum COBRA coverage period can apply to that participant's spouse and dependent children who become qualified beneficiaries due to the termination of employment or reduction in hours. The participant's maximum COBRA coverage period will remain 18 months in this case, but the other qualified beneficiaries will have a maximum continuation period that ends 36 months after the date of the participant's Medicare entitlement. If, for example, a participant became entitled to Medicare on July 1, 2005 and terminated employment on September 15, 2005:

- The participant's maximum COBRA coverage period would end on March 15, 2007.
- The participant's spouse and dependent children would have a maximum COBRA coverage period that ends on July 1, 2008.

#### *Social Security Administration Determination of a Qualified Beneficiary's Disability*

- The 18-month maximum COBRA coverage period (or the period of coverage resulting from Medicare entitlement as described in the preceding paragraph) may be extended to a total of 29 months from the date of termination of employment or reduction in hours if a qualified beneficiary receives a Social Security Administration determination that the qualified beneficiary is disabled. This extension will apply only if the Social Security Administration determines that you (or another individual who is entitled to COBRA coverage because of the same qualifying event) were disabled at any time during the first 60 days of COBRA coverage, you notify the COBRA Administrator in a timely fashion, and you remain disabled throughout the extension period. For this extension to be available, the COBRA Administrator must be notified in writing of the Social Security Administration determination.

#### *Second Qualifying Event*

For a participant's spouse and dependent children, the maximum COBRA coverage period may be extended to a total of 36 months from the date of the participant's termination or reduction in hours if,

during the first 18 months (or 29 months, if a disability extension applies) that COBRA coverage is in effect, a second qualifying event occurs.

- A second qualifying event for a participant's spouse may consist of the participant's death, legal separation or divorce, but only if the event would have caused the spouse to lose coverage under the Plan had the first qualifying event not occurred.
- A second qualifying event for a participant's dependent child may consist of the participant's death, legal separation or divorce, or the dependent child's ceasing to meet the dependent eligibility requirements under the Plan, but only if the event would have caused the dependent child to lose coverage under the Plan had the first qualifying event not occurred.
- **For this extension to be available, written notice of the event must be properly given to the COBRA Administrator.**

If notice is not provided to the COBRA Administrator within the applicable 60-day period, the extension of the maximum COBRA coverage period described in this paragraph will not be available as a result of that event.

### ***Limits on Extensions of the Maximum COBRA Coverage Period***

In no case will the total maximum COBRA coverage period for anyone be more than 36 months, and in no case will the total COBRA coverage period for a participant be more than 18 months (29 months in the case of disability, as provided above). For a child born to, adopted by, or placed for adoption with a participant during continuation coverage, these periods are measured from the date of the event that triggered the continuation coverage in effect at the time of birth, adoption, or placement. In no event is the coverage period for such a child based on the date of birth, adoption, or placement.

All of the COBRA coverage periods described above are maximums. COBRA coverage can end before the end of these maximum coverage periods for several reasons, which are described in the following section.

If a 36-month maximum COBRA coverage period applies, it cannot be extended under any circumstances.

### ***Medicare Entitlement***

Your COBRA coverage will terminate automatically if, after electing COBRA, you first become entitled to any Medicare benefits (Part A, Part B or both). You must notify the COBRA Administrator promptly after Medicare becomes effective. Regardless of whether this notice is provided, termination of COBRA coverage will be effective on the date of Medicare entitlement.

### ***Cessation of Disability***

Your COBRA coverage will terminate automatically if, after becoming entitled to a 29-month maximum coverage period due to your own or another qualified beneficiary's disability, during the extension, there is a final Social Security Administration determination that the disabled individual ceased to be disabled. Within 30 days after receipt of the Social Security Administration determination, the COBRA Administrator must be notified in writing of that determination according to the notice procedures. Termination of COBRA coverage will be effective on the first day of the first month that is more than 30 days after the date of the Social Security Administration determination, regardless of whether you give the required notice.

