

Effective September 1, 2023 to June 30, 2024*

BENEFITS OVERVIEW

July 1, 2023 to June 30, 2024



IN THE KNOW | PLAN FEATURES | HOW TO ENROLL

duq.edu/benefits



Office of Human Resources

Dear Colleagues,

At Duquesne University, we are committed to offering our employees a comprehensive and affordable medical benefits plan, despite rising health care costs. The University, with the guidance of a benefits consultant and the Compensation Committee comprised of faculty, administrative, staff and union representatives, has worked diligently to formulate a plan to help mitigate the effects of rising costs on the University's self-funded health plans.

Be a wise healthcare consumer and think of your healthcare investment just as you would any other important expense. Use the information provided in this booklet and www.duq.edu/benefits to make informed decisions.

- Participate in the Wellness In Motion program
- If you haven't already done so, find and schedule an appointment with a primary care doctor. Your primary care doctor is your first point of contact in the health care system. The PCP is there to help prevent you from getting sick and guide you through specialists if you do become ill.
- In-network preventive care is 100% covered—review the medical plans' preventive benefits schedule and receive immunizations and preventive services as outlined
- Use the providers' online tools to learn more about estimating costs, health coaches, healthy activities and lifestyle management programs
- Choose generic drugs
- Take advantage of the lower priced Telemedicine eVisits/Virtual Care options
- Visit an urgent care facility instead of the emergency room if you are not experiencing a true medical emergency
- Download an electronic copy of your identification card, vendor apps for access to important plan information, participating providers and wellness information

This booklet provides an overview of all of your benefit options. Much more information, including links to insurance carriers, is available at duq.edu/benefits.

I encourage you to evaluate all the available options before choosing the plans that best meet the needs of you and your family.

Best Regards,



Ryan Dawson, PHR, SHRM-CP
Associate Vice President of Human Resources and CHRO
Office of Human Resources

Table of Contents

ENROLLMENT PROCEDURE	3
Login to bswift	3
IN THE KNOW	4-5
MEDICAL PLAN PRICE TAGS.....	6
MEDICAL COVERAGE COMPARISON	7-11
PRESCRIPTION DRUG PLAN AND MEDICATION THERAPY MANAGEMENT PROGRAM	12-13
HEALTH SAVINGS ACCOUNTS.....	14
FLEXIBLE SPENDING ACCOUNTS	15
WELLNESS IN MOTION	16-17
DENTAL PLAN OVERVIEW AND PRICE TAGS.....	18
VISION PLAN OVERVIEW AND PRICE TAGS	19
EMPLOYEE ASSISTANCE PROGRAM (EAP)	20
LIFE INSURANCE, AD&D AND LONG TERM DISABILITY.....	21
RETIREMENT PLAN.....	22-23
OTHER BENEFITS AND TELEMEDICINE	24-25
COBRA	26
REQUIRED NOTICES	27-30
YOUR RIGHTS AND PROTECTIONS AGAINST MEDICAL BALANCE BILLING	31
RETIREMENT PLAN UNIVERSAL AVAILABILITY NOTICE	32
bswift SELF SERVICE.....	33
CUSTOMER SERVICE CONTACTS	34

OFFICE OF HUMAN RESOURCES MISSION STATEMENT PEOPLE INSPIRE US

We partner with the University Community to provide innovative and authentic people-centered services and solutions. We foster excellence and inclusion in the development of the whole person: mind, heart and spirit.

Notice to Participants: The information contained in this enrollment booklet represents only a portion of the actual provisions of the coverages mentioned. This document is not a contract. The complete terms and conditions concerning the discussed coverages are described in the actual plan documents. Official plan documents may be viewed at duq.edu/benefits/requirednotices. Any individual who provides fraudulent information will be subject to disciplinary action and/or prosecution. Duquesne University reserves the right, in its sole discretion, to amend this plan in whole or in part at any time and from time to time, or to terminate it at any time without advance notice. We encourage you, your spouse, and dependents to access the notices online and review them in conjunction with open enrollment and any time after. The notice of the availability of this information online and your ability to access the information is deemed to be delivery of those notices.

ENROLLMENT PROCEDURE



1. **EVALUATE** your choices. Review the Benefits Overview booklet and compare your benefit options from all available sources.
2. **VISIT** duq.edu/benefits and click the **Log In or Enroll Now** button.
3. **FOLLOW** instructions located below the **Log In or Enroll Now** button for access to your account.
4. **COMPLETE** selections.
5. **REVIEW** your selections carefully. Be sure your selections are what you want.
6. **REMEMBER**, even if you decide to waive the University medical coverage, you must still complete the enrollment process to select your other benefits, to review your demographic information, and to indicate your life insurance beneficiaries.
7. **REVIEW** your selections carefully. Be sure your selections are what you want. Compare your paycheck of against your online enrollment to verify your selections are correct. **Federal guidelines only permit benefit changes for a qualified life event after the your New Hire Enrollment period.**
8. **REMEMBER** to log into **bswift** anytime throughout the benefits plan year (July 1, 2023 - June 30, 2024) to review coverage, update life insurance beneficiaries or to complete a qualified life event.



Duquesne University uses a confidential, web-based benefits enrollment management system,

bswift.

Be sure to take advantage of

Ask Emma,

an interactive decision support tool designed to help you make more informed and personalized medical benefit decisions.



ask EMMA



- **Medical and Prescription ID Cards.** Enrollment information is electronically sent to our providers after the Enrollment process is finalized. It usually takes 10 to 15 business days from the time each company receives the information to print and mail ID cards. You can also print temporary cards by creating your online profile via the providers' member websites.
- **Dental and Vision ID Cards.** **Dental and vision providers do not print and mail ID cards.** You can print a card by creating an online account via the providers' member websites. Websites and customer service contact information are located on page 34.

