

# DUFlex Flexible Benefits Plan

## Summary Plan Description

Effective July 1, 2016

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# Introduction

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This summary plan description (“SPD”) describes the health and welfare benefits available to eligible employees of Duquesne University of the Holy Spirit (“Duquesne”) (the “University”) and their eligible dependents effective as of July 1, 2016. These benefits are governed by the certificates of insurance issued by the Insurers, administrative services agreements, this summary plan description, or other governing documents referenced herein. *See the “Administrative Information” section for plan document information.*

This SPD can help you better understand and use your health and welfare benefits, and replaces previous SPDs. It is to your advantage to read through this SPD, learn how the benefits work, and share this information with your family.

## **This SPD incorporates by reference the following documents:**

- Cigna High Deductible Health Plan Group #3335869 (Medical/Prescription Drug/ Mental Health/Substance Use).
- Cigna OAP Group #2500066 (Medical/Mental Health/Substance Use).
- Cigna PPO Group #3335869 (Medical/Mental Health/Substance Use).
- UPMC Health Plan EPO Group # 010218 (Medical/Mental Health/Substance Use).
- UPMC High Deductible Health Plan Group #010218 (Medical/Prescription Drug/ Mental Health/Substance Use).
- CVS Caremark Group #5813 (Prescription Drug).
- MetLife PDP Plus Network Group #151368 (Dental).
- VSP Choice Policy #30039552 (Vision).
- MetLife Policy #151368 (Long Term Disability).
- MetLife Policy #151368 (Life Insurance and Accidental Death and Dismemberment Insurance).
- MetLife Policy #151368-BTA (Business Travel Accident).
- Lytle Employee Assistance Program Partners Group #402684 (EAP)
- Discovery Benefits Group #16288 (Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, Limited Flexible Spending Account, Health Savings Account).
- Employee Vacation Administrative Policy

These listed documents are incorporated into this SPD and serve as the source of specific information relating to your health and welfare benefits. This SPD and the listed documents function as one document to summarize your benefits.

While this SPD and the incorporated documents describe your health and welfare benefits, if there is any inconsistency or discrepancy among the provisions of this document and the official plan documents, your rights and benefits will be determined under the official plan documents for the DUFlex Flexible Benefits Plan.

## Plan Contacts

For additional information about your health and welfare benefits, you may contact the following:

Contact	Reasons to Access
<p><b>Plan Administrator</b>            Duquesne University of the Holy Spirit            Human Resource Management            600 Forbes Avenue            Pittsburgh, PA 15282</p>	<ul style="list-style-type: none"> <li>▪ Verify your eligibility.</li> <li>▪ Review your benefits.</li> <li>▪ Get answers to most questions.</li> <li>▪ Get information about employee contributions.</li> </ul>
<p><b>Claims Administrators</b></p> <p>Cigna (High Deductible Health Plan, Open Access Plus, PPO)            Two Liberty Place            1601 Chestnut Street            Philadelphia, PA 19192</p> <p>UPMC Health Plan (UPMC Health Plan EPO, HSA PPO)            U.S. Steel Tower            600 Grant Street            Pittsburgh, PA 15219</p> <p>CVS Caremark Prescription Drug (prescription drug)            Customer Care Correspondence            PO Box 6590            Lee's Summit, MO 64064-6590</p> <p>VSP Choice (insured vision benefits)            3333 Quality Drive            Rancho Cordova, CA 95670</p> <p>MetLife PDP Plus Network (insured dental benefits)            Metropolitan Life Insurance Company            200 Park Avenue            New York, New York 10166</p> <p>Lytle EAP Partners (EAP)            200 Cedar Ridge Drive Suite 208            Pittsburgh, PA 15205</p> <p>Discovery Benefits (Flexible Spending Accounts and Health Savings Account)            4321 20th Avenue SW            Fargo, ND 58103</p> <p>MetLife (Life Insurance/Accidental Death and Dismemberment (AD&amp;D), Long Term Disability (LTD) and Business Travel Accident )            1000 Omega Drive # 1500            Pittsburgh, PA, 15205</p>	<ul style="list-style-type: none"> <li>▪ Review your benefits.</li> <li>▪ Locate a participating provider.</li> <li>▪ Obtain a predetermination.</li> <li>▪ Review your rights as a patient.</li> <li>▪ Speak with a claims service representative.</li> <li>▪ Request or download a claim form.</li> </ul>

# Your Health and Welfare Benefits

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## Your Health and Welfare Benefits

Participating employees of Duquesne University that meet eligibility requirements are eligible for health and welfare benefits under the Duquesne University Employee Benefits Plan which may include:

- Medical/prescription drug/substance abuse/mental health benefits/Health Savings Account (HSA).
- Dental benefits.
- Vision benefits.
- Long term disability (LTD) insurance.
- Life insurance.
- Accidental death and dismemberment insurance.
- Business Travel Accident.
- Dependent Care Flexible Spending Account (FSA).
- Health Care Flexible Spending Account (FSA).
- Limited Flexible Spending Account (vision and dental expenses only).
- Employee Vacation Purchase (Employee Vacation Administrative Policy).

The details of each of these health and welfare benefits are described in the incorporated documents.

## Cost of Coverage

The University pays the entire premium for basic life insurance, basic accidental death and dismemberment insurance, basic business travel accident insurance, basic long term disability insurance and EAP benefits. Medical premium payment, HSA contributions and Dependent Care FSA contributions are shared between you and the University. You will pay the entire premium for your working spouse medical contribution, for dental and vision coverage, optional life insurance, the entire amount of your health care flexible spending account contributions and the entire amount for vacation purchase. Depending on the particular benefits selected, your employee contributions may be deducted from your paycheck on a pre-tax basis or paid with after-tax dollars. *See the Open Enrollment materials for more information about paying for your benefits.*

The University determines the amount of your employee contributions prior to each enrollment period and will provide you with this information in your enrollment materials. You may also contact the Plan Administrator to receive information about your employee contributions.

## Flex Credit Dollars

The University offers flex credit dollars under the cafeteria plan option. Effective July 1, 2011, employees hired before April 2, 2011 will receive service credits only. These flex credit dollars are offered to each eligible employee to help offset the costs of benefit plan coverages. The amount of credits each employee receives is determined by their years of service. An additional \$20 per year of service will continue to be earned each year. The online enrollment system will indicate your years of service credits. Please note for benefits enrollment purposes only, this calculation is based on your years of service as of April 1. These are pre-tax

dollars, and depending on the employee's enrollment choices, the credits can be used on a pre-tax basis to purchase certain benefits. Any credits not used to purchase pre-tax benefits will be received as taxable income in the biweekly paycheck.

### **Participating Provider Networks and Directories**

You may, without charge, obtain the participating provider directories from the claims administrator for a particular benefit. See the *"Plan Contacts"* section for contact information.

### **Qualified Medical Child Support Orders ("QMCSO")**

A QMCSO is a judgment from a state court or an order issued through an administrative process under state law that requires a parent to provide health benefits for a child (often because of legal separation or divorce). A QMCSO cannot require the plan to cover any type or form of benefit not otherwise offered. However, an order may require the plan to comply with state laws regarding a child's coverage.

The plan provides health benefits for your child pursuant to the terms of a QMCSO. This coverage may apply even if you do not have legal custody of the child; the child is not dependent on you for support, and regardless of any enrollment season restrictions that might exist for dependent coverage.

Federal law requires that a QMCSO must meet certain form and content requirements to be valid. The University follows certain procedures to determine if a medical child support order is "qualified". You may request, free of charge, a copy of the plan's QMCSO administrative procedures from the Plan Administrator. If you become subject to an order, you will receive a copy of the QMCSO administrative procedures, free of charge, from the Plan Administrator.

If the University receives a valid QMCSO, you may enroll a dependent child for health benefits under the plan pursuant to the QMCSO's terms. The change you elect takes effect as of the date the Plan Administrator processes the QMCSO.

### **Standards for Mothers and Newborns**

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).

### **Your Rights Following a Mastectomy**

The plan includes health benefits for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, benefits 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.
- Treatment of physical complications at all stages of mastectomy, including lymphedema.

Benefits will be subject to the same annual deductibles and coinsurance provisions that apply for all other medically necessary procedures under the plan.

## **Coordination of Benefits**

The incorporated documents detail the way health and welfare benefits are paid if you or any one of your dependents is covered under more than one benefit plan.

## **Expenses for Which a Third Party May Be Responsible**

The plan provides payment for covered expenses if you or your dependents are ill or injured. However, if a third party (person or organization) is at fault for the illness or injury and you or your covered dependents bring a claim against the third party, you must reimburse the plan for any plan-paid benefits immediately after you collect damages. The plan will be reimbursed in full from any judgments, insurance policy proceeds or settlement before any amounts from such judgment, proceeds or settlements, including attorneys' fees you incur, are paid to any other person, regardless of the manner in which the recovery is structured.