### ***Special Rules on FMLA Leaves of Absence***

Loyola is subject to the Family and Medical Leave Act of 1993 (FMLA), and, when allowing leaves protected under the FMLA, Loyola allows participants to continue group health plan coverage at regular contribution levels while on the leave. Beginning an FMLA leave is *not* an event which qualifies you for continuation coverage (beginning a non-FMLA leave may be a COBRA qualifying event, however). If one of the qualifying events listed earlier in this notice occurs during an FMLA leave, however, and, under the terms of the Plan, it normally would result in loss of coverage, then the normal rules described

above concerning COBRA coverage would apply. In addition, if a participant who takes an FMLA leave does not return at the end of that leave, the last day of that leave may be treated as a reduction in hours for purposes of determining whether COBRA rights apply.

### ***Initial Payment for COBRA Coverage***

You are not required to send payment with your election of COBRA, but COBRA coverage under the Plan will not become effective until you have both properly elected coverage within the election period and paid your initial COBRA premium on time. Your initial COBRA premium is due no later than the 45<sup>th</sup> day after your election date. That initial payment must cover the premium for the period of COBRA coverage from the date on which Plan coverage would have ended if COBRA had not been elected through the last day of the month that ends before the due date for the initial payment

### ***Requirement to Pay for COBRA Coverage***

#### **If You Have Questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be directed to Loyola as indicated on the first page of this notice. 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 phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Questions about your COBRA continuation coverage once you have elected it, including questions regarding premiums and coverage changes, should be directed to the COBRA Administrator as indicated on the first page of this notice.

#### **Keep the Plan Informed of Address Changes**

In order to protect your family's rights, you should keep Loyola, and the COBRA Administrator after electing COBRA continuation coverage, informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to Loyola or the COBRA Administrator

Under the Plan, qualified beneficiaries who elect COBRA coverage must pay for that coverage. In most cases, the amount a qualified beneficiary may be required to pay may 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 coverage.

#### ***Failure to Pay Required Premiums***

Your COBRA coverage will terminate automatically if the premium for your continuation coverage is not paid by the due date and any applicable grace period for paying the premium has expired without the past due premium being paid. Termination of COBRA coverage will be effective at the end of the last month for which the full premium was paid before expiration of the grace period for that payment.

#### ***Plan Termination***

Your COBRA coverage will terminate automatically on the first date Loyola ceases to provide any group health coverage to any employee.



## 2009 Monthly Rate Sheet for Full-Time Faculty & Staff

<b>Health Insurance</b>			
<b>Level</b>	<b>BC/BS Option I</b>	<b>BC/BS Loyola Preferred</b>	<b>HMO Illinois</b>
Employee	\$95.00	\$80.00	\$85.00
Employee + Spouse	\$310.00	\$265.00	\$255.00
Employee + Child(ren)	\$266.00	\$230.00	\$258.00
Family	\$378.00	\$328.00	\$370.00
Employee + LDA	\$310.00	\$265.00	\$255.00
Employee + LDA + Child(ren)	\$378.00	\$328.00	\$370.00

<b>Dental Insurance</b>		
<b>Level</b>	<b>Delta Dental</b>	<b>DHMO</b>
Employee	\$12.50	\$6.00
Employee + Spouse	\$26.00	\$11.50
Employee + Child(ren)	\$30.00	\$14.00
Family	\$42.50	\$19.00
Employee + LDA	\$26.00	\$11.50
Employee + LDA Child(ren)	\$42.50	\$19.00

