This booklet, together with the applicable insurance policies, certificates of coverage or other component plan benefit booklets serve as both the official plan documents and as the summary plan descriptions for the benefits provided under the Loyola Marymount University Welfare Benefits Plan (Plan).

Loyola Marymount University reserves the right to amend, suspend or terminate the Plan or any of the benefits there under at any time and for any reason.

Only Loyola Marymount University, the Plan Administrator or the designated claims fiduciary is authorized to interpret the Plan and will do so only in writing. You should not rely on any representation—whether verbal or in writing—that any other individual may make concerning Plan provisions and your entitlement to benefits under the Plan.

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IMPORTANT Information

This booklet together with the applicable insurance policies, certificates of coverage or other component plan benefit booklets that you receive serve both as the official plan documents and as the summary plan descriptions for the following benefits provided under the Plan and sponsored by Loyola Marymount University ("LMU"):

Medical
Dental/Vision
Long-Term Disability (LTD) Insurance
Accidental Death and Dismemberment (AD&D) Insurance
Faculty/Staff Member and Dependent Life Insurance
Long-Term Care (LTC) Insurance
Voluntary Benefits
Flexible Spending Accounts (FSAs)
Commuter Benefits

You can also participate in the Employee Assistance Program (EAP), which is automatically provided – you do not need to enroll.

In the event of a conflict between the benefits information in this booklet and the applicable insurance policies, certificates of coverage or other benefit booklets, the insurance policy, certificate of coverage or other benefit booklet will prevail. Additional copies of the insurance policies, certificates of coverage and other benefit booklets are available through the Plan Administrator.

This booklet includes information about the administration of the benefits under the Plan and your rights under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Except as otherwise provided herein, this booklet and the applicable insurance policies, certificates of coverage or other component plan benefit booklets replace all summary plan descriptions previously issued with regard to the benefits provided under the Plan.

Plan Sponsor and Participating Employers

The Plan Sponsor for the Plan is LMU. The Internal Revenue Service assigns every employer an Employer Identification Number (EIN). The Plan Sponsor's EIN is 95-1643334. If you need to write to a government agency about a benefit plan, use this number along with the Plan name, Plan identification number, and the Plan Sponsor's name.

The term "Employer" as used herein refers to LMU and its participating affiliated entities that adopt the Plan with LMU's approval.

Participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular Employer is a sponsor of the Plan and if the Employer is a plan sponsor, the sponsor's address.

Plan Administration

Plan Administrator

Loyola Marymount University is the Plan Administrator with respect to the Plan. You can contact LMU at the following address and telephone number:

Loyola Marymount University
One LMU Drive, Suite 1900
Los Angeles, CA 90045
(310) 338-2723

Claims Administrator

LMU has delegated authority under the Plan to the respective insurance company or third party administrator to administer benefit claims under the applicable group insurance component plans. LMU may designate different Claims Administrators from time to time, at LMU's discretion. The Claims Administrator for each benefit is identified in the chart in the Summary Plan Information section below.

Discretionary Authority of Plan Administrator and Plan Fiduciaries

The Plan Administrator has the full and discretionary authority and power to administer and construe the Plan (and any component plans there under) except to the extent that such powers have been delegated to the Claims Administrator. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties:

- Except as otherwise provided below, to interpret and construe the provisions of the Plan and to decide any dispute which may arise regarding the rights of participants and beneficiaries under the Plan, which determinations shall be final and conclusive on all persons claiming benefits under the Plan; provided, however, that if an insurance certificate sets forth a specific claims procedure, such provisions shall apply for purposes of that component plan, consistent with the "Claims and Appeals Procedures" section below; and

- To make and enforce such rules and regulations as it may deem necessary or proper for the efficient administration of the Plan.

For component plans provided through group insurance, the insurance company, not LMU, is responsible for paying the actual cost of eligible claims you and your dependents incur. The insurance company providing such benefits has the full and final discretionary authority to interpret the component plan terms, determine benefit eligibility and is responsible for ensuring that claims are paid according to the provisions of the component plan. Such determinations shall be final and conclusive on all persons claiming such benefits.

Plan Funding and Plan Expenses

The source of contributions for the cost of coverage available under the Plan may be employer or employee contributions, or a combination of both, as determined by LMU and, in many cases, based on individual employee elections. You may be required to pay some or all of the cost of coverage for some or all of the component plans under this Plan. The benefits may be funded in different ways, depending on the type of benefit, as described below, and in the chart in the Summary Plan Information section below.

- **Self-Funded Benefits**

  The following benefits are self-funded from LMU's general assets: Health Care flexible spending account and Dependent Care flexible spending account.

- **Insured Benefits**

  The Employer pays premiums to an insurance company for the insured component benefit programs under the Plan. You may be required to contribute all or a portion of the cost of these premiums through payroll deductions. The insurance company, not the Employer, is responsible for paying the actual cost of eligible claims you and your dependents incur under the insured component programs. The health (HMO and PPO), dental (HMO and PPO), vision, life, AD&D and long term disability benefits under the Plan are fully insured.

- **Plan Expenses**

  LMU has the option of paying certain expenses in connection with the administration of the Plan and reserves the right to allocate and reallocate administrative costs between LMU and participants in the Plan.

Plan Limitations

Nothing contained in the benefit documents or this booklet creates any employment contract or in any way alters the Employer's policy and practice of employment at will contained in the Employer's employment application, handbook and policy manuals.

Plan Continuance and Amendment or Termination

LMU reserves the right at its discretion to amend or terminate the Plan, or any provision, benefit coverage or contribution under any component plan, at any time, for any reason.

Without limiting any other Plan provisions for the discontinuance of coverage, including but not limited to the provisions of any component plan as provided in the applicable insurance policy, certificate of coverage or other component plan benefit booklet, your coverage will terminate when LMU terminates the Plan, or when you are no longer eligible to receive benefits under the Plan, whichever occurs first. Neither you, your dependents, your beneficiaries nor any other person have or will have a vested or non-forfeitable right to receive benefits under the Plan.

Plan Records

The records of the Plan are kept on the basis of a "plan year." Plan Year is the twelve-month period which begins on January 1, and ends on the last day of the month of December.

