



Xavier University of Louisiana

Employee Benefits Guide

01/01/2010-12/31/2010



As a valued Xavier University of Louisiana employee, you are eligible for a comprehensive benefit package. This booklet contains valuable information about each of the benefits offered. You'll also find several important notices enclosed that Xavier University of Louisiana is required to distribute annually.

Important: Please note that the Medicare Part D notice is included in this packet on page 13.

Medical

Dental

Vision

**Transamerica
Cancer Plan**

Life/AD&D

LTD

**403(b) &
Supplemental
Retirement**



— Important Carrier Contact Information —

Refer to this list when you need to contact one of your benefit vendors. For general information contact Human Resources.

MEDICAL INSURANCE: _____ PG 3

Humana Health Care
Customer Service: (866) 427-7478
www.humana.com

DENTAL INSURANCE: _____ PG 5

Humana Dental
Customer Service: (800) 233-4013
www.humanadental.com

VISION INSURANCE: _____ PG 6

Humana Vision
Customer Service: (800) 233-4013
www.humanavisioncare.com

CANCER INSURANCE: _____ PG 7

Transamerica Worksite Marketing
Customer Service: (888) 763-7474
www.transamericaworksite.com

DISABILITY: _____ PG 7

The Standard
Long-Term Disability Customer Service: (800) 368-1135
www.standard.com

LIFE INSURANCE: _____ PG 8

The Standard
Life Insurance Customer Service: (800) 628-8600
www.standard.com

RETIREMENT/403(B) & SUPPLEMENTAL RETIREMENT PLANS: _____ PG 8

TIAA CREF
Customer Service: (800) 842-2776
www.tiaa-cref.org/xula

FLEXIBLE SPENDING ACCOUNTS: _____ PG 9

Ceridian
Customer Service: (877) 799-8820
www.ceridian-benefits.com



— Medical Insurance —

**NOTE: Medical insurance is effective
the first day of the month following hire as an
eligible full or part time faculty or staff member.**

Medical

Effective January 1, 2010, Humana Health Care will continue to be the medical insurance provider for Xavier University of Louisiana. The following chart summarizes the benefits of your medical plan. This plan is an “Open Access” plans (no referrals required). You have in and out of network benefits, but you will increase your savings by using in-network providers. A list of participating physicians can be found at www.humana.com.

Services	Humana Health Care Plans	
	Base Plan	Enhanced Plan
Physician Visit -Primary Care Doctor -Specialist	\$30 Copay \$40 Copay	\$25 Copay \$35 Copay
Deductible -Individual -Family	\$1,000 \$2,000	\$250 \$500
Hospitalization - Inpatient - Outpatient	Deductible + 0% Deductible + 0%*	\$300 Copay per admission Deductible + 0%*
Preventive Care	\$30 Copay (Office Visit)	\$25 Copay (Office Visit)
Diagnostic Lab & X-Ray - Provided in Physician’s Office - Provided in Other Settings	Covered at 100%* Covered at 100%*	Covered at 100%* Covered at 100%*
Emergency Room	\$100 Copay	\$100 Copay
Out of Pocket Max -Individual -Family	N/A N/A	N/A N/A
Prescription Drugs Retail -Tier 1 -Tier 2 -Tier 3	\$15 Copay \$30 Copay \$50 Copay	\$10 Copay \$25 Copay \$40 Copay
Out of Network Benefits -Deductible -Coinsurance -Out of Pocket Max	\$3,000/\$6,000 70% \$6,000/\$12,000	\$500/\$1,000 70% \$6,000/\$12,000
Lifetime Maximum	\$5,000,000	Unlimited

*Outpatient advanced imaging (PET, MRI, CAT, SPECT) is subject to the deductible, then covered at 100%

Base Plan Premiums for Medical Coverage (Per Paycheck)

Premium	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Monthly	\$61.00	\$297.85	\$174.49	\$411.35
Bi-weekly	\$30.50	\$148.92	\$87.24	\$205.68

Enhanced Plan Premiums for Medical Coverage (Per Paycheck)

Premium	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Monthly	\$80.42	\$392.68	\$230.04	\$542.32
Bi-weekly	\$40.21	\$196.34	\$115.02	\$271.16



Medical Plan – Dual Option Frequently Asked Questions

What are the major differences between the Base Plan and the Enhanced Plan?