The plan may file a lien against the third party, or the third party's agent or with the court, and you agree to consent to such lien. You must take any reasonable actions necessary to protect the plan's subrogation and reimbursement rights, including notifying the Plan Administrator if and when you or your covered dependents file a lawsuit or other action or enter into a settlement negotiation with another party (including his or her insurance company) in connection with the conduct of such party. You must cooperate with the plan's reasonable requests concerning its subrogation and reimbursement rights and must keep the Plan Administrator informed of any developments in any legal actions or settlement negotiations. You also agree that the plan may withhold any future benefits paid by the plan to the extent necessary to reimburse the plan under its subrogation and reimbursement rights.

The plan is subrogated to all the rights you may have against any third party, including an insurance company, liable for your injury or illness or for the payment for the medical treatment of such injury or illness up to the value of the benefits provided to you under the plan. The plan may assert its subrogation rights independently. You will cooperate with the plan and its agents to protect these subrogation rights by, among other things, providing the plan with relevant information that it requests, signing and delivering such documents as the plan may reasonably require to secure its rights and obtaining the plan's consent before releasing any party from liability for payment. Any litigation or settlement negotiations will be undertaken so as to not prejudice, in any way, the plan's subrogation rights.

# Your Flexible Spending Accounts

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## Health Care Flexible Spending Account

If you are eligible to participate in the Plan, you may elect to have salary reduction contributions, in an aggregate amount not to exceed the inflation-adjusted contribution limit for the Plan Year, credited to your health care flexible spending account ("Health FSA"). Maximum and minimum contribution limits on the amount you may contribute to your Health FSA will be determined by the Plan Administrator and announced to participants in advance of the dates they become effective. You can receive amounts from this account as reimbursement for eligible medical expenses (as defined in the Plan) incurred during the Plan Year and while you are a participant in the Health FSA.

Generally, eligible medical expenses are expenses that you, your spouse or your dependent (determined as described in the next paragraph) have incurred that are not covered under any plan or employer-provided medical coverage, that meet the Internal Revenue Code's definition of medical expenses (including legally obtained prescription drugs), and that have not been taken as a deduction in any tax year. Normally, expenses are reimbursable only if you have already incurred the expense (that is, if you have already received the services or medicine or supplies to which the expense applies). However, otherwise eligible expenses for orthodontia services that you pay before the services are actually provided can be reimbursed at the time the advance payment is actually made but only to the extent that you are required to make the advance payment to receive the services.

**NOTE:** *As required by applicable law, effective for expenses incurred after December 31, 2010, the Health FSA will not reimburse expenses for over-the-counter medicine (other than insulin), unless the medicine has been prescribed by a physician or another qualified health care provider.*

For purposes of Health FSA reimbursements, "dependent" includes anyone who is your dependent for federal income tax purposes. For expenses incurred after March 29, 2010, "dependent" also includes your biological, adopted or step-child or your eligible foster child if the child will be younger than 27 on the last day of the calendar year, even if the child is not a dependent for federal income tax purposes.

To be reimbursed from your Health FSA, you must submit to the Claims Administrator a request for reimbursement on a form provided by the Claims Administrator. You also must provide evidence of the amount, nature and payment of the underlying medical expense for which reimbursement is sought, as required by the Claims Administrator. Unless a later date is designated by the Plan Administrator, you must submit your requests no later than December 31 of the following Plan Year in which the expenses were incurred if you were an active employee on the last day of the Plan Year. If your employment terminates during the Plan Year, you must submit your expenses incurred while an active member of the plan, no later than December 31 of the following Plan Year in which the expenses were incurred, regardless of whether or not you elect to continue Health FSA benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). See the "COBRA Continuation Rights" section for more details.

If you do not use up your entire Health FSA balance with expenses incurred by the end of the Plan Year, there is also a "grace period" that lasts 2 ½ months after the end of the Plan Year (that is, until September 15th of the next Plan Year). Eligible expenses incurred during the grace period may also be reimbursed. The grace period applies only if you are still a participant in the Health FSA on the last day of the Plan Year. You will still be treated as participating in the Health FSA for this purpose if you elected COBRA continuation coverage under the Health FSA and that COBRA coverage is in effect on the last day of the Plan Year. If your participation in the Health FSA ends before the end of the Plan Year, there is no grace period.



Please note that amounts held in your Health FSA for which a valid request for reimbursement has not been received by the deadline described above will be forfeited.

### **Dependent Care Flexible Spending Account**

If you are eligible to participate in the plan, you may elect to have salary reduction contributions credited to your dependent care flexible spending account ("Dependent Care FSA"). All contributions, in the aggregate, must not exceed \$5,000 per calendar year or, for married participants filing separately, \$2,500 per calendar year. The minimum amount you must contribute is \$130.00 per calendar year. Effective July 1, 2015, if you elect the Dependent Care FSA, an employer contribution of \$500.00 will be credited to your Dependent Care FSA account, if you are an active employee at the time the employer contribution is made. You should keep in mind that the \$500.00 employer contribution and your salary reduction contributions combined must not exceed the aggregate maximum contribution limits stated above. You can receive amounts from this account as reimbursement for Employment-Related Expenses incurred during the calendar year and while you are a participant in the Dependent Care FSA.

The amount of any reimbursement for Employment-Related Expenses may not exceed the amount credited to your account at the time of your reimbursement request. Generally, under federal law, Employment-Related Expenses are expenses for household services and expenses related to the care of a "Qualifying Individual", which you incur to enable you to work.

"Qualifying Individual" is defined under federal law and currently means someone who is:

- Your child (including a stepchild), brother, sister, stepbrother or stepsister (or a descendent of any of those, such as your grandchild or your niece or nephew) who is under the age of 13, who has the same principal residence as you for at least half of the calendar year and who does not provide at least half of his or her own support for the current calendar year,
- Your spouse (for purposes of federal law) who is physically or mentally incapable of taking care of himself or herself and who has the same principal residence as you for at least half of the calendar year or
- Your dependent for federal income tax purposes who is physically or mentally incapable of taking care of himself or herself and who has the same principal residence as you for at least half of the tax year.

You are responsible for determining if someone is your dependent for purposes of this benefit (although the Claims Administrator always has the right to deny benefits if it determines that expenses for any person are not eligible for reimbursement). If you have any question about whether someone qualifies as your dependent for purposes of the Dependent Care FSA, you should consult a tax advisor. Also, note that the determination of whether someone is a Qualifying Individual must be made each time expenses are incurred. For example, if your child is age 12 at the start of the calendar year, otherwise eligible expenses for that child can be reimbursed under the Dependent Care FSA only for services provided before the child's 13<sup>th</sup> birthday (unless the child is mentally or physically incapable of taking care of himself or herself).

The amount of reimbursements that you may receive from your Dependent Care FSA on a tax-free basis in a calendar year cannot exceed the lesser of your Earned Income (as defined in the Plan) or your spouse's Earned Income. Any amount that you receive in excess of that amount will be taxable to you. Thus, for example, if you have \$5,000 in your Dependent Care FSA and you and your spouse have Earned Income of \$20,000 and \$4,000, respectively, you can receive \$4,000 worth of reimbursement from the account on a tax-free basis, and you will be taxed on \$1,000 worth of the reimbursement you receive. If your spouse is either a full-time student or is incapable of self-care, your spouse will be deemed to have Earned Income for each month that he or she is a full-time student or incapacitated. The amount of deemed earnings will be \$250 a month, if you provide care for one Qualifying Individual, or \$500 a month, if you provide care for more than one Qualifying Individual.

Employment-Related Expenses that are incurred for services outside your household may be reimbursed only if incurred for the care of (i) a Qualifying Individual who is a qualifying child under thirteen years of age (category (1) in the above definition of Qualifying Individual), or (ii) another Qualifying Individual who regularly spends at least eight hours each day in your household. In addition, if the services are provided by a Dependent Care Center (as defined below), the Center must comply with applicable laws and regulations of a State or local government. A "Dependent Care Center" is any facility that provides care for more than six individuals who do not reside at the center and receives a fee, payment or grant for providing services for any of the individuals.

No reimbursements will be made for Employment-Related Expenses for services rendered by any person for whom you or your spouse is entitled to a deduction on your federal income tax return for the applicable calendar year or who is your child (including a stepchild or a foster child) who will be under the age of 19 at the end of your calendar year.

To be reimbursed from your Dependent Care FSA, you must submit a reimbursement request to the Claims Administrator on a form provided by the Claims Administrator. You also must provide evidence of the amount, nature and payment of the underlying expense for which reimbursement is sought, as required by the Claims Administrator. Unless a later date is designated by the Plan Administrator, you must submit such requests no later than December 31 of the following Plan Year in which the expenses were incurred if you were an active employee on the last day of the Plan Year. If your employment terminates during the Plan Year, you must submit your expenses incurred while an active member of the plan, no later than December 31 of the following Plan Year in which the expenses were incurred, regardless of whether or not you elect to continue Dependent Care FSA benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). See the "COBRA Continuation Rights" section for more details.