Reimbursement, Recovery of Overpayment, and Subrogation

As a condition for receiving benefits under the Plan, you agree to and grant the Plan the rights of reimbursement, recovery of overpayment and subrogation. To the extent that a benefit booklet or insurance certificate also contains provisions regarding reimbursement, recovery of overpayment, and/or subrogation, this section and the applicable provisions of such booklet or certificate both apply so as to grant the Plan the greatest possible rights.

Agent of Service for Legal Process

Any legal process against the Plan in the event of an unresolved dispute over benefit plan provisions should be served on the Plan Administrator.

Claims and Appeals Procedures

If you feel an error has occurred in your records or in processing your claim for benefits, you should know that claims and appeals procedures are available to every participant and beneficiary. Except as otherwise provided in the applicable component plan document, your claim(s) for benefits will be processed according to the procedures set out in the applicable Appendix to this booklet; provided, however, that the claims will be processed in a time and manner no more stringent than is described in this booklet, as required under ERISA.

The claims and appeals procedures for each component plan are set out in the insurance policy, certificate of coverage, benefit booklet or other component plan document for that benefit. To the extent that a component plan provides for voluntary levels of appeal, the Plan agrees (i) to waive the right to assert that you failed to exhaust your administrative remedies by not submitting the dispute to the voluntary level of appeal; (ii) that the statute of limitation will be tolled during the time that such voluntary level of appeal is pending; and (iii) that you may elect to submit the benefit dispute to the voluntary level of appeal only after you have exhausted the appeals permitted under Department of Labor regulations.

Your Rights Under ERISA

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

- **Your Right to Receive Information About Your Plan and Benefits**

  Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites, all documents governing the Plan, including insurance

contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.

If applicable, receive a summary of the Plan's annual financial report.

■ Your Right to Continue Group Health Plan Coverage

Under ERISA, you are entitled to:

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Appendix entitled "COBRA Continuation Coverage" and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- A reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

■ Your Right to Prudent Actions by Plan Fiduciaries

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

■ How to Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits, which is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

■ Assistance with Your Questions

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

Summary Plan Information

Official Plan Name:	**Loyola Marymount University Welfare Benefits Plan**
Plan Number:	**001**
Type of Plan:	**Welfare benefit plan – group health, dental, vision, life, AD&D, and long-term disability**

Component Plan	Type of Benefit	Funding and Carrier Information	Claims Administrator
Health, Dental and Vision			
Group Health Plan	Medical & Prescription Drug Expense Coverage	Insured: *Anthem Blue Cross PPO* Group # 175175 M001 *Anthem Blue Cross HMO* Group # 175175 H001 *Kaiser Permanente HMO* Group # 100620-0000	Same as insurance carrier See Certificate of Insurance
Group Dental Plan	Dental	Insured: *Delta Dental – PPO* Group # 4454-0001 *DeltaCare USA HMO* Group # 6434-0001	Same as insurance carrier See Certificate of Insurance
Group Vision Plan	Vision	Insured: *Vision Service Plan* Group # 12011288	Same as insurance carrier See Certificate of Insurance

Group Life and AD&D			
Group Life Insurance	Life	Insured: *The Hartford* Group # GL-402280 (for Life, Optional Life)	Same as insurance carrier See Certificate of Insurance
AD & D	Accident	Insured: *The Hartford* Group # GL-402280	See Certificate of Insurance
Long Term Disability			
Group Long Term Disability Insurance	Disability	Insured: *The Hartford* Group # GL-402280 (for Long-Term Disability)	Same as insurance carrier See Certificate of Insurance

Health and Dependent Care Flexible Spending Account			
Flexible Spending Account	Health and Dependent Care	Self-funded: *WageWorks*	

Contact Information		
Benefit Plan	**Phone Number**	**Website**
Anthem Blue Cross PPO	(877) 800-7339	*www.anthem.com/ca*
Anthem Blue Cross HMO	(877) 800-7339	*www.anthem.com/ca*
Kaiser Permanente HMO	(800) 464-4000	*http://my.kaiserpermanente.org/ca/lmu*
Delta Dental PPO	(800) 765-6003	*www.deltadentalins.com*
DeltaCare USA (HMO)	(800) 422-4234	*www.deltadentalins.com*
Vision Service Plan (VSP)	(800) 877-7195	*www.vsp.com*
WageWorks (FSAs)	(877) 924-3967	*www.wageworks.com*
The Hartford (Life Insurance)	(800) 563-1124	*www.thehartfordatwork.com*
The Hartford (AD&D)	(800) 563-1124	*www.thehartfordatwork.com*
The Hartford (LTD)	(866) 945-7801	*www.thehartfordatwork.com*
John Hancock (LTC)	(866) 511-3087	*http://lmu.jhancock.com* *(user name: lmu; password:mybenefit)*
MetLife (Voluntary Benefits)	(800) GET-MET8	*www.metlife.com/mybenefits*
ComPsych GuidanceResources (EAP)	(800) 327-1850	*www.guidanceresources.com* Company/organization ID: LOYOLA
Diversified (Retirement Planning)	(888) 676-5512	*www.divinvest.com*
LMU Human Resources Westchester Campus)	(310) 338-2723	*MYLMU (click on "QuickLinks/Human Resources")*
LMU Human Resources (Law School)	(213) 736-1128	*Law School intranet*

APPENDIX -- Employee Eligibility and Termination of Coverage

Employee Eligibility

In general, the insurance policies, certificates of coverage or other component plan benefit booklets describe who is eligible to participate, as well as the requirements for enrollment waiting periods, if any, and when coverage commences.