REMEMBER, even if you decide to waive the University medical coverage, you must still complete the enrollment process to select your other benefits:

- Dental Plan
- Vision Plan
- Flexible Spending Account
- Voluntary supplemental term life insurance, dependent life insurance, long-term disability

MAKE THE MOST OF YOUR HEALTH PLAN DURING THIS PLAN YEAR

- Review all of your medical plan options and select the one that fits your medical needs the best. Compare the Duquesne University plan to other options that may be available to you, including spousal employee benefits.
- Employees considering enrollment in a High Deductible Health Plan (HDHP) should review medical expenses, including dental and vision copays, to determine if additional Health Savings Account (HSA) contributions are needed. An HSA is available for all HDHP options. Additional HDHP and HSA information is available on pages 6-11 and 14, respectively.
- A Flexible Spending Account (FSA) is available for other medical plan options; an FSA is not available with High Deductible Health Plans. If you expect to incur expenses that won't be reimbursed from your medical, dental or vision insurance, review the information on page 15 to see if you should consider making contributions to this account.
- Create and/or sign in to your insurance carrier's online member website to set up your profile. This can be done a few weeks after enrollment or once you get your ID card. Use the website to search medical treatment costs, review your claims, track your deductible and monitor your Wellness in Motion goals.
- Find a network primary care physician (PCP). While the selection of a PCP is not required, your PCP is often the one who knows your medical needs best and understands your medical history. Taking the time to find a doctor you trust when you are feeling well can save you stress when you get sick.
- Set-up and go to your wellness/preventive appointment to take advantage of the preventive services offered with your medical plan. Diagnosing and treating illness, injury or disease early may help save money and avoid further medical issues.
- Participate in the University's Wellness in Motion program. See additional information on pages 16 and 17.
- Remember that our medical plans provide for preventive screenings recommended by the U.S. Preventive Services Task force—all at no cost to you. Preventive services, listed on your medical plan website, save you money and may help you avoid future medical issues.
- Select the correct facility for your medical care. Visit your medical plan website to take advantage of their medical cost estimator tools to ensure you are using the most cost effective point of service.
- Actively participate in the disease management and coaching programs offered through The Center for Pharmacy Care and the medical plans. Refer to page 13 for information regarding \$0 cost if eligible for the Medication Therapy Management Program.
- Minimize your costs by using Telemedicine eVisits/Virtual Care and Medical Plan Health Information lines.

BENEFIT CHANGES OUTSIDE OF OPEN ENROLLMENT

When you enroll in health insurance, dental insurance, vision insurance, life insurance and/or the flexible spending accounts, your benefit elections remain in effect to the end of the plan year (June 30, 2024). You cannot make any changes until the next Open Enrollment unless you experience a qualified life event and the benefit change you request is consistent with the event. For example, a marriage is a family status change that would allow you to change from Employee health coverage to Employee Plus Spouse health coverage because acquiring a spouse is consistent with a gain in eligibility for health coverage. The following is a list of qualified life events defined by Section 125 of the Internal Revenue Code that will allow you to make a change to your elections:

- **Legal marital status.** Any event that changes your legal marital status, including marriage, divorce, death of a spouse or annulment.
- **Number of dependents.** Any event that changes your number of tax dependents, including birth, legal guardianship, death, adoption and placement for adoption.
- **Employment status.** Any event that changes your, your spouse's or your other dependent's employment status and results in gaining or losing eligibility for coverage. Examples include:
 - Beginning or terminating employment;
 - Starting or returning from an unpaid leave of absence;
 - Changing from part-time to full-time employment or vice versa; and
 - A change in work location.
- **Dependent status.** Any event that causes your tax dependent to become eligible or ineligible for coverage because of age, student status, tax dependent status or similar circumstances.
- **Residence.** A change in residence that causes an employee, spouse or dependent to gain or lose eligibility for a plan or a different benefit option available under the plan (e.g. moving outside your medical or dental program's network service area).
- **COBRA.** Eligibility of an employee, spouse or dependent for COBRA.
- **HIPAA Special Enrollment Events.** Events such as the loss of other coverage that qualify as special enrollment events under the Health Insurance Portability and Accountability Act (HIPAA) or an event that involves loss of Medicaid or State Child Health Insurance Program (CHIP) coverage or eligibility for state premium assistance.
- **Your spouse's Open Enrollment.**



Qualified life events must be reported on bswift within 30 days of the event.

See page 33 for bswift Self Service instructions.

All changes require proper documentation and must be consistent with a qualified life event. Do not wait for documentation to begin this process.

In order to comply with federal health care reform reporting, Duquesne University is required to gather Social Security Numbers for all covered spouses and children. Please remember to enter this information if it is missing on your dependent records. The government will use the information collected to assist in identifying those individuals who have health coverage or who should be purchasing health coverage through the Health Insurance Marketplace.

Remember to review your paycheck to ensure the proper premiums are being deducted for your enrollment elections.

EMPLOYEE STATUS	Highmark High Deductible	University Contribution to Health Savings Account	UPMC High Deductible	University Contribution to Health Savings Account	Highmark PPOBS	UPMC EPO	Working Spouse Contribution
	High Deductible Health Plans present medical card for prescription coverage as they are subject to deductible.				Highmark PPOBS and UPMC EPO present CVS Caremark card for prescription coverage.		
EMPLOYEE							
Annual	\$784.88	\$400.00	\$784.88	\$400.00	\$2,522.04	\$2,522.04	None
Biweekly	\$30.19	\$15.38	\$30.19	\$15.38	\$97.00	\$97.00	None
EMPLOYEE PLUS CHILD(REN)							
Annual	\$1,234.54	\$600.00	\$1,234.54	\$600.00	\$3,795.83	\$3,795.83	None
Biweekly	\$47.48	\$23.08	\$47.48	\$23.08	\$145.99	\$145.99	None
EMPLOYEE PLUS SPOUSE							
Annual	\$1,350.13	\$600.00	\$1,350.13	\$600.00	\$4,135.62	\$4,135.62	\$3,345.68
Biweekly	\$51.93	\$23.08	\$51.93	\$23.08	\$159.06	\$159.06	\$128.68
FAMILY							
Annual	\$1,683.69	\$600.00	\$1,683.69	\$600.00	\$5,501.37	\$5,501.37	\$3,345.68
Biweekly	\$64.76	\$23.08	\$64.76	\$23.08	\$211.59	\$211.59	\$128.68

WORKING SPOUSE CONTRIBUTION

Duquesne University will continue to offer medical coverage to legal spouses of eligible employees. However, if your spouse is eligible for his/her own employer-sponsored medical plan but chooses to enroll in the University’s medical plans, including the High Deductible Health Plans, an additional pre-tax contribution of \$128.68 per pay will be required. You will be asked to certify your spouse’s eligibility during enrollment.