If you do not use up your entire Dependent Care FSA balance with expenses incurred by the end of the Plan Year, there is also a "grace period" that lasts 2 ½ months after the end of the Plan Year (that is, until September 15 of the next Plan Year). Eligible expenses incurred during the grace period may also be reimbursed. The grace period applies only if you are still a participant in the Dependent Care FSA on the last day of the Plan Year. You will still be treated as participating in the Dependent Care FSA for this purpose if you elected COBRA continuation coverage under the Dependent Care FSA and that COBRA coverage is in effect on the last day of the Plan Year. If your participation in the Dependent Care FSA ends before the end of the Plan Year, there is no grace period.

Please note that amounts held in your Dependent Care FSA for which a valid request for reimbursement has not been received by the deadline described above will be forfeited.

Under the Internal Revenue Code, you also may reduce your taxes by taking a dependent care tax credit. However, any amounts which you exclude from income under the Dependent Care FSA will reduce, dollar for dollar, the tax credit available.

## Your Health Savings Accounts

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### **Health Savings Account (HSA)**

You are eligible to participate in this feature of the Plan if you are a participant in a High Deductible Health Plan offered under the Plan and qualify as an HSA-eligible individual under rules that apply under federal tax law. You may elect to make salary reduction contributions to a Health Savings Account (HSA) established in your name. Any limits on the amount you may contribute to your Health Savings Account will be determined by the Plan Administrator and announced to participants in advance of the dates they become effective. Health Savings Account contributions also are subject to annual limits that apply under the Internal Revenue Code. The maximum annual amount that an HSA Eligible Individual may elect to contribute to his HSA shall be the statutory maximum amount for HSA contributions applicable to the Participant's high deductible health plan coverage option (i.e., single or family) for the calendar year in which the contribution has been made. An additional catch-up contribution may be made by Participants who are age 55 or older, subject to statutory maximums.

The Employer may limit the amount you may contribute to your Health Savings Account through the Plan if it appears that contributions to the HSA exceed any limit that applies to you.

To be an "eligible individual" for purposes of HSA contributions, in addition to being enrolled in a High Deductible Health Plan, note that you may not be enrolled at the same time in certain other types of medical coverage that does not qualify as a High Deductible Health Plan. For example, if you are covered under a spouse's health plan that is not a high deductible health plan or if you are covered under Medicare, you are not an eligible individual and so you may not receive or make HSA contributions through the Plan. Also, if you are covered under the Plan's Health Care Flexible Spending Account, you are not considered an "eligible individual". Whether you are an eligible individual is determined on a monthly basis. If you participate in the High Deductible Health Plan offered under the Plan and actively participate in an HSA, you may elect to have salary reduction contributions credited to a Limited Flexible Spending Account for dental and vision expenses only. If you have any questions about whether any other coverage you have disqualifies you from being an "eligible individual," please contact the Plan Administrator.

Your HSA is considered your property and is not an Employer-sponsored plan. Payments provided through your HSA are not provided under this Plan. Generally, your HSA can be used to pay or reimburse eligible medical expenses, including amounts that are counted towards the deductible for your High Deductible Health Plan. For details about the HSAs that may be funded through the Plan, you should contact the financial institution that maintains your HSA or contact the Claims Administrator if you need help in getting those details.

## Eligibility

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You and your eligible dependents are eligible for the health and welfare benefits under the plan as follows:

### Your Eligibility

You are eligible to participate in the Medical/Prescription Drug Plan and in all other Benefit Package Options as follows:

Faculty, Librarians, Administrative Staff and non-union hourly employees who are regularly scheduled to work at least 35 hours per week;

Union employees in Local 95, Local 32 BJ and Local 502 who are regularly scheduled to work at least 40 hours per week;

Union employees in Local 249 who are regularly scheduled to work at least 40 hours per week are eligible to participate solely with regard to Long Term Disability Insurance Plan benefits under the Plan.

In addition, beginning with the 2015 plan year, Duquesne University will use a look back measurement method to determine whether you are working the required hours of service per week for purposes of coverage under the Medical/Prescription Drug Plan. For purposes of eligibility to participate in the Medical/Prescription Drug Plan only (and not with respect to the separate eligibility requirements described above which remain in effect for participation in all other Benefit Package Options), you are required to work at least 30 hours per week, beginning with the 2015 plan year. An hour of service is an hour for which you are paid, or entitled to be paid by Duquesne University for performance of duties for Duquesne University, and each hour for which you are paid, or entitled to be paid by Duquesne University for a period of time during which you perform no duties due to, for example, approved vacation, sick leave, holidays or other approved leave of absence. The look back measurement method is based on final Treasury Regulations under Internal Revenue Code Section 4980H.

The look back measurement method applies to all Duquesne University employees for whom it is reasonably expected that their hours of service will vary above and below that of a full-time employee as defined by the Treasury Regulations cited above or for whom it is reasonably expected that their employment will be seasonal in nature. The look back measurement method involves three different periods:

- A measurement period for counting an employee's hours of service. If you are an ongoing employee (hired before the start of the measurement period for a plan year), this measurement period (which is also called the "standard measurement period") ran from April 2, 2014 through April 1, 2015 and determines your Plan eligibility for the 2015 plan year (July 1, 2015 through June 30, 2016). The standard measurement period for future plan years will be the 12-month period that ends on April 1.
- A stability period is a period that follows a measurement period and administrative period. Your hours of service during the measurement period will determine whether you are a full-time employee who is eligible for coverage during the stability period. As a general rule, your status as a full-time employee or not a full-time employee is "locked in" for the stability period, regardless of how many hours you work during the stability period, as long as you remain employed. The stability period will last for 12 months. The stability period for ongoing employees will coincide with the plan year (July 1, 2015 through June 30, 2016).
- An administrative period is a short period (April 2, 2015 – June 30, 2015) (no more than 90 days) between the measurement period and the stability period when Duquesne University performs administrative tasks, such as determining eligibility for coverage.

Note that special rules apply if you are rehired or return from an unpaid leave of absence. The rules for the look back measurement method are very complex. This is just a general overview of how the rules work. More complex rules may apply to your situation. Duquesne University intends to follow the final Treasury Regulations and any future guidance issued by the Internal Revenue Service when administering the look back measurement method. If you have any questions about this measurement method and how it applies to you, please contact Duquesne University Office of Human Resources.

For new employees whose eligibility is based on a measurement period, if you are eligible you will be able to enroll as described above, following the end of your measurement period. You need to enroll in the plan to be covered by the health benefits and certain other benefits as specified in the Open Enrollment materials. If you do not enroll in the plan or select a waiver of coverage within 30 days, your failure to make a benefit election during the election period will be deemed an election to waive coverage for health benefits (medical, dental and vision), and you will need to wait until the next Open Enrollment to make your benefit elections.

### ***If You Become Ineligible***

If you remain an employee of the University but become ineligible because you no longer meet the eligibility requirements (for example, you no longer qualify as an eligible employee working the minimum required hours per week), you become eligible the first day of the month following the day you meet the eligibility requirements again.

### ***If You Become Disabled***

If you should become disabled, you may be able to continue your eligibility for some or all of the health and welfare benefits under the plan. Please refer to the Duquesne University Administrative Policies for the specific benefit to determine your eligibility to continue your benefits. In addition, you may be able to continue health benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). See the "COBRA Continuation Rights" section for more details.

## **Eligible Dependents**

### ***Dependent Eligibility***

For purposes of all benefits available under the Plan to dependents, your spouse is considered an eligible dependent.

Your child is eligible for coverage offered to dependents under the Plan based on the following rules:

- Coverage for Children under Age 26. Any child of the Participant who is under age twenty-six (26) is an Eligible Dependent under the Plan; and
- Coverage for Children with Disabilities. Any child of a Participant who is physically or mentally incapable of self-support, regardless of the child's age, provided the child became physically or mentally incapable of self-support and was covered under the Plan before reaching age twenty-six (26), is an Eligible Dependent under the Plan. Certification of the disability is required within 31 days of attainment of age 26. A certification form is available from the Claims Administrator and may be required periodically.
- Coverage for Working Spouse. If the participant's Spouse is eligible for coverage under his/her own employer-sponsored medical plan but chooses to enroll as a Dependent in the Medical Benefits Option of the Plan, the participant must pay a required pre-tax contribution per pay period for the Spousal Medical Benefits Option coverage of the Plan. The pre-tax contribution is in addition to the participant's monthly premium contributions under the Plan. Spousal coverage under the Plan shall be contingent upon receipt by the Plan Administrator of such applications, consents, marriage, elections, beneficiary designations, and other documents and information as may be prescribed by the Plan Administrator. The participant must certify the Spouse's eligibility during Open Enrollment. The Working Spouse Contribution does not apply in the following situations:

- The participant does not have a spouse;
- The participant has enrolled in a benefit option which does not require spousal contribution;
- The participant has elected to waive medical coverage;
- The spouse is also an employee of the University;
- The participant has elected not to enroll his/her spouse in a medical benefit option;
- The participant has elected to enroll his/her spouse in a medical benefit option under the plan and the spouse is not employed;
- The spouse is employed with an entity that does not offer employer-sponsored medical insurance;
- The spouse is not eligible for employer-sponsored medical insurance; or
- The spouse has medical coverage through Medicare or Medicaid.