Notwithstanding any provisions of those booklets, to be eligible to participate in any component benefits under the Plan, at a minimum, you must be:

- A regular full-time LMU faculty member;
- A regular full-time Westchester staff member working at least 40 hours a week;
- A regular full-time Loyola Law School faculty member;
- A regular full-time Loyola Law School staff member working at least 35 hours a week; or
- A part-time regular faculty or staff member (defined as any position that is at least 50 percent full-time equivalent, 50 percent time and effort or greater) who has been previously enrolled in the LMU plans as a full-time regular:
  - *Staff member* for 12 months of continuous service immediately prior to changing status to part-time regular.
  - *Staff member* for 12 months of continuous service, for which "breaks between terms" count toward the 12 months of continuous service (e.g., staff with 9-, 10-, and/or 11-month assignment).
  - *Faculty member* for one complete academic year. For purposes of this policy, *full-time regular faculty* includes tenure, tenure-track, and clinical only.

Dependents eligible for certain benefits include:

- Your legal spouse;
- Your registered domestic partner;
- Your dependent children under age 26, who are not eligible to enroll in a plan offered by their own employer (under age 21, or under age 25 if a full-time student, for family AD&D insurance);

■ Your unmarried disabled children (Each insurance company has special rules for children with disabilities. Ongoing proof of disability is required.)

For more information about eligibility, contact Human Resources.

You must also complete and submit the applicable enrollment materials and satisfy any other enrollment requirements for the component benefit.

You are not eligible for coverage under any of the component plans under this Plan however, if you are (A) not reported on the Employer's payroll records, or (B) classified by the Employer as (i) an on call, temporary, seasonal or per diem employee, (ii) an independent contractor or other self employed individual, even if a court or administrative agency determines you to be a common law employee, (iii) a leased employee, or (iv) an employee included in a unit subject to collective bargaining unless the applicable collective bargaining agreement provides otherwise.

An employee generally is considered an active employee or actively at work for purposes of administering the benefits plans (including making eligibility determinations) referenced in this booklet if the employee is present and capable of carrying out the assigned job duties of the Employer. In addition, for purposes of enrollment determinations under a group health plan (other than the dental plan), employees who are absent from work due to a health factor will be considered actively at work.

Termination of Coverage

- The insurance policies, certificates of coverage or other component plan benefit documents describe when coverage terminates under the respective component benefit plans. Where applicable, however, you may be eligible to continue your coverage under COBRA or convert to individual coverage.
- In addition to the provisions above, your covered dependent's benefits terminate on the date that the person no longer meets the definition of dependent, or such later date provided under the applicable insurance policies, certificates of coverage or other component plan benefit booklets. The dependent may be eligible for continuation of coverage under COBRA or conversion coverage, as applicable.
- If any of the plans are discontinued, coverage under the terminated plan will terminate on the date the termination is effective.
- If you or your dependent(s) engage in fraudulent conduct or furnish LMU, a Claims Administrator or other service provider with fraudulent or misleading material information relating to claims or application for benefits, your coverage and that of your dependents may be adversely affected up to and including termination of your benefits, effective on the date you engaged in fraudulent conduct or furnished fraudulent misleading material information, whichever is applicable. You shall be responsible to pay LMU or the applicable carrier for the cost of previously received services, less any copayments made or fees paid for such services.

- If you permit the use of your or any other person's identification card by any other person; use another person's card; or use an invalid card to obtain services, your coverage shall terminate immediately. Any person or dependent involved in the misuse of an identification card will be liable to and must reimburse the Employer or the applicable carrier for the cost of services received through such misuse.

APPENDIX – Change in Status

While you are a member of the Plan, you usually will only be allowed to make changes to your elections during the annual Open Enrollment Period, unless you have a "Change in Status."

A Change in Status may allow you to enroll, cancel your membership in the Plan, or change the amount of your contribution. However, the change in your election must be consistent with the Change in Status. That is, the change must be on account of and correspond with a Change in Status that affects eligibility for coverage under this Plan, or another employer's plan.

Change in Status Defined

The following events are considered to be a Change in Status:

- A change in your legal marital status which results in a loss or gain of eligibility for coverage under this Plan or another employer's plan, including:
    - Marriage;
    - Change in certified domestic partnership status;
    - Divorce;
    - Legal separation;
    - Annulment; or
    - Death of your spouse
- A change in the number of your dependents, including:
    - Birth of your child;
    - Adoption;
    - Legal guardianship;
    - Placement of child with your for adoption or;
    - Death of a dependent
- A change in employment status for you, your spouse, certified domestic partner or dependent which results in a loss or gain of eligibility for coverage under this Plan or another employer's plan including:
    - Commencement of employment
    - Termination of employment;
    - A commencement of or return of unpaid leave of absence; or
    - A change in work schedules (part-time or full-time to part-time)

- A dependent satisfies or ceases to satisfy eligibility requirements which result in a loss or gain of eligibility for coverage under this Plan or another employer's plan.

- Certain changes in cost or coverage.

- Any other event that LMU, in its sole discretion, determines is a Change in Status consistent with IRS rules and regulations and guidelines.

Example 1: Your spouse's employer adopts a new health care plan which is less expensive than the LMU plan. This is not a qualified status change.

Example 2: You get a divorce and lose coverage under your ex-spouse's health policy. Can you obtain coverage under the LMU health plan? What about some optional life insurance? Divorce is a qualified status change and LMU health coverage to replace the lost health coverage is consistent with the status change. But the acquisition of optional life insurance is not consistent unless it replaces insurance lost as a result of the divorce.

Example 3: Prof A is returning from an unpaid leave and Prof B is leaving for an unpaid leave. Both have qualified status changes which would allow them to modify their elections.

Company Approval and Determination of the Change in Status

It is important to remember that having a Change in Status does not automatically mean that you may change your election. The IRS has strict guidelines about when mid-year election changes may be made. LMU, in its sole discretion, will determine if you have had a Change in Status and if a requested election change is "consistent" with the Change in Status and consistent with IRS rules, regulations and guidelines. LMU reserves the right to deny any change request that LMU, in its sole discretion, determines is not permitted or appropriate under IRS rules and regulations.

If LMU determines that you have had a Change in Status, but the election change you have requested is not "consistent" with the Change in Status, you will not be allowed to change your before-tax election until the next annual Open Enrollment Period, or special enrollment event, even though you have had a Change in Status.

If you anticipate that for some reason you may want to adjust your contribution amount or cancel your membership in the Plan during the next Plan Year, you should contact your Human Resources representative before making your election to determine if your situation will qualify as a Change in Status.