- Diagnostic testing, lab work and x-rays associated with your doctor's visit (excluding advanced imaging) are covered at 100% after your office visit copay on both plans.
- The major categories of coverage where differences exist between the two plans:
 - Office Visit Copays
 - Visits are subject to copays and then covered at 100% on both plans
 - However, the Enhanced Plan copays are \$25 for a Primary Care Doctor visit and \$35 for a Specialist Doctor visit
 - The Base Plan copays are \$30 for a Primary Care Doctor visit and \$40 for a Specialist Doctor visit
 - Prescription Drug Copays
 - Both plans have copays for prescriptions dispensed by network pharmacies
 - However, the Base Plan has slightly higher copays
 - Inpatient Hospital Procedures
 - Subject to a \$300 Copay per admission and then covered at 100% on the Enhanced Plan
 - Subject to deductible (\$1,000 for an individual) and then covered at 100% on the Base Plan
 - Outpatient Hospital Procedures
 - Subject to the deductible and then covered at 100% on both plans
 - However, the deductible on the Enhanced Plan is \$250 for an individual and is \$1,000 for an individual on the Base Plan
 - Advanced Imaging (MRI, CAT, PET, and SPECT tests)
 - Subject to the deductible and then covered at 100% on both plans
 - However, the deductible on the Enhanced Plan is \$250 for an individual and is \$1,000 for an individual on the Base Plan
 - Out of Network Benefits
 - Both plans have benefits for services provided by non-network physicians and hospitals
 - However, the Base Plan has a higher deductible if you choose to receive services out-of-network
 - Lifetime Maximum
 - Unlimited on the Enhanced Plan
 - \$5,000,000 on the Base Plan
- The other major difference between the plans is the cost to you through payroll deduction. You will notice that the Base Plan offers a reduction in the premiums that you are paying today and has only slight changes from the coverage you currently enjoy for the most frequently utilized benefits.

Can I choose different plans for each of my family members?

You may only choose one plan option for your entire family.

Can I change plans mid-year?

Take your plan decision very seriously as you will be unable to move to a different plan until next year's open enrollment. You will be locked into your plan choice for the full coverage year.

PLEASE NOTE: It is YOUR responsibility to provide the Office of Human Resources proof of full-time student status once your child reaches age 21. If this information is not provided, coverage will end and claims will be denied. Likewise, you must notify the Office of Human Resources immediately if your child loses his/her full-time student status as he/she will become ineligible for the plan. Full-time students are eligible for coverage through age 24.



— Dental Insurance —

**NOTE: Dental insurance is effective
the first day of the month following hire as an
eligible full or part time faculty or staff member.**


Dental

Effective January 1, 2010, Humana Dental will be the new dental insurance provider for Xavier University of Louisiana. This dental plan allows you to seek treatment from the dentist of your choice. However, if you use a network dentist, you will not be responsible for any amounts charged over “Reasonable and Customary.” A list of participating dentists can be found at www.humanadental.com.

Humana Dental Plan	
Services	Amount You Pay
Preventive Services	Exams, cleanings, x-rays, perio cleanings – 100% coverage
Deductible	Applies to Basic and Major services only – \$50 per person (per calendar year)
Basic Services	Fillings, extractions – you pay 20% after deductible
Major Services	Gum disease, root canal, crowns, inlays, onlays, bridges, dentures – you pay 30% after deductible
Annual Maximum	The plan pays a maximum of \$2,500 per year per covered person
Orthodontia	\$2,500 lifetime maximum (dependent children under age 21 only)

Premiums for Dental Coverage (Per Paycheck)

Premium	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Monthly	\$27.93	\$55.80	\$59.06	\$92.48
Bi-weekly	\$13.97	\$27.90	\$29.53	\$46.24



Benefits Tip: You may set aside pre-tax dollars in a Flexible Spending Account to pay for health care related expenses such as dental work, deductibles, vision exams, over-the-counter medications and much more! See the “Flexible Spending Accounts” section on page 9 of this guide for additional information.



— Vision —

NOTE: Vision insurance is effective the first day of the month following hire as an eligible full or part time faculty or staff member.

Vision

Effective January 1, 2010, Humana Vision Care will be the new vision insurance provider for Xavier University of Louisiana. This vision plan includes discounts on exams and the purchase of eyeglasses, contact lenses and other prescription eyewear when provided by Spectera’s participating physicians. A list of network providers can be found at www.humanavisioncare.com.

