LOYOLA UNIVERSITY MARYLAND
HEALTH & WELFARE BENEFIT PLAN
WRAP SUMMARY PLAN DESCRIPTION

Loyola University Maryland
4501 North Charles Street
Baltimore, MD 21210

Loyola University Maryland Health & Welfare Benefit Plan

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Plan Administrator:

Loyola University Maryland
c/o Director of Benefits and Wellness Programs
4501 North Charles Street
Baltimore, MD 21210
410-617-1366

Agent for Service of Legal Process:

Loyola University Maryland
4501 North Charles Street
Baltimore, MD 21210
410-617-1366

Service of legal process may also be made upon the Plan Administrator.

Plan Administration:

Unless otherwise indicated in the Appendix, Component Programs available under the Plan are administered by Insurers who provide and guarantee the benefits. Certain self-insured Component Programs may be administered by the Plan Administrator (or a third-party administrator as may be designated by the Plan Administrator).

For Component Programs providing for benefits through insurance contracts, responsibility for administration of the Component Program resides with the respective Insurer, which includes administering claims, determining entitlement to and amount of benefits, authorizing payment of benefits, and conducting review of denied or modified claims. An Insurer has discretion to decide matters of fact and interpret Plan provisions as they relate to the Component Program it administers.

The Plan Administrator shall have sole discretion to determine eligibility for any Component Program under the terms of the Plan.

Claims Administrators:

for an Employee

rights under HIPAA. A complete description of your rights under HIPAA can be found in the Plan's Privacy Notice or, if appropriate, in the privacy notice provided by the Insurer. To obtain a copy of the Insurer's privacy notice, contact the Insurer. Questions or complaints about the privacy of health information should be directed to the Plan Administrator.

SPECIAL ENROLLMENT RIGHTS

If an Employee declines enrollment for themself, their Spouse or Dependents because of other health insurance or group health plan coverage, an Employee may be able to enroll themself and their Spouse and Dependents in this plan if an Employee or their Spouis7eau-t9(ct)0.3(n1 Tw 0S6d2J 0 Tce -0.001 Tc 0)s7( )]TJ 0.006 Tw [(a)-7.8(n)]TJ 0.006 Tc -0.006 .004 Tw

If a Component Program available under this Plan contains provisions regarding coordination of benefits with State Medicaid Programs, the language in the written materials for such Component Program will govern unless the language fails to comply with applicable laws and regulations.

SPECIAL RULES FOR MATERNITY AND INFANT COVERAGE

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 attending provider or physician, after consulting with the mother, from discharging the mother or her newborn earlier than

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

Benefits during a period of military leave must be as generous as benefits available to similarly situated employees on other employer-approved leaves of absence (e.g., family and medical leave).

COBRA COVERAGE

You (or your Spouse or dependent child, if applicable) will then be notified of the right to elect continuation health coverage and the cost to do so. The deadline for electing continuation health coverage is 60 days after the date the Plan ceases to cover you or your Spouse or dependent child, or 60 days from the date you, your Spouse, or dependent child are notified of your COBRA election rights, whichever is later.

If you (or your Spouse or dependent children, if applicable) do not elect continuation coverage, your health coverage will stop. If you (or your Spouse or dependent children, if applicable) choose continuation health coverage, the Plan will provide health coverage identical to that available to similarly situated active employees, including the opportunity

- You (or your Spouse or dependent child, if applicable) fail to pay the premium within 30 days after its monthly due date;
- You (or your Spouse or dependent child, if applicable) become covered, after the date of your COBRA election, under another group health plan, including a governmental plan, that does not contain any exclusion or limitation with respect to any preexisting condition of such qualified beneficiary (other than an exclusion or limitation that may be disregarded under the law);
- You (or your Spouse or dependent child, if applicable) become entitled to Medicare after the date of the COBRA election;
- You (or your Spouse or dependent child, if applicable) have extended continuation coverage due to a disability and then you are determined by the Social Security Administration to be no longer disabled;
- The maximum required COBRA continuation period expires; or
- For such cause, such as fraudulent claim submission, that would result in termination of coverage for similarly situated active employees.

In order to protect your family's rights, you should keep the Plan Administrator/COBRA Administrator informed of any changes in the addresses of your family members. You should also keep a copy of any notices you send the Plan or COBRA Administrator.

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Additional continuation rights may apply under state law. Please contact the Plan Administrator for further information.