If your spouse loses or obtains medical coverage after enrollment, you must notify the Benefits Office within 30 days. Refer to [bswift Self Service page 33](#) for additional information.

The Working Spouse Contribution **DOES NOT APPLY** in the following situations:

- You do not have a spouse
- You have elected to waive University medical coverage

- Your spouse is also a Duquesne University employee
- You have elected not to enroll your spouse in a University medical plan
- You have elected to enroll your spouse in a University medical plan and your spouse:
 - Is not employed;
 - Works for an entity that does not offer employer-sponsored medical insurance;
 - Is not eligible for their employer-sponsored medical insurance; or
 - Has medical coverage through Medicare or Medicaid.

When both spouses work at Duquesne University, the working spouse contribution will not be passed on.

HOW THE MEDICAL PLANS COMPARE

FEATURE	Highmark and UPMC High Deductible Health Plans (HDHP)	Highmark PPO Blue Sharing	UPMC Health Plan Exclusive Provider Organization (EPO)
Type of Plan	With a High Deductible Health Plan/Health Savings Account (HDHP/HSA) your coverage consists of two components—a traditional health plan to protect you against health care expenses (HDHP) and a tax-advantaged savings vehicle (HSA). Contributions to the HSA help you build savings for current and future medical expenses.	This Open Access Plus (OAP) plan includes prescription drug coverage provided by CVS Caremark. Highmark PPOBS gives you the flexibility to use in- or out-of-network providers and specialists without referrals. A higher level of benefits is provided when in-network providers are used, resulting in lower out-of-pocket costs for you.	When you select an Exclusive Provider Organization (EPO), you agree to use ONLY the plan's network of professionals and facilities. An EPO DOES NOT cover the cost of services received from non-participating providers, except in emergency situations. You are not required to select a Primary Care Physician.
Covered Services	All plans cover the same services; however, how much you pay for services is different in each plan.		
What is the Network?	Highmark PPO BCBS PPO Network and UPMC Health Plan Premium PPO Network	Highmark PPO Blue Sharing	UPMC Health Plan Exclusive Provider Organization (EPO) Premium Network
How do I know what my deductible will be?	The amount of the deductible is listed at the top of the plan design grid. Families and the Employee Plus Spouse or Child(ren) are responsible for meeting the full-family deductible. For High Deductible Health Plans, the entire amount of the family deductible must be met by one family member or by a combination of family members. This is a requirement of the IRS to ensure the plan meets the definition of a high deductible plan. This is different from the deductibles for Highmark PPOBS and UPMC EPO plans.	The amount of the deductible is listed at the top of the plan design grid. Families and the Employee Plus Spouse or Child(ren) are responsible for two individual deductibles. If there are four people in your family, once two people in the family or a combination of everyone in the family meets the deductible, then the entire family is covered. This is different from the HDHP deductible.	
How much do I pay for a physician visit that is not preventive care?	This plan does not offer office visit copays. You pay 100% of the cost until you meet your in-network deductible. Once you've met the in-network deductible, you pay 15% of the office visit costs until you reach the out-of-pocket maximum. Once you have reached the in-network out-of-pocket maximum, the plan pays 100% of the in-network covered services.	You pay a \$25 copay for primary care and \$45 copay for a specialist doctor's office visit. Laboratory or imaging fees are subject to the deductible and coinsurance.	
How do I pay for prescription drugs?	Present your medical card when obtaining your prescription drugs. You pay 100% of the cost until you meet your in-network deductible. Once you've met the deductible, you pay 15% of the costs until you reach the in-network out-of-pocket maximum. Once you have reached the in-network out-of-pocket maximum, the plan pays 100% of the covered services. Your eligible prescriptions also go toward your deductible.	Present your CVS Caremark card when obtaining your prescription drugs. Many prescriptions follow step therapy guidelines. Maintenance prescriptions (those used for chronic, long-term management) must be filled via CVS Caremark mail order or CVS retail stores. Copays are based upon the chart located on page 12. Once you meet your prescription out-of-pocket maximum as listed on page 12, the plan pays 100% of the covered prescription services.	
Can I open a Health Savings Account?	Yes, a Health Savings Account is available. If selected, the University will deposit: \$400 Employee, \$600 Employee Plus Child(ren), \$600 Employee Plus Spouse, \$600 Family. Limit = \$3,850 for Employee and \$7,750 for all other tiers. Once funds reach \$1,000, they can be invested in mutual funds. Contributions are pre-tax; earnings accumulate tax-free. Withdrawals for eligible expenses are not subject to federal income tax. Monies roll over from year to year. Funds used for non-qualified medical expenses are subject to taxes and penalties.	No, a Health Savings Account is not available. Per IRS regulations, you must be enrolled in a High Deductible Health Plan to be eligible for a Health Savings Account.	
Can I open a Flexible Spending Account for health care expenses?	Yes, a Limited Flexible Spending Account is available for dental and vision care expenses only. Contribution limit is \$3,050 per year. Unused balances will be forfeited.	Yes, a Health Care Flexible Spending Account is available for qualified medical, dental and vision expenses. Contribution limit is \$3,050 per year. Unused balances will be forfeited. Expenses must be incurred by September 15 (14 1/2 months) and claim forms/receipts postmarked by December 31 (18 months), or you will forfeit the monies in the account.	
How much should I contribute to a Health Savings or Flexible Spending Account?	This is a bank account opened to save money on a tax-favored basis to pay your share of qualified medical expenses. You can stop, increase or decrease your HSA contribution at any time during the year. The claims processing effective date is the day you open your HSA bank account. Your available amount is based on your biweekly contributions. Even though you may not have eligible expenses during the year, you can still set aside monies to build for the future. You own the account, even if you change health plans or leave the University.	Estimate your medical expenses for the coming plan year for office visits, deductibles, prescription copays, along with qualified dental and vision expenses. If you seldom use the doctor or do not have recurring medical expenses, this account may not be for you. The amount of money you "pledge" for the year is available for use effective July 1. Expenses must be incurred by September 15 (14 1/2 months) and claim forms/receipts postmarked by December 31 (18 months), or you will forfeit the monies in the account.	