Humana Vision Care Plan	
Services	Amount You Pay
Vision Screening/Exam	\$10 Copay – allowed once every 12 months
Lenses and Frames	\$25 Copay* – allowed new lenses once every 12 months, new frames once every 24 months

*Frames have a \$100 retail allowance at retail chain providers. In lieu of spectacle lenses and frames, a \$115 allowance is provided for contact lenses (for contacts outside of covered-in-full selection).

Premiums for Vision Coverage (Per Paycheck)

Premium	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Monthly	\$5.29	\$10.05	\$10.58	\$15.87
Bi-weekly	\$2.65	\$5.03	\$5.29	\$7.94

— **Transamerica Cancer Insurance** —
“Available Only at Open Enrollment”

Cancer Coverage

Cancer isn’t something we like to think about, but for 1 in 2 men and 1 in 3 women it will be a reality at some point in life. You are being offered a policy that pays benefits directly to you, in addition to any other coverage, in the event that you are diagnosed and treated for cancer. Apply now to begin coverage with Transamerica. The policy is yours individually and is fully portable. You have two plans to choose from:

	Benefits*	
	Plan 1	Plan 2
First Occurrence Benefit <i>(One time benefit)</i>	\$1,000	\$2,000
Radiation/Chemotherapy <i>(Once per 12 months)</i>	\$10,000	\$20,000
Experimental Treatment	\$10,000	\$20,000

*Brief summary of services and benefits. Please refer to the brochure for full details

Plan 1 Premiums for Cancer Coverage (Per Paycheck)

Premium	Individual	Single-Parent Family	Family
Monthly	\$17.14	\$19.39	\$31.01
Bi-weekly	\$8.57	\$9.70	\$15.51

Plan 2 Premiums for Cancer Coverage (Per Paycheck)

Premium	Individual	Single-Parent Family	Family
Monthly	\$31.10	\$35.27	\$56.41
Bi-weekly	\$15.55	\$17.64	\$28.21



— **Long-Term Disability Insurance** —

Long-Term Disability Insurance

Full-time regular staff and faculty and eligible part-time faculty, who have completed one year of employment, are eligible for this benefit. Eligible full-time employees who have a disabling illness or injury must complete a three-month waiting period before receiving payments from this benefit. This benefit is 100% employer paid – provided at no cost to you. Please refer to the summary plan description or contact the Human Resources department for specific information.



— Life Insurance —

Life Insurance (Basic)

Xavier University of Louisiana provides basic life insurance to eligible full and part-time staff and faculty. This benefit is provided at no cost to the employee and the amount of insurance is equivalent to one time the employee's annual salary. Please contact the Human Resources Department for specific information. An employee must complete an enrollment form and designate his or her beneficiary (ies).

If you need to update your life insurance beneficiary, please obtain a Beneficiary Designation Form from Human Resources. It is important that you keep this information current. You may update/change your beneficiary at any time.

Life Insurance (Voluntary)

In addition to the basic life insurance plan, full-time and eligible part-time staff and faculty may elect to participate in a voluntary life insurance plan. Insurance may be purchased for the employee, spouse and eligible dependent children. Specific information about voluntary life insurance is available from the Human Resources Department. This benefit is paid entirely by the employee through payroll deduction.



— Retirement/403(b) Plan — TIAA-CREF

Note: Upon eligibility it is the responsibility of the employee to inform the Office of Human Resources of any special enrollment circumstance that may waive the two year waiting period for the employer match.

Retirement/403(b) Plan & Supplemental Retirement Annuity (SRA) TIAA –CREF

To help you prepare for the future, Xavier University of Louisiana sponsors a 403(b) Plan through TIAA CREF as part of your benefits package. Full-time employees who are at least 21 years of age are eligible to join this tax deferred annuity plan (subject to Section 403(b) of the Internal Revenue Code) after two years of employment with Xavier University. You may elect to contribute a maximum of \$16,500 per year from your pay to be set aside for 403(b) contributions. Xavier University of Louisiana will match employee contributions up to 6%. You may receive this match immediately if you have completed two years of employment as a regular or part-time faculty or staff member at another institution of higher learning. If you have been working at the University for 15 years, you may contribute an additional \$3,000 in 2010. If you are age 50 or older, you may contribute an additional \$5,500 in 2010. You must enroll to activate your account before any amounts will be contributed to the 403(b).