If a participant's Spouse loses or obtains medical coverage after Open Enrollment, the Participant must notify the Plan Administrator within 30 days and complete documents and provide information as may be prescribed by the Plan Administrator.

The following definitions apply for purposes of this Dependent Eligibility section:

- Child means a natural child, a legally adopted child who is under age 18 at the time of the adoption, a child placed with you for adoption who is under age 18 at the time of the placement, a foster child (if the child is an "eligible foster child", as defined in the Internal Revenue Code, and the child is not a ward of the state) or a stepchild. Child also includes any other person whose welfare is your legal responsibility under a legal guardianship, written divorce settlement, written separation agreement or a court order.
- Spouse means the legal spouse under the laws of the state where the marriage was performed, provided that a state-issued marriage certificate is obtained. The Plan Administrator will require documentation proving a legal marital relationship.
- If you are an employee that is married to another University employee, you may enroll as an employee or a dependent under the Plan, but you cannot enroll as both a dependent and an employee. Eligible dependents may be enrolled under one employee's coverage only under the Plan.

Please note that the Plan Administrator has the sole right to determine who is eligible for health and welfare benefits under the plan and may require documentation proving a dependent's status. If you are unable to provide the required documentation, your dependent will not be eligible for benefits under the plan. In addition, you may be required to reimburse the University for any costs associated with covering an individual who is not an eligible dependent, and your, as well as your dependents', coverage may be terminated.

### ***State Eligibility Laws***

States sometimes pass laws that require employee benefit plans to provide benefits to individuals who otherwise are not eligible. For example, a state might require an employer to provide benefits to an ex-spouse or a child who exceeds the plan's age requirements.

However, due to the self-funded nature of certain benefits provided under the plan, a state's eligibility laws do not apply to the plan and will not govern the rights of your dependents to benefits under the plan. The claims administrators will rely upon the University and the Plan Administrator to determine whether or not a person meets the definition of a dependent to be eligible for benefits under the plan. This determination will be conclusive and binding upon all persons for the purposes of the plan.

## Enrollment/Effective Date

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The plan year runs from July 1 through June 30.

Generally, you can participate in the plan as follows:

Faculty, Librarians, Administrative Staff and non-union hourly employees are eligible to participate on the first day of the month coinciding with or next following their date of hire;

Union employees in Local 95, Local 32 BJ and Local 502 are eligible to participate on the first day of the month coinciding with or next following their completion of 60 calendar days of employment;

Union employees in Local 249 are eligible to participate solely with regard to Long Term Disability Insurance Plan benefits under the Plan. Local 249 employees are eligible to participate on the first day of the month coinciding with or next following their completion of one year of employment. All other benefits for Local 249 employees are provided through the Teamsters Health and Welfare Benefit Plan;

You must notify the Plan Administrator in a timely manner of your intent to enroll in the plan (*see the Open Enrollment materials to determine when you are eligible for benefits*). The Plan Administrator will provide the appropriate information for your enrollment in the plan.

### **Initial Enrollment**

Some health and welfare benefits are automatically provided to you under the plan at no cost to you. Please refer to the Enrollment materials to determine which benefits are automatically provided to you when you become an eligible employee.

You need to enroll in the plan to be covered by the health benefits and certain other benefits as specified in the Enrollment materials. To enroll yourself and/or your eligible dependents, you must enroll within 30 days of your eligibility date. If you do not enroll at this time, you may enroll during the next open enrollment period, a special enrollment period, or if you have a qualified change in status. *See the “Changing Your Coverage” section.*

Information regarding enrollment procedures will be provided to you by the Plan Administrator. When you enroll your eligible dependents, you will need to provide relevant documentation as requested by the Plan Administrator.

### **As a Rehired Employee**

If you terminate your employment, and are rehired by the University, you must enroll again in the plan to receive benefits.

### **Open Enrollment**

If you choose to change your benefit elections during the open enrollment period, your new elections will become effective on July 1 of the following plan year. If you do not make an election change during the open enrollment period, you may change your elections during the next open enrollment period, a special enrollment period, or if you have a qualified change in status. *See the “Changing Your Coverage” section.*

Information regarding enrollment procedures will be provided to you by the Plan Administrator.

## **Effective Date of Your Coverage**

### ***New Employees***

Generally, you and your dependents will become covered under the plan on the date set forth above, if you are actively employed on that date (*see the Enrollment materials to determine when you are eligible for benefits*). If you are not actively employed on that date due to your health status, your coverage will become effective on the date determined by the Plan Administrator. However, you will not be denied health coverage due to your health status.

### ***Current Employees***

If you enroll or make an election change during the open enrollment period, participation for you and your dependents begins on the next July 1.



# Changing Your Coverage During the Year

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Once you enroll in or decline health and welfare benefits under the plan, your election generally stays in effect for the plan year. However, you can make changes during the year if you have a qualified change in status, a special enrollment right, or other changes in circumstance.

## Qualified Change in Status

A qualified change in status is a specific change in circumstance that affects your eligibility for benefits and coverage under the plan. Changes in eligibility or coverage must be due to and consistent with the qualified change in status, which is any of the following:

- You get married, divorced, or your marriage is annulled.
- You have a baby, adopt, or have a child placed in your care for adoption.
- Your dependent dies.
- Your dependent gains or loses eligibility status.
- You or your dependent moves to a new place of residence outside of your present coverage area.
- You or your dependent has a change in employment status, such as:
  - Switching from full-time to part-time employment (or vice versa).
  - Beginning or ending employment (this provision does not apply if rehired within 30 days).
  - Experiencing a strike or a lockout.
  - Commencing or returning from an unpaid leave of absence.
  - Changing your worksite to a location that offers different benefits than are currently available to you.
- You experience a significant change in cost of benefits or coverage.

## Special Enrollment Rights

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) gives you additional flexibility in whom you can enroll for the health benefits under the plan due to marriage, birth, adoption, or placement for adoption:

- Non-enrolled employee: If you are eligible but not enrolled, you can enroll.
- Non-enrolled spouse: If you are enrolled, you can enroll your spouse when you marry. In addition, you can enroll your spouse if you acquire a child through birth, adoption, or placement for adoption.
- New dependents/spouse of a non-enrolled employee: If you are eligible but not enrolled, you can enroll your spouse or child who becomes your eligible dependent as a result of the event. However, you also must enroll.

## Other Changes in Circumstance

Certain other events also permit you to change your coverage during the year. The change you make must be consistent with the event:

- A QMCSO requires you or another individual to provide health benefits for a dependent.

- You or your dependent becomes eligible for or loses Medicaid coverage.
- You elected “no coverage” because you had coverage elsewhere (for example, under a spouse’s plan) and that other coverage experiences a substantial change or ends:
  - The coverage must end because of a loss of eligibility, such as a divorce, termination of employment, the other employer stops contributing to the other plan or the cost of coverage through the other employee increases significantly.
  - You cannot make a change during the year if your “other coverage” is lost because of something you do or do not do, such as not making your required contributions.
- Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) coverage from another employer for you or your dependent is exhausted.
- The enrollment period of another plan – for example, your spouse’s – is different from the University’s open enrollment period.
- If you or your dependent is eligible, but not enrolled, for health benefits, you are eligible to enroll if you meet either of the following conditions and you request enrollment no later than 60 days after the date of the event:
  - You or your dependent loses eligibility for Medicaid or Children’s Health Insurance Program (CHIP) coverage.
  - You or your dependent becomes eligible for premium assistance, with respect to coverage under the plan, due to coverage with Medicaid or CHIP.

### **How to Make Changes During the Year**

You can report your mid-year change to the Plan Administrator. However, you must submit the required paperwork within 30 days (60 days if due to Medicaid or CHIP eligibility) in order to make the change. If you do not report your mid-year change and provide the required paperwork within the 30-day or 60-day period, you will not be able to make changes until the next open enrollment period, unless you again meet one of the conditions for a change during the year.

As long as you notify the Plan Administrator within the required time frame, coverage changes take effect on a date determined by the Plan Administrator that will be no later than the first day of the month following receipt of your notice (except that, in the case of birth, adoption or placement for adoption, the coverage change will take effect on the date of the event).

## Continuing Coverage

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### **Uniformed Services Employment and Re-Employment Rights Act**

The Uniformed Services Employment and Re-employment Rights Act of 1994, as amended (“USERRA”), sets requirements for continuation of health coverage and re-employment in regard to an employee’s military leave of absence. These requirements apply to health coverage for you and your dependents.

#### ***Continuation of Coverage***

For leaves of less than 31 days, health coverage will continue, but you must make employee contributions for your coverage to continue. For leaves of 31 days or more, you may continue health coverage for yourself and your dependents as follows:

- You may continue coverage by paying the required contributions to the University, until the earliest of the following:
  - 24 months from the last day of employment with the University.
  - The day after you fail to return to work.
  - The day the plan terminates.
- The University may charge you and your dependents up to 102% of the total cost.

#### ***Reinstatement of Benefits***

If your health coverage ends during the leave of absence because you do not elect coverage under USERRA and you are reemployed by the University, health coverage for you and your dependents may be reinstated if:

- You gave the University advance written or verbal notice of your military service leave.
- The duration of all military leaves while you are employed with the University does not exceed five years.