How to Make the Change Effective

Once a Change in Status occurs, you will have an opportunity to change your before-tax election to make adjustments to your membership that are "consistent" with the Change in Status.

You must make the change by completing and returning a signed enrollment/change form to your Human Resources representative within 31 days from the Change in Status. If you are covered under Healthy Family and lose coverage, you will have 60 days to enroll from the time you lose coverage.

Remember, the change to your election must be completed and returned within 31 days of your Change in Status. If the change to your election is not completed and returned within 31 days of your Change in Status, you will not be allowed to make the change until your next annual Open Enrollment Period.

When the Change is Effective

For information on when the change will be effective, refer to Human Resources or the applicable underlying insurance and benefit booklets.

APPENDIX – Leaves of Absence

Except as provided in the underlying insurance and benefit booklets, this section describes how your coverage will be continued during certain leaves of absence. ***Thus, to know whether you will be eligible to continue coverage during a leave of absence, you must review the terms of the applicable insurance policies, certificates of coverage or component plan benefit booklets.*** If you have any questions contact Human Resources.

■ Paid Leave of Absence

In addition to other options that may be available, if you take an approved paid leave of absence, and coverage under one or more component benefits is continued, such as under the Family and Medical Leave Act ("FMLA"), your scheduled payroll deductions will automatically continue during your leave. If your paycheck does not cover the amount of any regularly scheduled contribution during your leave, you may make an after-tax payment to make up the difference.

If the full amount of any regularly scheduled contribution is not made within thirty days after it was due, your coverage under the applicable component benefit options under the Plan will be terminated for the remaining period of your leave of absence, retroactive to the last day for which a required contribution was made. If you return to work from your leave of absence, your coverage will be automatically reinstated as described in the section "Reinstatement Upon Return From Leave" below.

■ Unpaid Leave of Absence

If you take an approved unpaid leave of absence, including leave under the FMLA, you may elect either to terminate your coverage and to stop making required contributions during your leave, or to continue your coverage and continue making your required contributions on an after-tax basis. If you elect to continue your Plan membership during your leave, your required after-tax contribution payments are due at the same time your payroll deductions would have been taken.

If the full amount of any regularly scheduled contribution is not made within thirty days after it was due, your coverage under the applicable component benefit options under the Plan will be terminated for the remaining period of your leave of absence, retroactive to the last day for which a required contribution was made, and you will not be eligible for reimbursement of any claims incurred while your coverage was terminated. If you return to work from your leave of absence, your coverage will be automatically reinstated as described in the section "Reinstatement Upon Return From Leave" below.

■ Family and Medical Leave Act

Notwithstanding any other provision of this Plan, if you take an approved leave of absence under the FMLA, coverage under the group health plans (health and dental and flexible spending account benefits) under this Plan will continue to be made available during such leave period to you and your covered dependents under the same terms and conditions that coverage was made available immediately prior to the commencement of the leave. Continuation of coverage also may be available for other component benefits under the Plan. Contact the Plan Administrator or Human Resources for more information.

If you elect to continue your coverage during such a leave period, you must continue to pay any required employee-portion of the cost of the level of coverage elected. Upon returning from an approved FMLA leave, coverage under the Plan will immediately resume regardless of whether you elected to continue coverage during the FMLA leave.

LMU Contributions. While you are on an FMLA leave, LMU will continue to make the same contributions toward the cost of coverage continued under the Plan that it would have made had you not taken such leave of absence. LMU will continue to do so until the earlier of the date that (a) you fail to return to work on the expiration of the FMLA leave, or (b) you voluntarily give notice of your intent to terminate employment. For these purposes, you are considered to "terminate employment" when you give oral or written notice of your intent not to return to work due to reasons within your control.

If you voluntarily terminate your employment due to reasons within your control at or before the end of the FMLA leave, LMU shall have the right to be reimbursed by you for any and all contributions LMU has made on behalf of you and your covered dependents during the leave. In this regard, LMU shall have the right to obtain reimbursement from any funds that LMU might otherwise owe you following your voluntary termination, including (but not limited to) (a) any regular or overtime wages, commissions, salary, or bonuses; (b) accrued vacation pay or sick leave pay; or (c) other sources. In addition, LMU shall have the right to pursue reimbursement in a court of law. Regardless of whether or not you return from an FMLA leave, LMU shall be entitled to recover from you any required employee contributions LMU has made on behalf of you and your covered dependents during the unpaid leave to ensure continuity of coverage.

LMU may not recover any of its regular LMU contributions made on behalf of you and your covered dependents for the time you had been on an FMLA leave if your failure to return to employment at the expiration or exhaustion of such leave is due to (a) the continuation, recurrence, or onset of a serious health condition that would entitle you to the FMLA leave; or (b) other circumstances beyond your control (as set forth in LMU's policies and procedures).

Covered Employee. As soon as administratively feasible after you qualify for an FMLA leave, the Plan Administrator shall give you the opportunity to choose in writing between continued coverage during the leave of absence, or suspending coverage for the leave's duration. If you choose ongoing coverage, you must continue to make the same premium payments or contributions that you were making immediately before the leave took effect, as described above.

The obligation to provide ongoing coverage under this Plan for you and your covered dependents on an FMLA leave, if any, ceases if you are more than thirty (30) days late on making a required premium payment; provided, however, that LMU may—at its option—cover your missed payments so that coverage will be uninterrupted. In this event, LMU's advances may be recovered in the event you voluntarily terminate your employment under circumstances within your control.

■ Military Leave (Health and Dental Plans)

LMU may grant a leave of absence to any employee due to military service in the Armed Forces of the United States in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA), and applicable state law. In general, during such a leave of absence under USERRA, you may be eligible to elect to continue group health plan coverage for yourself and your enrolled dependents (if any) for up to 24 months.