The University also offers a Supplemental Retirement Annuity (SRA). The University does not match contributions to this account. This account may not exceed the IRS legal limit of \$16,500 combined with the TIAA CREF Retirement. Specific information about the retirement plans may be found in the summary plan description, which is available from the Human Resources Department.

— Flexible Spending Accounts —



Flexible Spending Accounts

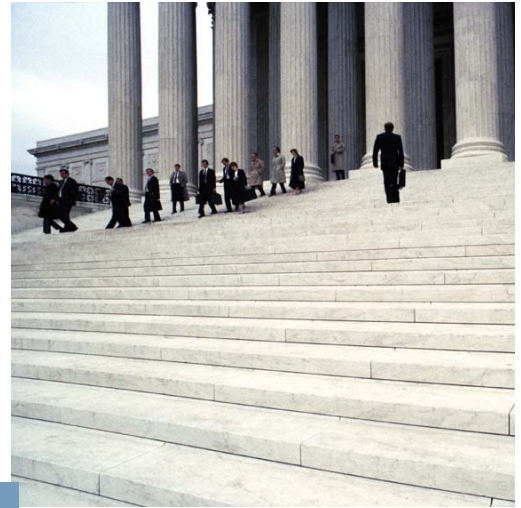
As an employee of Xavier University of Louisiana, you are eligible to set aside money from your paycheck on a pre-tax basis for health care and dependent care expenses. The plan, administered by Ceridian, requires eligible employees to complete a new election form each year. You can elect to contribute up to \$2,500 per year for the Medical Expense Reimbursement Account and/or up to \$5,000 in the Dependent Care Expense Account. For additional information, call (877) 799-8820 or visit www.ceridian-benefits.com.

Important Points to Remember about Flexible Spending Accounts:

- Pre-tax elections are irrevocable for the plan year. In other words, a participant ordinarily may not change an election mid-year unless a participant has a qualifying event (marriage, divorce, birth, death, loss of other coverage, etc).
- Funds allocated to the Flexible Spending Accounts must be used during the Plan Year, otherwise the money will be forfeited. The Plan Year is from January 1st through December 31st.
- Participants must submit claims for expenses that were incurred in the Plan Year by March 31st following the end of the Plan Year.

Legislative Brief

Women's Health and Cancer Rights Act of 1998



When is the law effective?

The law applies to plan years beginning on or after October 21, 1998. Health plan benefits established under a collective bargaining unit may be modified to comply with this law. This amendment shall not be treated as a termination of the collective bargaining agreement.

Who must comply with this law?

The law applies to ERISA group health plans, state and local government plans, individual plans, and health insurers.

What if my state also has a law regarding breast reconstruction benefits?

This federal law does not preempt any state law in effect on or before October 21, 1998 if the state law requires at least the level of coverage as provided by the Women's Health Act.

What coverage is required?

Plans that provide medical and surgical benefits for a mastectomy shall also provide coverage for:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prosthesis and treatment of physical complications in all stages of mastectomy, including lymphedemas.

Coverage is determined by the health plan in coordination with the physician and patient.

May a health plan apply a deductible or charge a copayment for breast reconstruction benefits?

Yes. Breast reconstruction surgery benefits may be subject to an annual deductible or coinsurance provision if it is consistent with the cost-sharing measures imposed on other similar benefits under the plan.

What notices are required?

1. Initial Notice
A one-time notice must be furnished as part of the first general mailing made after October 21, 1998 or in the yearly informational packet sent out regarding the plan, but in no event can the one-time notice be furnished later than January 1, 1999.
2. At Enrollment
Notice must be provided to participants upon enrollment in the plan.
3. Annually
A notice must be provided annually to participants under the plan.

Legislative Brief

Women's Health and Cancer

Rights Act of 1998

If notice is provided to a participant at the time of enrollment, does the annual notice also have to be provided again during the year?

No. If a plan or health insurer provides appropriate notice to a participant upon enrollment in the plan, then the plan does not have to provide another notice to that participant during the year.

Must the notice be provided separately?

No. The Department of Labor recently indicated that the annual notice provided in open enrollment materials can serve to satisfy the annual notice requirement. The annual notice can also be provided in a company newsletter.

How must the annual notice be delivered?