You and your dependents will be subject to only the balance of a waiting period, if appropriate, that was not yet satisfied before the leave began. However, if an injury or illness occurs or is aggravated during the military leave, full plan limitations will apply.

If your health coverage under this plan terminates as a result of your eligibility for military health coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

### **Family and Medical Leave Act**

Your health coverage will be continued during a leave of absence under the Family and Medical Leave Act of 1993, as amended (“FMLA”). The Plan Administrator will give you more detailed information about the FMLA. The FMLA allows eligible employees to take a leave for up to a total of 12 work weeks in a 12-month period for one or more of the following reasons:

- The birth of your child and to care for the newborn child.
- The placement of a child with you for adoption or foster care.
- To care for a family member (child, spouse, or parent) with a serious health condition.
- Your own serious health condition that makes you unable to perform the functions of your job.

- Any qualifying exigency arising out of the fact that your spouse, child, or parent is a covered member in the Armed Forces on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation.

If eligible, you may also take leave for up to a total of 26 work weeks in a single 12-month period to care for a covered member of the Armed Forces with a serious injury or illness.

Contact the Plan Administrator for more details about FMLA leave.

### ***Benefits Coverage While on FMLA Leave***

The University will continue your health coverage under the plan during your FMLA leave just as if you were still working. The cost of your health coverage during an FMLA leave must be paid, and you must make all required employee contributions in accordance with the agreement reached between you and the University prior to your FMLA leave becoming effective.

A newly-acquired dependent is eligible for coverage while your coverage is continued during an FMLA leave.

Continued coverage ends on the earliest date that you:

- Terminate employment.
- Do not make required contributions.
- Exhaust your approved period of FMLA leave and do not return to work from your FMLA leave.

If your employment does not terminate during your FMLA leave, but you do not return to work once your FMLA leave ends, you can choose to continue health coverage under the COBRA continuation rules. See *the “COBRA Continuation Rights” section for more details.*

### ***Reinstatement of Canceled Coverage Following FMLA Leave***

Upon your return to your employment following an FMLA leave, any terminated health coverage will be reinstated as of the date of your return. You will not be required to satisfy any eligibility or benefit waiting period, if appropriate, to the extent that they had been satisfied prior to the start of the FMLA leave.

### ***State Family and Medical Leave Laws***

The University's FMLA policy must comply with any state law that provides greater family or medical leave rights than those provided under its FMLA policy. If your leave qualifies under the FMLA and under a state law, you will receive the greater benefit.

### ***If University Changes Benefits***

If the University offers new benefits or changes its benefits while you are on an FMLA leave, you are eligible for the new or changed benefits, but your contributions for these benefits may increase.

Contact the Plan Administrator for more details about the University policy on other leaves of absence.

# Termination of Coverage

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## Employees

Your coverage under the plan will cease when any one of the following events described below occurs:

- You terminate employment (in which case participation shall cease in accordance with the terms of Related Documents, individual plans, programs, insurance contracts, and benefit components).
- You cease to be an employee who is eligible for coverage.
- If permitted by law, you report for active duty as a member of the armed forces of any country.
- If participant contributions are required, you cease making contributions to the plan.
- One or more benefits under the plan are terminated by action of the University.

## Dependents

Coverage for your dependents will cease when any one of the following events described below occurs:

- You terminate employment (in which case participation shall cease in accordance with the terms of Related Documents, individual plans, programs, insurance contracts, and benefit components).
- You cease to be an employee who is eligible for coverage.
- If permitted by law, your dependent reports for active duty as a member of the armed forces of any country.
- If participant contributions are required, you cease making contributions to the plan.
- A dependent ceases to qualify as a dependent.
- One or more benefits under the plan are terminated by action of the University.

Coverage under the plan may also be terminated for any individual (or any employee or dependent covered under the same family coverage as that individual) who engages in fraud or who makes a material misrepresentation of fact relating to the coverage. For example, if someone knowingly files a claim for benefits for medical services or supplies that were not actually provided, that would be considered fraud and would lead to termination of coverage. An example of a material misrepresentation of fact would include an employee signing an enrollment form indicating that an individual is eligible for coverage as a dependent at a time when the employee knows that the individual does not qualify as the employee's dependent. In such cases, coverage may be terminated retroactively, if appropriate, based on the details.

For medical coverage that is subject to the Affordable Care Act, a retroactive termination of coverage may occur in only two situations. First, as indicated above, if you fail to make any required contribution toward the cost of coverage by the applicable deadline, coverage would be terminated retroactive to the end of the period for which the required contributions were made. A retroactive termination also may occur if you or your dependent (or any person seeking coverage for you or your dependent) engages in fraud with respect to the plan, or makes an intentional misrepresentation of a material fact. In that case, the plan will provide at least 30 days advance written notice to any person who will be affected by the retroactive termination of coverage.

## **Continuation of Coverage**

When coverage ends, you and/or your dependents may be eligible to continue health benefits under COBRA. See the *“COBRA Continuation Rights”* section for more details. You may also have the right to apply for individual coverage for certain benefits. See the *incorporated documents* for more information.

# COBRA Continuation Rights

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## Coverage Continuation Rights Under COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”), created the right to continue health coverage in certain circumstances.

COBRA coverage is a temporary continuation of health (e.g., medical, dental, or vision) coverage when it otherwise would end because of a “qualifying event”. After a qualifying event, COBRA coverage must be offered to each “qualified beneficiary”. You, your spouse, and your dependent children could become qualified beneficiaries if you have health coverage under the plan on the day before the qualifying event and that coverage is lost because of the qualifying event. Qualified beneficiaries also include any children born to you or placed for adoption with you during the COBRA continuation period.

## COBRA Qualified Beneficiaries

- **Employee.** You become a COBRA qualified beneficiary if you lose your health coverage under the plan because of one of the following qualifying events:
  - Your hours of employment are reduced.
  - Your employment ends for any reason other than your gross misconduct.
  
- **Spouse.** Your spouse becomes a COBRA qualified beneficiary if he or she loses health coverage under the plan because of one of the following qualifying events:
  - Your hours of employment are reduced.
  - Your employment ends for any reason other than gross misconduct.
  - You die.
  - You become divorced or legally separated from your spouse.
  - You enroll in Medicare benefits (under Part A, Part B or both).
  
- **Dependent children.** Dependent children become COBRA qualified beneficiaries if they lose health coverage under the plan because of one of the following qualifying events:
  - Your hours of employment are reduced.
  - Your employment ends for any reason other than gross misconduct.
  - You die.
  - You become divorced or legally separated from your spouse.
  - The child loses eligibility for coverage as a “dependent child” under the plan.
  - You enroll in Medicare benefits (under Part A, Part B or both).

If you cover individuals under the plan who are not your spouse or your dependent children, those individuals are not qualified beneficiaries for purposes of COBRA coverage. Although these individuals do not have an independent right to elect COBRA coverage, if you elect COBRA coverage for yourself, you may also cover these individuals even if they are not considered qualified beneficiaries under COBRA. However, these individuals’ coverage will terminate when your COBRA coverage terminates. Note in the “How Long COBRA Coverage Lasts” section, the provisions regarding “Disability Extension of 18-Month Period of COBRA Coverage” and “Second Qualifying Event Extension of 18-Month Period of COBRA Coverage” are not applicable to these individuals.

## **When COBRA Coverage Is Available**

The plan offers COBRA 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 your employment, the reduction in your work hours, or your death, the University will notify the Plan Administrator of the qualifying event.

For other qualifying events (your divorce or legal separation or a dependent child losing eligibility for coverage as a dependent child) or the occurrence of a second qualifying event, you or your qualified beneficiary must notify the Plan Administrator within 60 days after the later of the date the qualifying event occurs or the day you lose coverage because of the qualifying event. If you or your qualified beneficiary fails to notify the Plan Administrator within 60 days after the qualifying event, then your dependent will not be entitled to elect COBRA coverage.

## **How COBRA Coverage Is Offered**

After the Plan Administrator receives notice that a qualifying event has occurred, COBRA coverage is offered to each qualified beneficiary.

You may elect COBRA coverage on behalf of your spouse, and parents may elect COBRA coverage on behalf of their children. It is critical that you (or anyone who may become a qualified beneficiary) maintain a current address with the Plan Administrator to ensure that you receive a COBRA enrollment notice following a qualifying event.

You and your eligible dependents have 60 days from the date coverage ends due to a qualifying event or from the date of your COBRA notice, whichever is later, to elect COBRA coverage. If you fail to elect COBRA coverage within the applicable time frame, then you will lose the opportunity to continue coverage under COBRA.

## **How Long COBRA Coverage Lasts**

COBRA coverage is a temporary continuation of coverage. It lasts for up to a total of 36 months when the qualifying event is:

- Your death.
- Your divorce or legal separation.
- A dependent child losing eligibility as a dependent child.