<b>Life Insurance</b>			
<b>Supplemental Life</b>		<b>Dependent Life</b>	
<b>Age</b>	<b>Rate per \$1,000</b>	<b>Coverage</b>	<b>Rate</b>
		Spouse:	
< 30	\$0.06	\$5,000	\$2.65
30-34	\$0.08	\$10,000	\$5.64
35-39	\$0.10	\$15,000	\$8.87
40-44	\$0.13	\$20,000	\$11.69
45-49	\$0.20	\$25,000	\$14.12
50-54	\$0.35	\$30,000	\$16.44
55-59	\$0.62	\$35,000	\$18.46
60-64	\$0.88	\$40,000	\$20.38
65-69	\$1.39	\$45,000	\$21.95
70-74	\$2.06	\$50,000	\$22.86
75-79	\$2.06	\$60,000	\$26.97
80<	\$3.43	\$70,000	\$31.82
		\$80,000	\$37.55
		\$90,000	\$44.32
		\$100,000	\$52.30
		Children:	
		\$5,000	\$0.37

<b>Vision Service Plan, or Always Vision</b>	<b>Rate</b>
Employee	\$8.34
Employee + Spouse	\$13.24
Employee + Child(ren)	\$13.52
Family	\$21.80
Employee + LDA	\$13.24
Employee + LDA + Child(ren)	\$21.80

<b>Hyatt Legal Plan</b>
\$15.00

<b>Personal Accident (AD&amp;D) Rate per \$1,000</b>	
Employee	0.030
EE + Family	0.045



## 2009 Monthly Rate Sheet for Part-Time Faculty & Staff

<b>Health Insurance</b>			
<b>Level</b>	<b>BC/BS Option I</b>	<b>BC/BS Loyola Preferred</b>	<b>HMO Illinois</b>
Employee	\$455.00	\$312.00	\$353.00
Employee + Spouse	\$1,069.00	\$734.00	\$831.00
Employee + Child(ren)	\$937.00	\$643.00	\$728.00
Family	\$1,351.00	\$928.00	\$1,050.00
Employee + LDA	\$1,069.00	\$734.00	\$831.00
Employee + LDA + Child(ren)	\$1,351.00	\$928.00	\$1,050.00

<b>Dental Insurance</b>		
<b>Level</b>	<b>Delta Dental</b>	<b>DHMO</b>
Employee	\$33.00	\$16.00
Employee + Spouse	\$64.00	\$29.00
Employee + Child(ren)	\$72.00	\$32.00
Family	\$101.00	\$47.00
Employee + LDA	\$64.00	\$29.00
Employee + LDA + Child(ren)	\$101.00	\$47.00

<b>Life Insurance</b>			
<b>Supplemental Life</b>		<b>Dependent Life</b>	
<b>Age</b>	<b>Rate per \$1,000</b>	<b>Coverage</b>	<b>Rate</b>
		Spouse:	
< 30	\$0.06	\$5,000	\$2.65
30-34	\$0.08	\$10,000	\$5.64
35-39	\$0.10	\$15,000	\$8.87
40-44	\$0.13	\$20,000	\$11.69
45-49	\$0.20	\$25,000	\$14.12
50-54	\$0.35	\$30,000	\$16.44
55-59	\$0.62	\$35,000	\$18.46
60-64	\$0.88	\$40,000	\$20.38
65-69	\$1.39	\$45,000	\$21.95
70-74	\$2.06	\$50,000	\$22.86
75-79	\$2.06	\$60,000	\$26.97
80<	\$3.43	\$70,000	\$31.82
		\$80,000	\$37.55
		\$90,000	\$44.32
		\$100,000	\$52.30
		Children:	
		\$5,000	\$0.37

<b>Vision Service Plan, or Always Vision Plan</b>	<b>Rate</b>
Employee	\$8.34
Employee + Spouse	\$13.24
Employee + Child(ren)	\$13.52
Family	\$21.80
Employee + LDA	\$13.24
Employee + LDA + Child(ren)	\$21.80

<b>Hyatt Legal Plan</b>
\$15.00

<b>Personal Accident (AD&amp;D) Rate per \$1,000</b>	
Employee	0.030
EE + Family	0.045