MEDICAL COVERAGE COMPARISON

This guide is an overview of services, refer to the Summary of Benefits and Coverage (SBC) as you are completing your online enrollment. Copies are also available at duq.edu/benefits.

SERVICES	Highmark High Deductible Health Plan		UPMC High Deductible Health Plan		Highmark PPO Blue Sharing Plan		UPMC Exclusive Provider Organization
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Prescription Drug Coverage	Present medical card to obtain prescriptions as they are subject to deductible.				Present CVS Caremark card to obtain prescriptions.		
Network	Highmark PPO Blue Sharing Plan		UPMC Health Plan Premium PPO Network		Highmark PPO Blue Sharing		UPMC Health Plan EPO Premium Network
Deductible Per Plan Year	A deductible is the flat dollar amount you must pay each plan year for certain services before the plan begins to pay for covered services. The amount you pay for out-of-network services counts toward both your in-network and out-of-network plan deductibles.						
Employee Deductible	\$1,600	\$3,200	\$1,600	\$3,200	\$400	\$1,200	\$400
Maximum Deductible All tiers other than Employee	\$3,200 Family	\$6,400 Family	\$3,200 Family	\$6,400 Family	\$800	\$2,400	\$800
How do I know what my deductible will be?	<p>All tiers other than Employee only are responsible for meeting the full-family deductible.</p> <p>For this High Deductible Health Plan, the entire amount of the family deductible must be met by one family member or by a combination of family members.</p> <p>This is a requirement of the IRS to ensure the plan meets the definition of a high deductible plan.</p> <p>This is different from the deductibles for Highmark PPO Blue Sharing and UPMC EPO plans.</p>				<p>All tiers other than Employee only are responsible for two individual deductibles. If there are four people in your family, once two people in the family or a combination of everyone in the family meets the deductible, then the entire family is covered.</p>		
Plan Coinsurance	<p>Coinsurance is a cost sharing arrangement in which you and the plan each pay a percentage of the covered expenses after the deductible is met. The amount you pay for out-of-network coinsurance counts toward both your in-network and out-of-network coinsurance.</p> <p>The out-of-pocket maximum limits how much you pay for your share.</p>						
Employer-Paid Plan Coinsurance	85% after deductible until out-of-pocket limit is met, then 100%	65% after deductible until out-of-pocket limit is met, then 100%	85% after deductible until out-of-pocket limit is met, then 100%	65% after deductible until out-of-pocket limit is met, then 100%	85% after deductible until out-of-pocket limit is met, then 100%	65% after deductible until out-of-pocket limit is met, then 100%	85% after deductible until out-of-pocket limit is met, then 100%
Employee-Paid Coinsurance	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible
Employee Out-of-Pocket Maximum Per Plan Year	All deductibles, copays and coinsurance expenses contribute to the out-of-pocket maximum. Note that no individual within a family will incur an in-network out-of-pocket maximum in excess of \$8,150.				All medical deductibles, copays, and medical coinsurance expenses contribute to this medical out-of-pocket maximum. A separate out-of-pocket maximum applies to prescriptions.		
Employee	\$4,800	\$10,000	\$4,800	\$10,000	\$3,000	\$9,000	\$3,000
All Other Tiers	\$8,150	\$20,000	\$8,150	\$20,000	\$6,000	\$18,000	\$6,000
Primary Care Physician	No Primary Care Physician is Required						
Physician Office Visit	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	\$25	You pay 35% after deductible	\$25
Specialist Office Visit	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	\$45	You pay 35% after deductible	\$45
Telemedicine eVisits and Virtual Care	You pay 15% after deductible. Register or schedule an appointment at Well360VirtualHealth.com		You pay 15% after deductible. upmc.com/anywherecare		\$5 Register or schedule an appointment at Well360.com .		\$5 upmc.com/anywherecare
Pre-Existing Conditions Limitations	No pre-existing conditions limitations						

SERVICES	Highmark High Deductible Health Plan		UPMC High Deductible Health Plan		Highmark PPOBS Open Access Plus Plan		UPMC Exclusive Provider Organization
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Transition of Care Requires timely completion of forms. Request form immediately if needed.	Provides in-network coverage to employees changing plans at Open Enrollment when the employee's doctor is not part of the newly selected plan's network and there are approved clinical reasons why the patient should continue to see the same doctor.						
Lifetime Benefit Limit	No Lifetime Benefit Limit						
Precertification Requirements	Provider Responsibility	Patient Responsibility	Provider Responsibility	Patient Responsibility	Provider Responsibility	Patient Responsibility	Provider Responsibility
Preventive Care	<p>ALL PREVENTIVE CARE IS COVERED AT 100% PLAN PAYMENT PER ESTABLISHED GUIDELINES.</p> <p>Preventive Services will be covered in compliance with the requirements under the Affordable Care Act (ACA). Please refer to medical plan website for Preventive Services Reference Guide for additional details. Be sure to take advantage of the plan provisions for routine exams, routine OB/GYN checkups, mammograms, PAP smears and immunizations.</p>						
Well-Baby Visits Pediatric Immunizations Routine Adult Physical Exams Adult Immunizations Routine GYN Exam Routine PAP Annual Routine Mammogram	100% per established guidelines	Not Covered	100% per established guidelines	Not Covered	100% per established guidelines	Not Covered	100% per established guidelines
Health Savings OR Flexible Spending Account	Health Savings Account		Health Savings Account		Flexible Spending Account		Flexible Spending Account
Emergency Room Services	You pay 15% after deductible		You pay 15% after deductible		\$150 per visit (payment waived if admitted)		\$150 per visit (payment waived if admitted)
Urgent Care Facility	You pay 15% after deductible		You pay 15% after deductible		\$45		\$45
Hospital Services - Inpatient/Outpatient	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible Private room stays may result in extra charges.
Maternity Services First Office Visit Subsequent Pre-Natal Visits Hospital Delivery Services Infertility Counseling Testing Assisted Fertilization Procedures	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	\$25 - \$45 You pay 15% after deductible You pay 15% after deductible You pay 15% after deductible	You pay 35% after deductible	\$45 You pay 15% after deductible You pay 15% after deductible You pay 15% after deductible
Medical/Surgical Services (except office visits)	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible
Chiropractic Services Limit per benefit period	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	\$45	You pay 35% after deductible	\$45
	25 visits						