COBRA coverage generally lasts for up to a total of 18 months when the qualifying event is the end of your employment or reduction of your work hours. This 18-month period of COBRA coverage can be extended in two ways:

### ***Disability Extension of 18-Month Period of COBRA Coverage***

If a qualified beneficiary 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 all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months, if all of the following conditions are met:

- Your COBRA qualifying event was your termination of employment or reduction in work hours.
- The disability started at some time before the 60<sup>th</sup> day of COBRA coverage and lasts at least until the end of the 18-month period of COBRA coverage.
- A copy of the Notice of Award from the Social Security Administration is provided to the Plan Administrator within 60 days of receipt of the notice and before the end of the initial 18 months of COBRA coverage.



- An increased premium of 150% of the monthly cost of coverage is paid, beginning with the 19<sup>th</sup> month of COBRA coverage.

### ***Second Qualifying Event Extension of 18-Month Period of COBRA Coverage***

If another qualifying event occurs during the first 18 months of COBRA coverage, your spouse and dependent children can receive up to 18 additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator.

This extension may be available to your spouse and any dependent children receiving COBRA coverage if you die, get divorced or legally separated, or your dependent child is no longer eligible under the plan as a dependent child, but only if the event would have caused your spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

### **Medicare Extension for Your Dependents**

If the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B, or both) within the 18 months before the qualifying event, COBRA coverage for your dependents will last up to 36 months after the date you became enrolled in Medicare. Your COBRA coverage will last for 18 months from the date of your termination of employment or reduction in work hours.

### **What COBRA Coverage Costs**

COBRA participants must pay monthly premiums for coverage.

Premiums are based on the full cost per covered person set at the beginning of the plan year, plus 2% for administrative costs. Dependents making separate elections are charged the same rate as a single employee.

Payment is due at enrollment, but there is a 45-day grace period from the date you mail your enrollment form to make the initial payment. The initial payment includes coverage for the current month, plus any previous month(s).

Ongoing monthly payments are due on the 25<sup>th</sup> of the month preceding the next coverage period, but there is a 30-day grace period (for example, June payment is due June 1, but will be accepted if postmarked by June 30).

If you or your dependent elects COBRA coverage:

- You or your dependent can keep the same level of coverage you had as an active employee or choose a lower level of coverage.
- You or your dependent's coverage is effective as of the first day of the month following the qualifying event; however, if you waive COBRA coverage and then revoke the waiver within the 60-day election period, your elected coverage begins on the date you revoke your waiver.
- You or your dependent may change your coverage:
  - During the Plan's open enrollment period.
  - If you have a mid-year change in status.
  - If you have a change in circumstance recognized by the Internal Revenue Service ("IRS").
- You may enroll any newly-eligible spouse or child under plan rules.

### **When COBRA Coverage Ends**

COBRA coverage ends before the maximum continuation period if one of the following occurs:

- You or any of your covered dependents become covered under another health plan not offered by the University.

- You or your covered dependent fails to make contributions by the due date as required.
- The University stops providing health benefits to any employee.

COBRA coverage also may be terminated for any reason the plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

### **Special Rules for Health Care Flexible Spending Accounts**

For a health care flexible spending account (“health FSA”), COBRA continuation coverage is available only if the amount that a qualified beneficiary would be required to pay for the coverage for the remainder of the Plan Year is less than the amount of reimbursements that would be available to the qualified beneficiary if he or she elected COBRA coverage. Also, even if COBRA continuation coverage is available, it is available only for the remainder of the Plan Year in which the qualifying event occurs. COBRA continuation coverage for the health FSA cannot be extended beyond that time for any reason.

*EXAMPLE: Assume that an employee elected to contribute a total of \$1,200 to her health FSA account for a Plan Year and then her employment terminates six months after the start of that Plan Year. By that time, she has contributed \$600 to her FSA account through payroll deductions. Assume that she has already received \$800 in reimbursements from her account for eligible expenses she paid before her employment terminated. In that case, the maximum benefit she could receive from her account for any eligible expenses she incurs for the rest of the Plan Year is \$400. However, if she were permitted to continue to participate in the FSA for the rest of the Plan Year, she would be required to pay a total of \$600 (plus about \$12 in additional premiums allowed under COBRA) to continue that coverage. In that case, the amount she would be required to pay (about \$612) is more than the maximum that she would be eligible to receive in reimbursements (\$400), so she would not be offered COBRA continuation coverage under the FSA. On the other hand, if she had incurred expenses of \$588 or less before her employment terminated, she would be offered the opportunity to elect COBRA continuation coverage under the FSA for the remainder of the Plan Year because her maximum benefit under the Plan for the rest of the Plan Year would be more than the amount she would be required to pay (\$612).*

Any filing deadlines or other rules for filing a request for reimbursement under the Health FSA, as described earlier in this Summary Plan Description, will continue to apply if you elect continuation coverage under the Health FSA.

# Claim Determination Procedures

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Disagreements about benefit eligibility or benefit amounts can arise. The University has formal appeal procedures in place for the plan.

## **Claims Procedures**

The following summary of the plan's claims procedures is intended to reflect the Department of Labor's claims procedures regulations and, for certain medical benefits, the applicable requirements of regulations issued under federal health care reform law, and should be interpreted accordingly. If there is any conflict between this SPD and those regulations, the regulations will control. In addition, any changes in applicable law will apply to the plan automatically effective on the date of those changes.

For any insured benefits, the Insurer's claims procedures will apply instead of the claims procedures described in this SPD. The Insurer's claims procedures are described in the benefits booklet that describes the specific benefit. If you have questions about claims procedures for any insured benefit, you should contact the Insurer directly.

Note that, for certain claims for a benefit, such as claims for dependent care flexible spending account benefits, the Department of Labor's regulations do not apply. For those claims, the claims procedures described in this section that apply for benefits other than health or disability benefits will apply, but any requirement that the Plan Administrator provide notice to a claimant about any right will not apply to such a claim.

Note that certain requirements described below apply only to medical coverage and are based on regulations issued pursuant to the Affordable Care Act. Those requirements generally applied beginning July 1, 2011, but the Plan will not be treated as in violation of those regulations for those specific requirements for periods before July 1, 2011, as long as it is making reasonable good faith efforts to comply. Those requirements include the requirements described in the "*Additional Requirements for Non-Grandfathered Medical Plans*" subsection later in this Claim Determination Procedures summary. Although the Plan will make good faith efforts to comply with those requirements, note that compliance was not required until July 1, 2011, as long as the plan continued to make those good faith efforts.

To receive plan benefits, you must follow the procedures established by the Plan Administrator and/or the insurance company which has the responsibility for making the particular benefit payments to you. If you do not follow the plan's claims procedures, you may lose your right to a benefit under the plan, including any right you may have to file a legal action for benefits.

## **Initial Claims**

Initial claims for plan benefits are made to the Plan Administrator or, if the benefit is insured, to the Insurer providing that benefit. The remainder of these procedures uses the term "Reviewer" to refer to either the Plan Administrator or the Insurer, whichever is responsible for reviewing a claim. All claims must be submitted, in writing (except to the extent that oral claims are permitted for urgent care claims, as described below), to the Reviewer. The Reviewer will review the claim itself or appoint an individual or an entity to review the claim, in accordance with the following procedures. (For purposes of these procedures, "health benefits" or "health claims" refers to benefits or claims involving medical, dental, or vision coverage.)

- ***Non-Health and Non-Disability Benefit Claims.***

For any claim that is not a health claim or a disability claim, the Claimant will be notified within 90 days after the claim is filed whether the claim is allowed or denied, unless the Claimant receives written notice from the Reviewer before the end of the 90-day period stating that circumstances require an extension of the time for decision, in which case the extension will not extend beyond 180 days after the day the claim is filed.

- ***Health Benefit Claims.***

1. Urgent Care Claims. If the Claimant's claim is for urgent care health benefits, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the plan receives the claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In cases where the Claimant fails to provide sufficient information to decide the claim, the Reviewer will notify the Claimant as soon as possible, but not later than 24 hours after the plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Reviewer will notify the Claimant of the plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

A health benefits claim is considered an urgent care claim if applying the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim.

2. Concurrent Care Claims. If the plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Reviewer will notify the Claimant of the adverse determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by a Claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim, provided that any such claim is made to the plan at least 24 hours before the expiration of the prescribed period of time or number of treatments.

3. Other Health Benefit Claims. For any health benefit claim not described above:

- For any pre-service health benefit claim, the Reviewer will notify the Claimant of the plan's determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the plan receives the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 15 days after the plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 30 days after receiving the claim. If such an

extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

- A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.
- For any post-service health benefit claim, the Reviewer will notify the Claimant of the plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 30 days after the plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 45 days after receiving the claim. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.
- A health benefit claim is considered a post-service claim if it is a request for payment of services which the Claimant has already received.