## Benefit Contacts

<b>PLAN TYPE</b>	<b>PROVIDER or ADMINISTRATOR</b>	<b>PHONE #</b>	<b>WEBSITE</b>
<b>MEDICAL</b>	BC/BS PPO HMO Illinois PPO/HMO	1-866-266-3674 1-800-892-2803 Provider Finders	<a href="http://www.bcbsil.com">www.bcbsil.com</a> <a href="http://www.bcbsil.com">www.bcbsil.com</a> <a href="http://bcbsil.com/providers/index.htm">http://bcbsil.com/providers/index.htm</a>
<b>DENTAL</b>	Delta Dental PPO Guardian/First Commonwealth - DHMO	1-800-323-1743 1-866-494-4542	<a href="http://www.deltadentalil.com">www.deltadentalil.com</a> <a href="http://www.guardianlife.com">www.guardianlife.com</a>
<b>LIFE</b>	CIGNA	1-800-732-1603	<a href="http://www.cigna.com">www.cigna.com</a>
<b>BENEFITS / ELIGIBILITY &amp; GENERAL QUESTIONS</b>	Loyola University Benefits Department	1-312-915-6175	<a href="http://www.luc.edu/hr/">www.luc.edu/hr/</a>
<b>FLEXIBLE SPENDING ACCOUNTS</b>	Benefit Express	1-877-837-5017	<a href="http://www.loyolaexpress.com">www.loyolaexpress.com</a>
<b>TRANSIT PLAN</b>	Benefit Express	1-888-Your CTA, or 1-877-837-5017	<a href="http://www.chicago-card.com">www.chicago-card.com</a> <a href="http://www.loyolaexpress.com">www.loyolaexpress.com</a>
<b>COUNSELING SERVICES</b>	Perspectives, Ltd Employee Assistance Program (EAP)	1-800-456-6327	<a href="http://www.perspectivesltd.com/login.htm">www.perspectivesltd.com/login.htm</a> The user name is: LOY500. The password is: perspectives.
<b>COBRA (Continuation of Insurance Coverage)</b>	Benefit Express	1-877-837-5017	<a href="http://www.luc.edu/hr/">www.luc.edu/hr/</a>
<b>GROUP LEGAL PLAN</b>	Hyatt Legal Services	1-800-821-6400	<a href="http://www.legalplans.com">www.legalplans.com</a>
<b>LONG-TERM CARE</b>	CNA Insurance	1-800-528-4582	<a href="http://www.ltcbenefits.com">www.ltcbenefits.com</a>
<b>TIAA-CREF</b>	TIAA-CREF	1-800-842-2252	<a href="http://www.tiaa-cref.org">www.tiaa-cref.org</a>
<b>AIG Retirement VALIC</b>	AIG Retirement Customer Service	1-800-448-2542	<a href="http://www.AIGRetirement.com">www.AIGRetirement.com</a>
<b>FIDELITY INVESTMENTS</b>	Fidelity Investments	1-800-642-7131	<a href="http://www.fidelity.com">www.fidelity.com</a>
<b>TUITION BENEFIT</b>	Human Resources	1-312-915-6175	<a href="http://www.luc.edu/hr/">www.luc.edu/hr/</a>
<b>VISION</b>	Vision Service Plan Always Vision	1-800-877-7195 1-888-729-5433 Ext. 2013	<a href="http://www.vsp.com">www.vsp.com</a> <a href="http://www.alwaysvision.com">www.alwaysvision.com</a>

This booklet is not a contract of employment. The booklet serves as a resource to the benefits enrollment process and does not replace your policies or certificates. It provides a brief description of the University benefits and should answer your general questions about your benefits. Every effort has been made to provide an accurate summary of the plans, but the booklet does not describe all the provisions of the Plans. Only the Plans can give any person a right to benefits. If there is any conflict or discrepancy between the descriptions in this booklet and the Plan documents and/or insurance company contracts, the documents or contracts will decide your rights and benefits under the Plans. You are not vested under the Plans, Loyola University Chicago reserves the right to amend, modify, or terminate the provisions of the benefit plan(s) at any time.

January 1, 2009