SERVICES	Highmark High Deductible Health Plan		UPMC High Deductible Health Plan		Highmark PPO Blue Sharing Plan		UPMC Exclusive Provider Organization	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network		
Advanced Imaging (MRI, CAT Scan, PET Scan, etc.)	REQUIRES PRIOR AUTHORIZATION							
Basic Diagnostic (standard imaging, diagnostic medical, lab/pathology, allergy testing)	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	
	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	
Rehabilitation Therapy	MUST HAVE AN APPROVED TREATMENT PLAN							
Physical and Occupational Therapy	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	\$45	You pay 35% after deductible	\$45	
Limit per benefit period	30 visits combined with Pulmonary Rehabilitation		Covered up to 30 visits for combined therapies		30 visits combined with Pulmonary Rehabilitation		Covered up to 30 visits for combined therapies	
Pulmonary Rehabilitation	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	\$45	You pay 35% after deductible	\$45	
Limit per benefit period	30 visits combined with Physical and Occupational Therapy		Covered up to 24 visits per benefit period		30 visits combined with Physical and Occupational Therapy		Covered up to 24 visits per benefit period	
Speech Therapy	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	\$45	You pay 35% after deductible	\$45	
Limit per benefit period	Covered up to 30 visits per benefit period		Covered up to 30 visits per benefit period		Covered up to 30 visits per benefit period		Covered up to 30 visits per benefit period	
Durable Medical Equipment and Prosthetics	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	
Skilled Nursing Facility Care	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	
Limit per benefit period	Covered up to 100 days per benefit period							
Home Health Care	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	
Limit per benefit period	Based on Medical Necessity Provisions							
Private Duty Nursing	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	
	Based on Medical Necessity Provisions							
Allergy Serums, Treatments and Injections	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	
Emergency Transportation	You pay 15% after deductible. Non-emergency (transportation from hospital back to home) is generally not covered.							
Dental Services Related to Accidental Injury	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	
Diabetes Treatment	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	
Home Infusion Therapy	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	

SERVICES	Highmark High Deductible Health Plan		UPMC High Deductible Health Plan		Highmark PPO Blue Sharing Plan		UPMC Exclusive Provider Organization
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Therapy Services (Chemotherapy, Radiation Therapy and Dialysis)	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible
Cardiac Rehabilitation	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	\$45	You pay 35% after deductible	\$45
Limit per benefit period	36 days		12 weeks		36 days		12 weeks
Hospice Care	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible
Transplant Services	Inpatient covered at 100% at Life Source center, otherwise same as plan's inpatient hospital facility benefit. Travel maximum of \$10,000 per transplant if using Life Source facility.		You pay 15% after deductible		You pay 35% after deductible		You pay 15% after deductible
TMJ, Surgical and Non-surgical	Not Covered						
Vision Care	Not Covered						One eye exam every 24 months for 21 and older. One eye exam every 12 months for under 21.
Behavioral Health							
Inpatient	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible
Outpatient	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	\$25 per visit	You pay 35% after deductible	\$25 per visit
Substance Abuse Services							
Inpatient Detoxification	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible
Inpatient Rehabilitation	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible
Outpatient Rehabilitation	You pay 15% after deductible	You pay 35% after deductible	You pay 15% after deductible	You pay 35% after deductible	\$25 per visit	You pay 35% after deductible	\$25 per visit
Nationwide Out-of-Area Care	You pay 15% after deductible Highmark Plan network available nationwide	You pay 35% after deductible Highmark Plan network available nationwide	You pay 15% after deductible for emergency/urgent care while traveling. Contact UPMC Health Plan or Assist America to find a provider.		You pay 15% after deductible Highmark Plan network available nationwide	You pay 35% after deductible Highmark Plan network available nationwide	Covered only for emergency/urgent care while traveling. Contact UPMC Health Plan or Assist America to find a provider.
Out-of-Country Care	You will need to pay upfront for care received from non-participating providers. Maintain copies of itemized receipts and submit via Highmark. Axa Assistance coverage is available for domestic and international travel.		Emergency/Urgent Services. Maintain copies of itemized receipts and submit via UPMC. Assist America coverage for domestic and international travel.		You will need to pay upfront for care received from non-participating providers. Maintain copies of itemized receipts and submit via Highmark. Axa Assistance coverage is available for domestic and international travel.		Emergency/Urgent Services. Maintain copies of itemized receipts and submit via UPMC. Assist America coverage for domestic and international travel.

The prescription drug plan you receive is based upon your medical plan selection.

IF YOU CHOOSE

THEN

High Deductible Health Plan

Coverage, **subject to deductibles** listed on page 8, is provided using your Highmark HDHP or UPMC HDHP medical plan card. Refer to your medical plan customer service number for additional information.

Highmark PPOBS or UPMC EPO

Coverage is provided using the CVS Caremark prescription drug card **based upon the copayments outlined below**. If you meet the separate prescription drug out-of-pocket maximums for these plans, then the plan will begin to pay at 100%.