More specifically, if you are absent from work for more than 31 days in order to fulfill a period of duty covered by USERRA, you will be treated as having experienced a "qualifying event," as that term is defined under the Plan's COBRA continuation coverage provisions, see below, as of the first day of your the absence for such duty. This means that in addition to having the option to elect to continue coverage under COBRA, you will become eligible to elect continuation coverage under USERRA using procedures similar to those required by COBRA. The Plan Administrator or its designee will furnish you with a notice of the right to elect continuation coverage, which will include information about the premiums you will have to pay for such coverage. This notice will allow you the opportunity to elect such coverage for up to 24 months (so long as you continue to be on a leave of absence under USERRA) beginning on the date your USERRA leave commenced. Nothing in the Plan limits your right to continue your coverage under COBRA instead of under this section.

If qualified to continue coverage pursuant to USERRA, you may elect to continue coverage under the Plan by notifying the Plan Administrator and providing payment of any required contribution for the health coverage. The required contribution may include the amount we normally pay on your behalf, unless the period of coverage is fewer than 31 days. If you do not make an election within 60 days of being provided with the notice mentioned above, you will no longer be eligible to continue coverage under the Plan, except as required by USERRA.

If you elect to continue coverage under USERRA, the period of extended group health plan coverage shall run concurrently with the maximum continuation coverage period that may be available under COBRA. Regardless of whether you continue your health coverage, if you return to your position of employment in the time and manner required under USERRA, health coverage for you and your enrolled dependents (if any) will be reinstated under the Plan as required under USERRA. No exclusions or waiting period may be imposed on you or your enrolled dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

■ Reinstatement Upon Return From Leave

Except as provided above, if you elect to not continue your Plan membership during your leave, or if your Plan membership is terminated due to your taking a leave of absence, and you return to work when your leave ends (during the same Plan Year as when your leave commenced), your membership in the Plan will be automatically reinstated.

APPENDIX -- QMCSO Procedures

A "QMCSO" is a QUALIFIED MEDICAL CHILD SUPPORT ORDER that applies only to group health plans.

ERISA requires that, as part of a divorce action, a court, domestic relations magistrate or administrator can enter an order (a Medical Child Support Order or MCSO) which grants a child the right to receive health benefits under one of his parent's group health plans, regardless of whether the parent is the custodial parent of the child. However, to be valid or "qualified" (a "QMCSO"), the MCSO must meet certain statutory requirements which are identified below.

Upon receipt of a notice of a MCSO and request for coverage under the group health plan for one or more children of an employee or covered spouse, the following will occur:

- The Plan Administrator will send a letter acknowledging receipt of the MCSO. The letter will be sent to the Plan participant (the employee) and to each child affected by the MCSO.

  The Plan Administrator will review the MCSO to make certain that it:

  - was issued pursuant to a valid state domestic relations law;
  - specifically provides for a dependent (or dependents) to receive benefits under the group health coverage(s);
  - provides the name and last known mailing address of the employee (Plan participant) and each child covered by the MCSO;
  - provides a reasonable description of the coverage to be provided by the Plan(s) or the manner in which the coverage can be determined. The MCSO cannot require a Plan to provide any benefit or option that is not otherwise provided. If it does, it is not a qualified MCSO or "QMCSO";
  - specifies the time period to which the Order applies;
  - names each group health benefit to which the MCSO applies.

- You may be required to provide necessary identifying information about the child(ren), such as social security number(s), so that the Plan Administrator can comply with the requirements of the law.

- Upon completion of its review, the Plan Administrator will send a letter to the Plan participant (employee) and each affected child advising whether or not the MCSO has been determined to be a qualified MCSO (a "QMCSO").

- If the MCSO is determined to be qualified, each child affected is entitled to all reporting and disclosure requirements to which other Plan participants are entitled under ERISA. Any child affected by the MCSO is also permitted to designate a representative to receive copies of any notices regarding this matter or any coverage or benefits matters. Any such designation should be sent to the Plan Administrator.

APPENDIX -- COBRA Continuation Coverage

■ In General

It is important that all covered individuals take the time to read this information carefully and be familiar with its contents. If there is a covered dependent whose legal residence is not yours, please provide the covered dependent's name and address to the Human Resources Department so a notice can be sent to him or her as well.

Under federal COBRA law, most employers are required to offer covered employees and covered family members the opportunity for a temporary extension of health coverage (called "Continuation Coverage") at group rates when coverage under the health plan would otherwise end due to certain qualifying events. This section is intended to inform you (and your covered dependents, if any), in a summary fashion of your potential future options and obligations under the Continuation Coverage provisions of the COBRA law. Should an actual qualifying event occur in the future, the Plan Administrator will send you additional information and the appropriate election notice at that time. The information described in this section replaces any discussion of COBRA continuation coverage contained in the insurance certificate or benefit booklet and is only intended to provide COBRA continuation coverage to the extent required by law; provided however that if the plan provides coverage for certified domestic partners or same sex spouses, COBRA Continuation Coverage will be provided to the extent provided under the terms in the insurance certificate or benefit booklet.

■ Qualifying Events

*Qualifying Events for Covered Employee** – If you are the covered employee, you may have the right to elect COBRA Continuation Coverage if you lose your group health coverage because of a termination of your employment (for reasons other than gross misconduct on your part) or a reduction in your hours of employment.

*Qualifying Events for Covered Spouse** – If you are the covered spouse of a covered employee, you may have the right to elect COBRA Continuation Coverage for yourself if you lose group health coverage under your spouse's employer's group health plan(s) because of any of the following reasons:

- A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in his or her hours of employment with his employer.
- The death of your spouse.
- Divorce or, if applicable, legal separation from your spouse.
- Your spouse becomes entitled to Medicare.

*Qualifying Events for Covered Dependent Children** – If you are the covered dependent child of a covered employee, you may have the right to elect Continuation Coverage for yourself if you lose group health coverage under your parent's group health plan because of any of the following reasons:

- A termination of your parent's employment (for reasons other than gross misconduct) or reduction in his or her hours of employment with his employer.
- The death of your parent (the covered employee).
- Your parents divorce or, if applicable, legally separate.
- Your parent (the covered employee) becomes entitled to Medicare.
- You cease to be a covered dependent under the terms of the Plan.