▪ ***Disability Benefit Claims.***

For any disability benefits claim, the Reviewer will notify the Claimant of the plan's adverse determination within a reasonable period of time, but not later than 45 days after receipt of the claim. If, due to matters beyond the control of the plan, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 45 days after the Reviewer receives the claim, of those special circumstances and of when the Reviewer expects to make its decision but not beyond 75 days. If, before the end of the extension period, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to 105 days, provided that the Reviewer notifies the Claimant of the circumstances requiring the extension and the date by which the Reviewer expects to render a decision. The extension notice will specifically explain the standards on which entitlement to a disability benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed from the Claimant to resolve those issues, and the Claimant shall be afforded at least 45 days within which to provide the specified information.

1. Manner and Content of Denial of Initial Claims. If the Reviewer denies a claim, it will provide to the Claimant a written or electronic notice that includes:

- A description of the specific reasons for the denial;
- A reference to any plan provision or insurance contract provision upon which the denial is based;
- A description of any additional information that the Claimant must provide in order to perfect the claim (including an explanation of why the information is needed);
- Notice that the Claimant has a right to request a review of the claim denial and information on the steps to be taken if the Claimant wishes to request a review of the claim denial;
- A statement of the Claimant's right to bring a civil action following any denial on review of the initial denial.
- In addition, for a denial of health benefits or disability benefits, the following will be provided to the Claimant:
  - A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon request by the Claimant and without charge); and

- If the adverse determination is based on the plan's medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the exclusion or limit to the Claimant's medical circumstances (or a statement that the same will be provided upon request by the Claimant and without charge).

(For an adverse determination concerning a health claim involving urgent care, the information described in this Section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished not later than three days after the oral notification.)

### ***Reviews of Initially Denied Claims.***

If you submit a claim for plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the following procedures.

1. Non-Health and Non-Disability Benefit Claims. For benefits other than health and disability benefits, a request for review of a denied claim must be made in writing to the Reviewer within 60 days after receiving notice of the initial denial of the claim. The decision on review will be made within 60 days after the Reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after receipt of a request for review.
  - The Reviewer will provide the Claimant an opportunity to review and receive, without charge, all relevant documents, information and records and to submit issues and comments in writing to the Reviewer. The Reviewer will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.
2. Health and Disability Benefit Claims. A Claimant whose initial claim for health or disability benefits is denied may request a review of that denial no later than 180 days after the Claimant receives the notice of an adverse determination. Except as provided below for an expedited review of a denied urgent care health claim, a request for review must be submitted to the Reviewer in writing.
  - A Claimant may request an expedited review of a denied initial urgent care health claim. Such a request may be made to the Reviewer orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the plan and the Claimant by telephone, facsimile or other available similarly expeditious method.
  - In addition to providing the right to review documents and submit comments, a review will meet the following requirements:
    - The plan will provide a review that does not afford deference to the initial adverse determination and that is conducted by an appropriate named fiduciary of the plan who did not make the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination.
    - The appropriate named fiduciary of the plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual.

- The plan will identify to the Claimant the medical or vocational experts whose advice was obtained on behalf of the plan in connection with the review determination, without regard to whether the advice was relied upon in making the review determination.
- For purposes of any medical coverage, the plan will allow a Claimant to review the claim file and to present evidence and testimony and will comply with the following additional requirements:
  - The plan will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan in connection with the claim as soon as possible and sufficiently in advance of the plan 's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date; and
  - Before the plan issues a final decision on review based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale for the Plan's decision as soon as possible and sufficiently in advance of the plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date.

***Deadline for Review Decisions.***

1. Urgent Health Benefit Claims. For urgent care health claims, the Reviewer will notify the Claimant of the plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the plan receives the Claimant's request for review of the initial adverse determination by the plan; unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan.
2. Other Health Benefit Claims.
  - For a pre-service health claim, the Reviewer will notify the Claimant of the plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after receipt by the plan of the Claimant's request for review of the initial adverse determination.
  - For a post-service health claim, the Reviewer will notify the Claimant of the plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after the Plan receives the Claimant's request for review of the initial adverse determination
3. Disability Benefit Claims. For disability claims, the decision on review will be made within 45 days after the Reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 90 days after receipt of a request for review.

***Manner and Content of Notice of Decision on Review.***

Upon completion of its review of an adverse initial claim determination, the Reviewer will provide the Claimant a written or electronic notice of its decision on review. For any adverse determination on review that notice will include:

- A description of its decision;
- A description of the specific reasons for the decision;
- A reference to any relevant plan provision or insurance contract provision on which its decision is based;

- A statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the Claimant's claim for benefits;
- If applicable, a statement describing the Claimant's right to bring an action for judicial review;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge upon request; and
- If the adverse determination on review is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided without charge upon request.

### **Additional Requirements for Non-Grandfathered Medical Plans**

For any adverse determination involving medical coverage that is not provided under a plan that is a grandfathered plan under the Affordable Care Act, any notice of an adverse determination will be provided in a culturally and linguistically appropriate manner in accordance with applicable law regarding such notices and will include (in addition to other requirements described above):

- Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code (and an explanation of its meaning), if requested, and the treatment code (and an explanation of its meaning), if requested;
- A discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the plan's standard, if any, that was used in denying the claim;
- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and
- Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Affordable Care Act to assist individuals with internal claims and appeals and external review processes.

Also, for all claims involving coverage that is subject to the Affordable Care Act and is not a grandfathered plan under that Act, the plan will ensure that claims and appeals are decided in a manner designed to ensure the independence and impartiality of individuals involved in claims decisions. Decisions regarding hiring, compensation, termination, promotion, or similar matters will not be made based on the likelihood that any person involved in making claims decisions will support the denial of benefits.

#### *External Review*

If, after exhausting your internal appeals under the plan's medical benefits program, you are not satisfied with the determination made by the Claims Administrator, or if the Claims Administrator fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of the Claims Administrator's determination. This process is available at no charge to you. Refer to your benefit booklets and other incorporated documents for additional information regarding federal external review.

### **Calculation of Time Periods**

For purposes of the time periods specified in this Claims Procedures section, the period during which a benefit determination must be made begins when a claim is filed in accordance with the plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period



is extended because a Claimant fails to submit all information necessary for a claim for non-urgent care health benefits or for disability benefits, the period for making the determination will be "frozen" from the date the notification requesting the additional information is sent to the Claimant until the day the Claimant responds or, if earlier, until 45 days from the date the Claimant receives (or was reasonably expected to receive) the notice requesting additional information.

### **Claimant's Failure to Follow Procedures**

A Claimant must follow the claims procedures described above to be entitled to file any legal action for benefits under the plan (unless the plan fails to follow those procedures).

### **Plan's Failure to Follow Procedures**

If the plan fails to follow the claims procedures described above, a Claimant will be deemed to have exhausted the administrative remedies available under the plan and will be entitled to pursue any available remedy on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. For any claim involving medical coverage that is not a grandfathered plan under the Affordable Care Act, effective July 1, 2011, a Claimant is deemed to have exhausted the plan's internal claims and appeals process if the plan does not strictly adhere to the applicable requirements of the U.S. Department of Labor's claims procedure regulations (or corresponding regulations issued by the Department of the Treasury or the Department of Health and Human Services). Exhaustion of the plan's internal claims and appeals process will not be deemed to occur when the plan's failure to follow the claims procedures is de minimis, non-prejudicial, attributable to good cause or matters beyond the plan's control, occurs in the context of an on-going good faith exchange of information, or is not reflective of a pattern or practice of non-compliance.

In such cases, in addition to the right to pursue any available remedy under State law, the Claimant will have the right to pursue any remedy under any available external review process provided under federal or State law in accordance with the Affordable Care Act.

Effective July 1, 2011, for purposes of any coverage that is subject to the Affordable Care Act and is not a grandfathered plan, the plan will comply with the applicable requirements of any external review process that applies under federal or State law. For any non-grandfathered coverage that is self-funded, the Plan will comply with the external review procedures set forth in Department of Labor Technical Releases 2010-01 and 2011-02 until those procedures are superseded by other guidance and the Plan will begin complying with any superseding guidance on or before the date that guidance becomes applicable to such coverage under the Plan. If you have any questions about those procedures, please contact the Plan Administrator for details.

### **Insured Benefits and State Law**

For any insured benefit under this plan, nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable State law that regulates insurance, except to the extent that such law prevents application of the plan's claims procedures.

### **Statute of Limitations for Plan Claims**

Please note that no legal action may be commenced or maintained to recover benefits under the plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

## HIPAA Privacy Rights

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The HIPAA Privacy Rule applies to “Protected Health Information”, which is defined as any written, oral, or electronic health information that meets the following three requirements:

- The information is created or received by a health care provider, the plan, or the health carrier (i.e. covered entity).
- The information includes specific identifiers that identify you or could be used to identify you.
- The information relates to one of the following:
  - Providing health care to you.
  - Your past, present, or future physical or mental condition.
  - The past, present, or future payment for your health care.