Prescription Drug Card	CVS Caremark caremark.com • Customer Care Service via RxBenefits 1.877.352.7987
Provided for Highmark PPOBS and UPMC EPO plans only. The high deductible health plans use the medical card to obtain prescriptions since they are subject to deductible.	CVS Caremark will mail a separate card for participants. Visit the prescription plan online to compare pricing, track mail orders and review accounts. The prescription drug plan participates in the RightRx program. This voluntary program reviews prescriptions and recommends a lower cost therapeutic equivalent to the prescribing doctors.
Prescription Out-of-Pocket Maximum	All prescription copays contribute to the prescription drug out-of-pocket maximums. Note that no individual can incur an in-network out-of-pocket maximum total in excess of \$8,150.
Employee	\$5,150
All Other Tiers	\$10,300
Retail - One Month Supply - Prescriptions written for non-chronic, short-term conditions	
Generic	\$10 maximum
Preferred Brand	30% employee copayment with a \$20 minimum and \$55 maximum
Non-Preferred Brand	50% employee copayment with a \$40 minimum and \$110 maximum
Generic Step Therapy	The prescription drug plan requires you to try a lower-cost generic medicine first to treat your condition.
Specialty	Specialty drugs may be eligible for the Specialty Drug Copay Savings Program. Communications regarding this program will be mailed to participant if eligible.
	20% employee copayment with a \$50 minimum and \$100 maximum
	Specialty drugs are prescription medications that require special handling, administration or monitoring. Specialty drugs are to be dispensed through CVS Caremark Specialty Drug Management Program at 1.800.237.2767.
Maintenance Choice	Maintenance prescriptions (long-term medications that your doctor prescribes for chronic conditions that you take on an ongoing basis) will need to be filled by using the CVS Caremark mail order services or a CVS retail store.
Generic	\$20 maximum
Preferred Brand	20% employee copayment with a \$40 minimum and \$85 maximum
Non-Preferred Brand	30% employee copayment with a \$70 minimum and \$210 maximum



EACH PRESCRIPTION DRUG PLAN has their own drug formulary. Prescriptions on one plan's formulary may not be on another. The formulary may also be changed during the plan year. Contact CVS Caremark or the medical plans, review website information and discuss your specific prescription drug requirements with your doctor to ensure you understand the various medications available on each formulary.

MEDICATION THERAPY MANAGEMENT PROGRAM (MTM)

The Center for Pharmacy Care also offers a **Medication Therapy Management (MTM) program**. The MTM offers **free prescriptions** for eligible employees and spouses for the following conditions upon completion of a comprehensive health assessment and educational training:

- Cholesterol
- Chronic Pain Management
- Depression
- Diabetes
- Hypertension (High Blood Pressure)
- Asthma*

* Eligible children enrolled in the University CVS Caremark prescription plan will receive a \$10 copayment for their covered asthma prescriptions.

Participants receive:

- An initial health assessment; you will be responsible for making any follow-up appointments
- Comprehensive review of all your medications
- A personalized medication treatment plan
- Education and training to enhance your understanding of medication use
- Coordination of the medication therapy management services with your other health care providers to ensure your best outcomes
- No copay for prescriptions as listed above
- Wellness in Motion dollars upon enrollment, completion and follow-up with the MTM program



TO SCHEDULE AN INITIAL CONFIDENTIAL, FREE MEDICATION ASSESSMENT, contact The Center for Pharmacy Care at 412.396.2155 or cpc@duq.edu.

Medication Therapy Management program offers:

- **FREE** confidential education
- **FREE** confidential counseling
- **FREE** prescriptions—no copay for eligible prescriptions—Duquesne University pays the full cost

Who is eligible for the MTM program:

- Employees and spouses with Highmark PPOBS or UPMC EPO plans
- **Due to Affordable Care Act regulations, employees with a High Deductible Health Plan are not eligible for the zero copay, however they are still eligible for education and counseling**

HOW TO SAVE ON PRESCRIPTION DRUGS

- Request a comparable generic version of your prescription.
- Enroll in the Medication Therapy Management program if eligible. See details above.
- Set up a health care flexible spending account to use pre-tax dollars to pay for your prescriptions. Remember that you can list your wex debit card as your payment method on your mail order profile.

MAINTENANCE MEDICATION PROGRAM

If you take a maintenance prescription drug to treat an ongoing medical condition, you must ask your doctor to write a prescription for a 90-day supply and have it filled in one of the following ways:

- CVS Caremark mail order services, 1.877.352.7987
- CVS retail store

When you are newly diagnosed with a chronic condition and prescribed a maintenance medication, you will be permitted to obtain the initial fill and one subsequent refill to ensure your medications are managing your condition before you will be required to use the maintenance medication program.

MANAGE YOUR MEDICATIONS ONLINE

Register with a CVS Caremark online account so you can manage your prescriptions and benefits online. After registering, you will be able to obtain faster refills, view prescription history, receive email alerts and check order status. The website also contains FAQs, medication information and drug cost. Access the online site at caremark.com and register today!



HEALTH SAVINGS ACCOUNTS (HSAs) are available to High Deductible Health Plan members only.

Employees enrolled in Medicare Part B or listed as a dependent on another person’s tax return are not eligible for Health Savings Accounts.

HSAs resemble individual retirement accounts, except the money is earmarked for healthcare expenses.