* ***Important*** *– Required Employee, Spouse, and Dependent Notifications*. Under the law, covered individuals, including the employee, spouse, or other family member, have the responsibility to notify the Plan Administrator of a divorce, legal separation, or a child losing dependent status. This notification must be made within 60 days after the later of the date on which the qualifying event occurs or the date on which a qualified beneficiary loses or would lose coverage as a result of the qualifying event. You must provide this notice by mail or personal delivery to Loyola Marymount University, Attention Plan Administrator, One LMU Drive, Suite 1900, Los Angeles, CA 90045. This notice must identify: (i) qualified beneficiaries and their respective addresses, phone numbers and dates of birth, (ii) the qualifying event, (iii) the date the qualifying event occurred, (iv) include evidence supporting the occurrence of the qualifying event acceptable to the COBRA Administrator; and (v) the name of the plan under which you are losing coverage and the level of coverage at the time of the event. For example, in the case of a Social Security Disability, the notice must include a copy of the Social Security Administrator's determination of disability.

If notification is not completed according to the Plan Administrator's procedures and within the required 60-day notification period, then rights to Continuation Coverage will be forfeited. Carefully read the applicable dependent eligibility rules so you are familiar with when a dependent ceases to be a covered dependent under the terms of the applicable benefit.

■ Electing COBRA Coverage

Election Period and Coverage. Once LMU learns of a qualifying event, LMU will notify WageWorks the COBRA Administrator which will notify covered individuals (also known as qualified beneficiaries) of their rights to elect COBRA Continuation Coverage. Each qualified beneficiary has independent COBRA election rights and will have 60 days to elect Continuation Coverage. The 60-day election window is measured from the later of the date of COBRA notification on or after the qualifying event or the date coverage is lost. This is the maximum period allowed to elect COBRA. If a qualified beneficiary does not elect Continuation Coverage within this election period, then rights to continue coverage under the applicable Plan will end and he or she ceases to be a qualified beneficiary.

To elect Continuation Coverage, you must complete the applicable election form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect Continuation Coverage. For example, the covered employee's spouse may elect Continuation Coverage even if the covered employee does not. Continuation Coverage may be elected for only one, several, or for all covered dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any covered dependent children. The covered employee or his or her spouse can elect Continuation Coverage on behalf of all of the qualified beneficiaries.

APPENDIX – SPECIAL INFORMATION APPLYING TO GROUP HEALTH PLAN BENEFITS

In considering whether to elect Continuation Coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of Continuation Coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get Continuation Coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of Continuation Coverage if you get Continuation Coverage for the maximum time available to you.

If, during the election period, a qualified beneficiary waives Continuation Coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of Continuation Coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date that they are sent to the Plan Administrator, or its designee for COBRA administration.

■ Length of Continuation Coverage

18 Months. If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction in work hours, then each qualified beneficiary will have the opportunity to continue coverage for 18 months from the date of the qualifying event.

Extension for Social Security Disability. The 18-month coverage period described above may be extended for 11 months if you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of Continuation Coverage. To receive this extension, you must notify the Plan Administrator of the disability determination within 60 days after the latest of the following events: (i) the date of the Social Security Administration's disability determination; (ii) the date on which the qualifying event occurs; or (iii) the date coverage is or would be lost as a result of the qualifying event; provided the notice is not made later than your initial 18-month period of Continuation Coverage. You must provide this notice by mail or personal delivery to the COBRA Plan Administrator, WageWorks, P.O. Box 14055 Lexington, KY 40512-4055; Fax (877) 220-3249, and that notice must include all of the information, as applicable, described above in the paragraph entitled, "***Important*** *– Required Employee, Spouse, and Dependent Notifications*" under the "Qualifying Events" Section.

This extension applies separately to each qualified beneficiary. If the disabled qualified beneficiary chooses not to continue coverage, all other qualified beneficiaries are still eligible for the extension.

Note, it is also the qualified beneficiaries' responsibility to notify the Plan Administrator within 30 days if a final determination has been made that they are no longer disabled. In this case, you are required to notify the Plan Administrator of this change in disability status in the manner described above.

Extension for Secondary Events. Another extension of the 18-month or above mentioned 29-month continuation period can occur, if during the 18 or 29 months of Continuation Coverage, a second event takes place (divorce, legal separation, death, Medicare entitlement, or a dependent child ceasing to be a Covered Dependent). If a second event occurs, then the original 18 or 29 months of Continuation Coverage can be extended to 36 months from the date of the original qualifying event date for eligible dependent qualified beneficiaries. If a second event occurs, it is the qualified beneficiaries' responsibility to notify the Plan Administrator or its designee in writing by mail or personal delivery within 60 days of the second event and within the original 18 or 29-month COBRA timeline. You must provide this notice by mail or personal delivery to COBRA Plan Administrator WageWorks, P.O. Box 14055, Lexington, KY 40512-4055, Fax: (877) 220-3249, and that notice must include all of the information, as applicable, described above in the paragraph entitled, "***Important*** *– Required Employee, Spouse, and Dependent Notifications*" under the "Qualifying Events" Section.

In no event, however, will Continuation Coverage last beyond 36 months from the date of the event that originally made the qualified beneficiary eligible for Continuation Coverage. A reduction in hours followed by a termination in employment is not considered a second event for COBRA purposes.

36 Months. If the original event causing the loss of coverage was the death of the covered employee, divorce, legal separation, Medicare entitlement, or a dependent child ceasing to be a covered dependent child under the Plan, then each qualified beneficiary will have the opportunity to continue coverage for 36 months from the date of the qualifying event.

The maximum coverage period for a qualified beneficiary who is the spouse or dependent child of the retired covered employee ends 36 months after the death of the retired covered employee.

CAL-COBRA

If you are a California resident and your coverage is less than 36 months, you may be eligible for Cal-COBRA coverage. You generally will be notified if you qualify or contact the insurance carrier directly.

■ Coverage Options, Cost, and Timing of Payments

An Employer is required to provide the qualified beneficiary with coverage that is identical to the coverage provided under the Plan to similarly situated non-COBRA covered individuals. Should coverage change or be modified for non-COBRA covered individuals, then the change and/or modification will be made to your coverage as well.