The Notice of Privacy Practices for the plan contains a complete explanation of your rights under the HIPAA Privacy Rule. The notice describes how Protected Health Information may be used and disclosed, and how you can get access to that information. The following is a summary of those uses and disclosures of Protected Health Information and your rights with respect to Protected Health Information:

- The plan may use or disclose your Protected Health Information for purposes of conducting health care operations or paying your health care claims.
- The plan may use or disclose your Protected Health Information to tell you about treatment alternatives, or to provide you with information about other health-related benefits or services that may be of interest to you.
- The plan may disclose your Protected Health Information to the University, as sponsor of the plan, to assist the University in the performance of plan administrative functions; the plan also may provide summary health information to the University, as plan sponsor, so that the University may obtain premium bids or modify, amend or terminate the plan; summary health information does not directly identify you, but summarizes claims history, claims expenses or types of claims experienced; finally, the plan may disclose your enrollment and disenrollment information to the University as plan sponsor.
- The plan may disclose your Protected Health Information when required to do so by any federal, state, or local law, and when permitted to do so under the circumstances set out in the University’s Notice of Privacy Practices.
- The plan may disclose your Protected Health Information to a law enforcement official for certain law enforcement purposes; for example, the plan may disclose your Protected Health Information pursuant to a law requiring the reporting of certain types of wounds or other physical injuries.
- The plan may disclose your Protected Health Information to health care providers to assist them in connection with their treatment or payment activities; in addition, the plan may disclose your Protected Health Information to other entities subject to the HIPAA Privacy Rule to assist them with their payment activities or certain of their health care operations; for example, the plan might disclose your Protected Health Information to a health care provider when needed by the provider to render treatment to you.
- Other than as permitted or required by law, the plan will not use or disclose your Protected Health Information without your written authorization; if you authorize the plan to use or disclose your Protected

Health Information, you may revoke that authorization in writing at any time; if you revoke the authorization, the plan no longer will use or disclose your Protected Health Information for the reasons covered by your written authorization; your revocation will not affect any uses or disclosures the plan already has made prior to the date the plan receives notice of the revocation.

In general, you have the following rights regarding the Protected Health Information retained by the plan:

- You have the right to request that the plan restrict uses and disclosures of your Protected Health Information to carry out payment or health care operations.
- You have the right to request that the plan communicate with you in a certain way if you feel that the disclosure of your Protected Health Information could endanger you.
- You have the right to inspect and obtain a copy of your Protected Health Information.
- If you believe that the Protected Health Information the plan has about you is inaccurate or incomplete, you have the right to request a correction.
- You have a right to request a list of disclosures made by the plan of your Protected Health Information, other than those disclosures for which an accounting is not required.
- You have a right to request and receive a paper copy of the Notice of Privacy Practices for the plan, even if you have received this notice previously or agreed to receive this notice electronically.

For more information regarding these rights and the privacy policies of the plan, please review the Notice of Privacy Practices for the plan. The Notice of Privacy Practices for the plan is available from the appropriate insurance carrier.

## Administrative Information

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This section contains important information about how your benefits are administered and funded. It also contains information about your rights and responsibilities as a participant and steps you can take if certain situations arise.

### **Plan Name/Identification**

As indicated in the “Introduction” section, the benefits described in this SPD are governed by the official plan documents. The official plan documents are the certificates of insurance issued by the Insurers, the administrative services agreements, this summary plan description, or other governing documents referenced herein.

The DUFlex Flexible Benefits Plan is an employer-sponsored welfare benefit plan. This plan is also called a “cafeteria plan” because it allows you to choose the benefits you will receive from the plan. You are given the opportunity to direct the University to redirect a specified amount of your salary. You then can use the redirected amount of the salary to purchase benefits under the plan. For certain benefits, because a portion of your salary is redirected (and thus your salary is reduced) before federal taxes (and, in most states, state taxes) are imposed, you pay less in taxes if you participate in the plan. (Some benefits may require that you make after-tax contributions).

The plan number assigned by the University is 501.

### **Plan Information**

This SPD includes this document and the incorporated documents listed in the “Introduction” section. In addition, you can get information about the plan and your health and welfare benefits from:

- Applicable summaries of material modifications (“SMMs”) to this SPD.
- Enrollment materials and other general communications identified as containing plan information.
- The pertinent contracts between the University and claims administrators that provide services under the plan.

### **Plan Employer/Plan Sponsor/Employer Identification Number**

The employer/plan sponsor for the plan is:

Duquesne University  
Office of Human Resources  
600 Forbes Avenue  
Pittsburgh, PA 15282  
Phone Number: 412.396.5106

The employer identification number is 25-1035663.

## **Participating Employers**

There are no other Employers participating in the Plan at this time.

## **Plan Administrator**

The Plan Administrator for the plan is:

Duquesne University  
Office of Human Resources  
600 Forbes Avenue  
Pittsburgh, PA 15282  
Phone Number: 412.396.5106

## **Health Claims Administrators**

The claims administrators for the health benefits under the plan are:

Cigna (High Deductible Health Plan, Open Access Plus, PPO)  
Two Liberty Place  
1601 Chestnut Street  
Philadelphia, PA 19192

UPMC Health Plan (UPMC Health Plan EPO and UPMC Health Plan HSA PPO)  
U.S. Steel Tower  
600 Grant Street  
Pittsburgh, PA 15219

CVS Caremark Prescription Drug (prescription drug)  
Customer Care Correspondence  
PO Box 6590  
Lee's Summit, MO 64064-6590

VSP Choice (insured vision benefits)  
3333 Quality Drive  
Rancho Cordova, CA 95670

MetLife PDP Plus Network (insured dental benefits)  
Metropolitan Life Insurance Company  
200 Park Avenue  
New York, New York 10166

Lytle EAP Partners (EAP)  
200 Cedar Ridge Drive Suite 208  
Pittsburgh, PA 15205

Discovery Benefits (Flexible Spending Accounts and Health Savings Account)  
4321 20th Avenue SW  
Fargo, ND 58103

MetLife (Life Insurance/Accidental Death and Dismemberment (AD&D), Long Term Disability (LTD) and Business Travel Accident)  
1000 Omega Drive # 1500  
Pittsburgh, PA, 15205

## **COBRA Administrator**

The COBRA administrator for the plan is:

Duquesne University  
Office of Human Resources  
600 Forbes Avenue  
Pittsburgh, PA 15282  
Phone Number: 412.396.5106

## **Agent for Service of Legal Process**

The agent for service of legal process under the plan is:

Duquesne University  
Office of Human Resources  
600 Forbes Avenue  
Pittsburgh, PA 15282  
Phone Number: 412.396.5106

## **Plan Year**

The plan year runs from July 1 to June 30.

## **Funding and Source of Contributions**

The benefits under the plan are funded by employer and employee contributions. The University reserves the right to change the amount of required employee contributions for coverage under the plan at any time, with or without advance notice to employees. Employer contributions are made from University revenues. For the fully-insured benefits under the plan, the University pays an insurance company or other provider a premium, from University revenues and employee contributions, for providing coverage under the insured options.

## **Claims Administrators and Authority to Review Claims**

Your eligibility for, and the provision of, health and welfare benefits is determined by the plan. The Plan Administrator has the full discretionary authority to interpret the plan in accordance with its terms and determine eligibility under the plan. The Plan Administrator has delegated its authority for the administration of the plan and its authority to make final claims determinations to the claims administrators. In some cases, the claims administrators may delegate this authority to certain other organizations on behalf of the University. Benefits under the plan are paid only if the claims administrators, or their delegates, decide in their discretion that the claimant is entitled to them.

The claims administrators' decisions are final and binding on all parties to the full extent permitted under applicable law, unless the participant or beneficiary later proves that a claims administrator's decision was an abuse of administrator discretion.

## **No Employment Rights or Guarantee of Benefits**

All terms of the plan are legally enforceable. However, neither the plan nor this SPD constitutes a contract of employment or guarantee of any particular benefit.

## **Amendment/Termination**

Although the University presently intends to continue the plan, it reserves the right to, at any time, change or terminate any and all health and welfare benefits under the plan, to change or terminate the eligibility of classes of employees to be covered by the plan, to amend or eliminate any other plan term or condition, and to terminate the entire plan, or any part, subject to applicable law. The procedures by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or

terminated, or by which part or all of the plan may be amended or terminated are contained in the plan document, which is available for inspection and copying from the Plan Administrator. No consent of any participant is required to terminate, modify, amend, or change the plan. Termination of the plan will have no adverse effect on any benefits to be paid under the plan for any expenses incurred prior to the date that the plan terminates. Likewise, any extension of income protection benefits under the plan due to your or your dependent's total disability which began prior to and has continued beyond the date the plan terminates will not be affected by the plan's termination. No extension of benefits or rights will be available solely because the plan terminates.

### **University's Right to Use Your Social Security Number for Administration of Benefits**

The University retains the right to use your Social Security number for benefit administration purposes, including tax reporting.

### **Your Rights**

As a participant in the DUFlex Flexible Benefits Plan, you are entitled to certain rights and protections. All plan participants shall be entitled 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 and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if applicable, 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 collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable, 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, if applicable. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if this summary is applicable to the plan.

#### ***Continue Group Health Plan Coverage***

- 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 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, there are also duties imposed upon the people who are responsible for the operation of the plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of all 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.

#### ***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.

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, if applicable, 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.
- 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, 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 write to:

Division of Technical Assistance and Inquiries  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue N.W.  
Washington, DC 20210