The features include:

- Your deposits are tax free and your money grows, year after year, tax free.
- You own the account and decide how to invest and grow your money—even when you leave or retire.
- You can use funds anytime to pay for eligible medical expenses including deductibles, coinsurance, prescriptions, vision and dental care.
- At age 65 or after, you can withdraw funds without penalty. You will have to pay taxes on the withdrawal if the funds are used for anything other than eligible medical expenses.
- Funds withdrawn before age 65 for non-medical expenses are subject to taxes and penalties.
- **You receive triple tax advantages: contributions are deposited tax free, earnings accumulate tax-deferred and withdrawals for eligible expenses are not subject to federal income tax.**
- Unused funds remain in the account and roll over from year to year.
- The maximum contributions for this plan year are:
 - \$3,850 for Employee;
 - \$7,750 for Employee plus Child(ren);
 - \$7,750 for Employee plus Spouse;
 - \$7,750 for Family; and
 - Any participant who turns 55 or older during the plan year may also contribute an additional \$1,000.
- If you and your spouse each have insurance coverage that qualifies you for an HSA, and you both make contributions to an HSA, the \$7,750 limit may be 100% deposited into one spouse's account, or shared between the two accounts. No family may have more than the \$7,750 amount.
- Use the medical plan websites to locate information regarding the cost and quality of treatment options, doctors and hospitals to help lower your medical costs.
- You may also open a **Limited Flexible Spending Account** for dental and vision expenses only.
- You are permitted to select, change or stop health savings account contributions during the plan year.
- Employees enrolled in either the Highmark High Deductible Health plan or UPMC High Deductible Health plan will use Healthcare Bank with wex for the Health Savings Account deposits.
- Duquesne University pays the monthly administrative fee for the Health Savings Account at Healthcare Bank with wex.

Employees MUST SELECT the Health Savings Account option in order to receive a University contribution of:

- \$400 per year for Employee subscribers
- \$600 per year for all other subscribers



Review the Wellness in Motion activities list for opportunities to earn additional contributions to your Health Savings Account.

FLEXIBLE SPENDING ACCOUNTS

Do you have predictable health care or daycare expenses? If so, a Flexible Spending Account (FSA) can save you money. An FSA allows you to **set aside pre-tax dollars** to reimburse yourself for eligible out-of-pocket expenses. wex administers this plan for the University. Use the calculators, list of eligible expenses and planning tools available on the wex website at wexinc.com to learn more about these accounts. Monies set aside are deducted each pay period on a pre-tax basis. Expenses may be paid with your wex debit card or via electronic claim submission.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

- The plan year to incur expenses is extended through September 15, 2024.
- Deadline to submit eligible claims for reimbursement is December 31, 2024.
- You may contribute from \$130 to \$3,050 per year.
- Selections do not carry forward. You must indicate enrollment during every Open Enrollment period.
- Receive immediate access to the total amount you contribute.

Be conservative. If you don't use the money in your account within the plan year, you lose it.

SUBSTANTIATION

- The IRS requires dates of service, description of service or item purchased, dollar amount incurred, provider name and in some cases a Medical Necessity Form or physician letter.
- Debit card purchases still require substantiation.
- If debit card is used to pay for ineligible expenses or expenses without required documentation, you will be required to pay back the improper payment amounts to wex.

SAVE MONEY with flexible spending accounts.

ELECTIONS do not carry forward—you must indicate enrollment every year.

FLEXIBLE SPENDING ACCOUNTS follow a “use it or lose it” rule.

SAVE YOUR RECEIPTS! While the FSA debit card is a great way to pay for many eligible expenses, use of the debit card does not take away the IRS requirement of submitting documentation. wex will contact you when manual claims substantiation is required. Failure to submit documentation within the deadline will result in the cancellation of the debit card.

Visit wexinc.com for specific details on flexible spending accounts, including a complete list of eligible expenses.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

- **If Dependent Care FSA is selected during Enrollment, Duquesne University will deposit \$500 as a lump sum in your account.**
- Contributions may range from \$130 to \$5,000 per year and are dependent on marital and tax filing statuses. Duquesne University's \$500 contribution will count toward the maximum limit you can contribute.
- Reimbursements are only up to the amount available in your account.
- In order to participate, parent(s) must be employed or enrolled in school. Additionally, you may use the account if your spouse is disabled or a full-time student for at least five months during the year.
- Plan year to incur expenses is extended through September 15, 2024.
- Deadline to submit eligible claims for reimbursement is December 31, 2024.

ELIGIBLE EXPENSES

- Care for dependents age 12 or younger, or dependents regardless of age who are physically or mentally incapable of caring for themselves and whom you claim as a dependent on your federal income tax return. You (and your spouse if you are married) must maintain a home that you live in for more than half of the year with your qualifying child or dependent.
- Care when you are at work. If you are married, your spouse must also be at work, school (as a full-time student), searching for a job, or mentally or physically disabled and unable to provide care for a dependent.
- If your spouse is a stay-at-home mom or dad, you cannot participate in Dependent Care FSAs.

THE UNIVERSITY will contribute a \$500 lump sum amount if you elect a Dependent Care Flexible Spending Account.



A Healthy Lifestyle Program for Employees

Wellness in Motion program

July 1, 2023 to June 30, 2024

Employees may earn up to \$300 in Wellness in Motion dollars

Eligible Spouses may earn up to \$300 in Wellness in Motion dollars

Review Wellness in Motion information, including list of activities at www.duq.edu/benefits.

WELLNESS IN MOTION OVERVIEW

What is the Wellness in Motion program?

While the University offers one “Wellness in Motion” program, both medical plans offer customized wellness programs and provide their own online wellness platforms: **Highmark's Wellness** platform and **UPMC Health Plan's HealthyU** platform.

Each healthy activity, such as biometric screenings, online health assessment, and participation in various online coaching programs, has a corresponding Wellness in Motion dollar value.

Am I eligible?

To be eligible to participate in the Wellness in Motion program, you and your eligible spouse must be active members of the University medical plan.

What are the rewards?

- Employees may earn up to \$300 in Wellness in Motion dollars
- Eligible spouses may earn up to \$300 in Wellness in Motion dollars

HOW DO I GET STARTED?

Create an online profile with medical vendor

If you have not already done so, create an online profile with your medical vendor (Highmark or UPMC Health Plan). Instructions available at duq.edu/benefits.

Schedule your screening

Set up an appointment with your PCP to obtain a biometric screening.

-OR-

Contact The Center for Pharmacy Care at 412.396.2155 or cpc@duq.edu to schedule a free on-campus screening in the first floor of the Muldoon Building.