If a qualified beneficiary elects Continuation Coverage, he or she will be required to pay the entire cost for the coverage, plus a 2% administration fee. Note that the cost for Continuation Coverage provided during the disability extension will increase to 150%. If you

elect Continuation Coverage, you must make your first payment for Continuation Coverage not later than 45 days after the date of your election. If you fail to make your first payment for Continuation Coverage in full before the end of the 45-day period following the date of your election, you will lose all Continuation Coverage rights under the Plan and COBRA.

After you make your first payment for Continuation Coverage, you will be required to make periodic payments for each subsequent coverage period. Under the Plan, each of these periodic payments for Continuation Coverage is due on the first day of the coverage period. However, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your Continuation Coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to Continuation Coverage under the Plan and COBRA.

■ Eligibility and Potential Conversion Rights

A qualified beneficiary does not have to show he or she is insurable to elect Continuation Coverage, however, he or she must have been actually covered by the Plan on the day before the qualifying event to be eligible for COBRA Continuation Coverage. An exception to this rule is if while on Continuation Coverage a baby is born to or adopted by a covered employee qualified beneficiary. If this occurs, the newborn or adopted child can be added to the Plan and will gain the rights of all other qualified beneficiaries. The COBRA timeline for the newborn or adopted child is measured from the date of the original qualifying event. Contact the COBRA Plan Administrator for the procedures and timelines for adding these individuals. The COBRA Plan Administrator reserves the right to verify COBRA eligibility status and terminate Continuation Coverage retroactively if you are determined to be ineligible or if there has been a material misrepresentation of the facts.

At the end of the 18, 29, or 36 months of Continuation Coverage, a qualified beneficiary must be allowed to enroll in an individual conversion health plan provided under the group health plan if an individual conversion plan is available at that time.

Special rules for qualified beneficiaries in a health flexible spending arrangements. COBRA continuation coverage under the Plan will be made available when coverage would otherwise end because of a qualifying event described above provided that:

- at the time of the qualifying event the covered employee was a participant in the Plan; and
- the remaining balance in the covered employee's account available for reimbursement under the Plan exceeds the amount of premium payments he or she would be required to make to such account for the remainder of the Plan Year in which the qualifying event occurred.

Note, however, that upon the occurrence of a qualifying event where the above conditions are satisfied, a qualified beneficiary may not establish a new account under the Plan under COBRA. Instead, as illustrated by the following examples, a qualified beneficiary may only elect COBRA continuation coverage in the account originally established by the covered employee.

Example 1: Assume Employee A is married and enrolled in the Plan, electing to contribute $1,200 to his account for 2009. As of July 31, 2009, Employee A made no requests for reimbursement under the Plan but has contributed $700 to his health flexible spending account (HFSA) through payroll deductions. Employee A's employment is terminated on July 31, 2009. Because Employee A experienced a qualifying event and because the amount available to Employee A under his HFSA ($1,200) is greater than the amount of premium contributions he would have to make for the remainder of the Plan Year ($500), COBRA continuation coverage will be made available for the remainder of the Plan Year.

If Employee A elects COBRA continuation coverage with respect to his HFSA, his spouse may continue to have her expenses reimbursed under the HFSA; however, she may not elect to establish her own account under the Plan.

Example 2: Using the same facts as in Example 1, if Employee A chooses not to elect to continue his HFSA coverage under COBRA, his spouse may elect to do so provided she makes a timely election and pays the applicable COBRA premiums. The same would also be true if Employee A died, for example, instead of being terminated from employment.

Notwithstanding anything contained in this notice, COBRA continuation coverage under the Plan may not continue beyond the end of the Plan Year in which the qualifying event occurred.

■ Early Termination of COBRA Continuation Coverage

COBRA Continuation Coverage will end prior to the maximum continuation period for any of the following reasons:

- LMU ceases to provide any group health plan to any of its employees.
- Any required premium for Continuation Coverage is not paid in a timely manner.
- A qualified beneficiary first becomes, after the date of COBRA election, covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary other than such an exclusion or limitation which does not apply to or is satisfied by such beneficiary by reason of the Health Insurance Portability and Accountability Act of 1996.

- A qualified beneficiary first becomes, after the date of COBRA election, entitled to Medicare.
- A qualified beneficiary extended Continuation Coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled.
- A qualified beneficiary notifies the COBRA Plan Administrator he or she wishes to cancel COBRA Continuation Coverage.
- For cause, on the same basis that the Plan terminates the coverage of similarly situated non-COBRA participants.

Notification of Address Change. To ensure all covered individuals receive information properly and efficiently, it is important that you notify the COBRA Plan Administrator and the COBRA Administrator of any address change as soon as possible. Your failure to do so may result in delayed COBRA notifications or a loss of Continuation Coverage options.

■ Any Questions?

Remember, this notice is simply a summary of your potential future options under COBRA. Should an actual qualifying event occur and it is determined that you are eligible for COBRA; you will be notified of your actual COBRA rights at that time. If any covered individual does not understand any part of this summary notice, or has questions regarding the information or his obligations, please contact the COBRA Administrator.

In addition, for more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

APPENDIX – Rules Regarding Use and Disclosure of Protected Health Information

■ Use and Disclosure of Protected Health Information

The Plan will use or disclose "Protected Health Information" (PHI) to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the regulations issued thereunder, as amended from time to time, including 45 CFR Parts 160 and 164, subparts A and E (HIPAA Privacy Rule) and 45 CFR Parts 160 and 164, subpart C (HIPAA Security Rule).

■ Use and Disclose PHI as Permitted by Authorization of the Participant or Beneficiary

As soon as practicable following the receipt of an authorization from a participant or his or her duly appointed personal representative, the Plan will disclose PHI in accordance with the authorization.

■ Disclosure to the Employer

Upon request of the Employer, the Plan will disclose summary health information and enrollment and disenrollment information to the Employer as permitted pursuant to Section 164.504 of the HIPAA Privacy Rule.

The Plan will disclose PHI other than summary health information and enrollment and disenrollment information for purposes related to "plan administration," "treatment," "payment" and "health care operations" as described above to the Employer only upon receipt of a certification from the Employer that the applicable Plan documents have been amended to incorporate the provisions set forth in the remaining sections of this Appendix.