CLAIMS PROCEDURES FOR THE PLAN

Claims for benefits under each Component Program that is either insured or self-insured will be reviewed in accordance with procedures contained in the Certificate for the particular benefit option provided by the Insurer or by the Third Party Administrator specified in the Certificate. In the event that the Certificate does not specify the manner in which claims are to be made, the following procedure will apply. All other general claims or requests should be directed to the Claims Administrator. If a claim under the Plan is denied in whole or in part, Claims Administrator will notify you or your beneficiary in writing of such denial within 90 days of receipt of the claim. (This period may be extended to 180 days under certain circumstances.) The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after receipt of a notice of denial, you or your beneficiary may submit a written request for reconsideration of the application to the Claims Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Claims Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended to 120 days under certain circumstances.) In the response, the Claims Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Claims Administrator has the exclusive right to interpret the provisions of the Plan. Decisions of the Claims Administrator are final, conclusive and binding.

CLAIMS PROCEDURE FOR BENEFITS BASED ON DISABILITY DETERMINATION

The following claims procedures shall apply specifically to claims made for disability benefits under one or more Plan features, including any rescission of disability coverage under such Plan features with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that

(iii) demonstrates compliance with the administrative processes and safeguards designed to ensure and verify that benefit determinations are made in accordance with governing plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants; or

(iv) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relieu(w)22.2(h) -0.001 <</Attached [s 99(a)Tj EMC /LBody6.3252 10.08 11.75-0.00l

- a statement describing the Plan's optional appeals procedures, and your right to receive information about such procedures, as well as your right to bring a lawsuit under Section 502(a) of ERISA and any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;
- the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency;" and
- a discussion of the decision, including, an explanation of the basis for disagreeing with or not following:
  - (i) the views presented by the health care professionals treating you and vocational professionals who evaluated you;
  - (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - (iii) a disability determination regarding you presented by you to the Plan made by the Social Security Administration;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, aliera5fic a8fie32.9(o)-eyj.c812.9q e

information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Care Claims

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition could cause severe pain. In these situations:

- you will receive notice of the benefit determination in writing or electronically as soon as possible, but not later than 72 hours after the Claims Administrator receives all necessary information, or such other timeframe as required under federal law, taking into account the seriousness of your condition.
- notice of denial may be oral with a written or electronic confirmation to follow within 3 days.
- if you filed an Urgent Care Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- the Claims Administrator's receipt of the requested information; or
- the end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided as soon as

- in the case of an Urgent Care Claim, a description of the expedited review process to which you may be entitled.

In addition to the notice standards described above, to the extent required by the Affordable Care Act, all adverse benefitdetermination notices will include the following: (a) information identifying the claim involved, including the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code, and the corresponding meaning of those codes; (b) the reason or reasons for the adverse benefit determination that includes the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used to deny the claim (for notices of final internal adverse benefit determinations, the description will include a discussion of the decision); (c) a description of available internal appeals and external review processes, including how to initiate an appeal; and (d) contact information fo any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist individuals with the internal claims and appeals and external review processes.

How to Appeal a Claim Decision

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- patient's name.
- plan identification number.
- date(s) of health care service(s).
- provider's name.
- reason(s) you believe the claim should be paid.
- documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.
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If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision.

Please note that the Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

Urgent Care Claim Appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- the appeal does not need to be submitted in writing. You or your doctor should call the Clal5tThe dd ca 7-1.1
- the Claims Administrator will provide you with a written or electronic determination asoon as possle, (d c)4.2(a

Appeal Deterination Notice

PLAN AMENDMENT OR TERMINATION

The Employer expects to maintain the Plan indefinitely but reserves the right to amend or terminate the Plan if the Employer believes the situation so requires. If you have elected to participate in the Plan, you will be notified in writing if there is any significant amendment or if the Plan is terminated. If the Plan is terminated, the Employer will cease deducting contributions from your salary to pay for Component Programs. However, all previous salary deductions will be used to pay for Component Programs that you have elected.

CIRCUMSTANCES THAT MAY CAUSE LOSS OF BENEFITS

The Plan contains numerous restrictions on the type and amount of benefits payable and the circumstances when paid. You should review the benefits booklets and other relevant materials for further information. You may lose coverage

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Plan Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, and your Spouse and Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Spouse or Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

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 Plan 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 accordance with the terms of the Plan. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court in accordance with the terms of the Plan. 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 in accordance with the terms of the Plan. 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

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