Notices must be sent in a manner reasonably calculated to ensure actual receipt and the notice must be sent by a method likely to result in full distribution. For example, the notice may be provided by first-class mail or via e-mail.

Who must provide the notice?

A group health plan or an insurance company must provide the notice. For insured plans, the insurer can provide the notice. The law does not require that both the insurance company and the employer provide the notice.

Must a separate notice be provided to each plan beneficiary?

The Department of Labor recommends that a separate notice be provided to a plan beneficiary whose last known address is different from the address of the primary plan beneficiary. For example, families where the parents are divorced and the non-custodial parent provides coverage.

What information must be included in the Women's Health Act notice?

The sample notice on the following page can be used to provide notice at enrollment and annually thereafter.

The Women's Health and Cancer Rights Act of 1998

Important Notice

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prosthesis and treatment of physical complications in all stages of mastectomy, including lymphedemas.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

SPECIAL ENROLLMENT NOTICE

This notice is being provided to insure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage 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 toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

Marriage, Birth or Adoption

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

Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact:

Contact: Adicia Waddell, Associate Director of Human Resources
Address: 1 Drexel Drive, New Orleans, LA 70125
Phone Number: (504) 520-7537

*Note: If you and your eligible dependents enroll during a **special enrollment period**, as described above, you are not considered a late enrollee. Therefore, your group health plan may not require you to serve a pre-existing condition waiting period of more than 12 months. Any preexisting condition waiting period will be reduced by time served in a qualified plan.*

Important Notice from Xavier University of Louisiana About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Xavier University of Louisiana and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Xavier University of Louisiana has determined that the prescription drug coverage offered by Humana Health Care is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Xavier University of Louisiana coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Xavier University of Louisiana coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Xavier University of Louisiana and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information at (504) 520-7537. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Xavier University of Louisiana changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date: January 2010
Name of Entity/Sender: Xavier University of Louisiana
Contact--Position/Office: Adicia Waddell, Associate Director of Human Resources
Address: 1 Drexel Drive, New Orleans, LA 70125
Phone Number: (504) 520-7537

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

** CONTINUATION COVERAGE RIGHTS UNDER COBRA **

Date of Notice: November 10, 2008

TO:	All Employees of Xavier University of Louisiana
FROM:	Xavier University of Louisiana Human Resources Department 1 Drexel Drive New Orleans, LA 70125

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. BOTH YOU AND YOUR SPOUSE SHOULD TAKE TIME TO READ THIS NOTICE CAREFULLY.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice does not fully describe COBRA continuation coverage or other rights under the plan. For additional and more complete information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage.

EMPLOYEE

If you are an employee, you will become a qualified beneficiary entitled to elect COBRA continuation coverage if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

SPOUSE

If you are the spouse of an employee, you will become a qualified beneficiary entitled to elect COBRA continuation coverage if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes eligible for Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse. In the event your spouse, who is the employee, reduces or terminates your coverage under the Plan in anticipation of a divorce or legal separation which later occurs, the divorce or legal separation may be considered a qualifying event even though the coverage was reduced or terminated before the divorce or separation.

DEPENDENT CHILDREN

Your dependent children, including any child born to or placed for adoption with a covered employee during the period of COBRA coverage who is thereafter properly enrolled in the Plan, or a child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order, will become qualified beneficiaries entitled to elect COBRA continuation coverage if they lose coverage under the Plan because any of the following qualifying events happens:

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

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming eligible for Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator in writing within 60 days after the qualifying event occurs. You must provide this notice to Adicia Waddell in Human Resources. The Plan procedures for this notice, including a description of any required information or documentation, can be found in the most recent

Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, you will lose your right to elect COBRA continuation coverage.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. If COBRA continuation coverage is not elected within the 60-day election period, a qualified beneficiary will lose the right to elect COBRA continuation coverage.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming eligible for Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. 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. The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, there will be no disability extension of COBRA continuation coverage. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, there will be no extension of COBRA continuation coverage due to a second qualifying event.

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

The name of the group health plan and name (or position), address and telephone number of the party or parties from whom additional information about the plan and COBRA continuation coverage can be obtained on request are as follows: Adicia Waddell, Human Resources, 1 Drexel Drive, New Orleans, LA 70125 – (504) 520-7537.

Please refer to the Plan's most recent summary plan description for any updated Plan contact information.

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.