To receive PHI as described in the preceding paragraph, the Employer shall certify to the Plan that it agrees to

- not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the Plan;
- ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;
- not use or disclose PHI for employment-related actions and decisions unless authorized by the individual that is the subject of the PHI or his or her duly appointed personal representative;

- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;
- report to the Plan any security incident, as defined under the HIPAA Security Rule, or any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
- if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made. Where the return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction not feasible.

■ **Adequate Separation Between the Plan and the Employer Must Be Maintained**

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

- Privacy Officer
- Designated members of the Human Resources, Payroll and Accounting Departments.
- Designated members of the Information Technology Department.
- Designee(s) of the Privacy Officer.

The persons described in this section may only have access to and use and disclose PHI for the purposes described above.

If the persons described in this section do not comply with this plan document, the Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

APPENDIX – Claims and Appeals Procedures

■ Application

Except to the extent a component benefit plan provides for more stringent procedures in reviewing a claim or reviewing an adverse determination of a claim, the procedures outlined below will apply.

■ Summary

The following tables summarize important deadlines involved in resolving claims for benefits or requesting reviews of adverse determinations.

Initial Claims

	Health Benefits			*Disability Benefits*	*Other Benefits (e.g., Life Insurance)*
Claims Procedure	*If your claim is for Urgent Care*	*If your claim is for a service not yet incurred*	*If your claim is for a service that you have received*	*If your claim involves a disability determination*	*If you make a claim for benefits*
Time Claims Administrator has to advise you of its initial determination	***24 hours***	***15 days***	***30 days***	***45 days***	***90 days***
Extension of time by Claims Administrator to respond	***Not permitted***	***15 days, one time only***	***15 days, one time only***	***30 days, two times only***	***90 days, one time only***
Time Claims Administrator has to notify you if your claim is defective	***24 hours***	***5 days***	***N/A***	***N/A***	***N/A***
Amount of time you then have to perfect a defective claim	***48 hours***	***45 days***	***45 days***	***45 days***	***N/A***

APPENDIX – SPECIAL INFORMATION APPLYING TO GROUP HEALTH PLAN BENEFITS

Appeals of Adverse Determinations

	Health Benefits			*Disability Benefits*	*Other Benefits (e.g., Life Insurance)*
Appeals Procedure	*If your claim is for Urgent Care*	*If your claim is for a service not yet incurred*	*If your claim is for a service that you have received*	*If your claim involves a disability determination*	*If you appeal a prior adverse determination*
The time to submit your appeal following receipt an adverse claim determination	***180 days***				***60 days***
Time Claims Administrator has to advise you of its determination regarding your appeal	***72 hours***	***30 days***	***60 days***	***45 days***	***60 days***
Extension of time by Claims Administrator to respond to your claim	***Not permitted***	***Not permitted***	***Not Permitted***	***45 days, one time only***	***60 days, one time only***

APPENDIX – SPECIAL INFORMATION APPLYING TO GROUP HEALTH PLAN BENEFITS

All Plans

■ Filing Claims for Benefits

Contact the Claims Administrator and the applicable benefit booklets for copies of a claim form and instructions on how to file.

You may file any claim yourself, or you may designate another person as your "authorized representative" by notifying the Claims Administrator in writing of that person's designation. In that case, all subsequent notices will be provided to you through your authorized representative and decisions concerning that claim will be sent to your authorized representative.

Special Note For Urgent Care Claims— If your claim involves urgent care, you may initiate a claim for urgent care benefits yourself if you are able or your treating physician may file the claim for you. The claim may be made by telephone, U.S. Mail, hand delivery, facsimile, or as an attachment to electronic mail. If your claim is filed by telephone, you will be responsible for completing any follow-up paperwork the plan may require in support of your claim.

■ Changes in the Law

The Patient Protection and Affordable Care Act as amended by the Health Care and Education Affordability Reconciliation Act of 2010 and subsequent guidance issued by the Internal Revenue Service, Department of Labor and Health and Human Services have left the area of claims and appeals in a period of transition. Beginning in 2012, new rules regarding claims and appeals, including rules governing internal and external reviews when benefits are denied, will take effect. Accordingly, for current procedures regarding the filing of claims and appeals, please see the most current evidence of coverage booklet provided by your plan provider.

APPENDIX – Required Notices (Group Health Plans Only)

■ Women's Health and Cancer Rights Act of 1998

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). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

APPENDIX – SPECIAL INFORMATION APPLYING TO GROUP HEALTH PLAN BENEFITS

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the applicable component benefit. Refer to the insurance certificate or benefit booklet for information on the deductibles and coinsurance that apply.

If you would like more information on WHCRA benefits, call your Plan Administrator at: 818-876-1389.

■ Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

■ Notice of HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after you or your dependents' coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself or your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

You also may have special enrollment rights under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). These rights occur when an employee or dependent child –

- loses eligibility for coverage under Medicaid or a State Children's Health Insurance Program (acronym "CHIP," for children whose families do not qualify for Medicaid); or

- becomes eligible for premium assistance from Medicaid or CHIP allowing him or her to enroll in a group health plan.

However, you must request enrollment within 60 days after the date of coverage loss or eligibility for Medicaid or CHIP premium assistance, whichever applies.

APPENDIX – SPECIAL INFORMATION APPLYING TO GROUP HEALTH PLAN BENEFITS

To request special enrollment or obtain more information, contact the Plan Administrator at Loyola Marymount University, Attention Plan Administrator, One LMU Drive, Suite1900, Los Angeles, CA 90045.

■ Notice for Pre-existing Condition Exclusion Limitation

The underlying group health plan benefit may impose pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might to have to wait a certain period of time before the medical plan benefit will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy, nor to a child who is enrolled in the plan within thirty days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months from your first day of coverage, or, if you are in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

If you have any questions about the pre-existing condition exclusion and creditable coverage, or you would like to request a certificate of creditable coverage, you should contact the Plan Administrator at Loyola Marymount University, Attention Plan Administrator, One LMU Drive, Suite 1900, Los Angeles, CA 90045 or call (310) 338-2723.