Complete an online Health Assessment with medical vendor

Login to your online profile with your medical vendor (Highmark or UPMC Health Plan) to complete your confidential online Health Assessment. Eligible spouses must also login or create an online profile with your medical vendor.

Complete additional Wellness in Motion activities listed on the employee's online profile. They include, but are not limited to:

- Health Coaching
- Condition Management
- Immunizations
- Events sponsored by the Benefits Office
- Maternity
- Cancer Screenings

HOW DO I RECEIVE WELLNESS IN MOTION DOLLARS?

Wellness in Motion dollars are earned as each activity is completed.

Review information to the right to determine how your Wellness in Motion dollars will be received.

Highmark PPOBS and UPMC EPO members can review their Explanation of Benefits (EOB) to confirm the use of their Wellness in Motion dollars as eligible medical claims are processed.

Note that it may take three to four weeks from the completion of activities for processing of Wellness in Motion dollars. **Wellness in Motion dollars cannot be processed after an employee's last day worked.**

WHAT HAPPENS IF I DO NOT USE ALL OF MY WELLNESS IN MOTION DOLLARS?

Highmark PPOBS and UPMC EPO members will have their unused Wellness in Motion dollars automatically rollover to the next plan year. There is a maximum rollover of two times the annual plan deductible.

This question does not apply to High Deductible Health Plan members as they automatically own their Health Savings Account and maintain access to these funds when they change medical plans, change jobs or retire.

WE HAVE PARTNERED WITH HIGHMARK, UPMC HEALTH PLAN AND THE CENTER FOR PHARMACY CARE TO OFFER THIS COMPREHENSIVE PROGRAM.

Designed to improve health, well-being and productivity, the goals of the program are to:

- Provide eligible employees and their eligible spouses with information regarding their current health status
- Help set realistic wellness goals
- Arm eligible employees and their eligible spouses with the tools and resources to help reach their goals
- Manage health care costs—participation in an effective wellness program not only has lifestyle benefits, it may help save money on future health care costs

Participation in this effort is voluntary and will allow eligible employees and their eligible spouses to:

- Access lifestyle coaching services to help set, reach and maintain goals
- Complete an online Health Assessment
- Participate in biometric screenings to help identify potential issues and risks
- Earn Wellness in Motion dollars throughout the year



Highmark's Wellness platform is located on the Highmark member website at highmarkbcbs.com

Highmark PPOBS members will receive their Wellness in Motion dollars in a health reimbursement account (HRA). Wellness in Motion dollars in this account can be automatically applied to medical deductibles and coinsurance only.

Highmark HDHP members will receive their Wellness in Motion dollars as a deposit in their wex Health Savings Account (HSA).

Note that it may take three to four weeks from the completion of activities for processing of Wellness in Motion dollars.



UPMC HealthyU is located on the UPMC Health Plan member website at upmchealthplan.com.

UPMC EPO members will receive Wellness in Motion dollars in a health incentive account (HIA). Wellness in Motion dollars in this account can be automatically applied to medical deductibles and coinsurance only.

UPMC HDHP members will receive Wellness in Motion dollars as a deposit in their wex Health Savings Account (HSA).

Note that it may take three to four weeks from the completion of activities for processing of Wellness in Motion dollars.

Your dental benefits are provided through **MetLife Preferred Dentist Provider (PDP)** plan. Use dentists within the PDP Plus network to receive the highest level of coverage. Remember to request pre-determination of benefits before you receive extensive dental services. This will ensure you know what your actual out-of-pocket cost will be before treatment begins.

MetLife Preferred Dentist Provider (PDP) plan does not provide identification cards. In-network providers automatically submit electronic claims on your behalf.

DENTAL PRICE TAGS

EMPLOYEE STATUS		METLIFE PDP BASIC	METLIFE PDP ENHANCED
EMPLOYEE	Annual	\$219.36	\$436.44
	Biweekly	\$8.44	\$16.79
EMPLOYEE PLUS CHILD(REN)	Annual	\$501.96	\$981.24
	Biweekly	\$19.31	\$37.74
EMPLOYEE PLUS SPOUSE	Annual	\$451.44	\$883.20
	Biweekly	\$17.36	\$33.97
FAMILY	Annual	\$738.96	\$1,436.04
	Biweekly	\$28.42	\$55.23

SUMMARY OF BENEFITS	BASIC PREFERRED DENTIST PROVIDER (PDP) PLUS PLAN		ENHANCED PREFERRED DENTIST PROVIDER (PDP) PLUS PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Per Plan Year	Deductible Does Not Apply to Preventive Care	Deductible Does Not Apply to Preventive Care	Deductible Does Not Apply to Preventive Care	Deductible Does Not Apply to Preventive Care
Employee	\$50	\$50	\$50	\$50
All Other Tiers	\$100	\$100	\$100	\$100
Plan Year Maximum Benefit	\$1,000 per person, per plan year	\$1,000 per person, per plan year	\$2,000 per person, per plan year	\$2,000 per person, per plan year

DIAGNOSTIC AND PREVENTIVE				
Cleanings and Exams (Two times per plan year)	All Diagnostic and Preventive services are covered 100% of Allowance	All Diagnostic and Preventive services are covered 100% of Allowance	All Diagnostic and Preventive services are covered 100% of Allowance	All Diagnostic and Preventive services are covered 100% of Allowance
Fluoride (One time per plan year for child under age 19)				
Sealants (One per molar in 3 years for child under age 14)				
Full Mouth X-Rays (One per 3 plan years)				
Bitewing X-Rays (Two sets per plan year)				
Space Maintainers (Non-orthodontic for child under age 19)				
Emergency Palliative Treatment				
BASIC SERVICES				
Amalgam Fillings	All Basic Services are covered 80% of Allowance	All Basic Services are covered 80% of Allowance	All Basic Services are covered 80% of Allowance	All Basic Services are covered 80% of Allowance
Resin Composite Fillings				
Endodontics (Root Canal)				
Repairs of CIO, Dentures and Bridges				
Simple Extractions				
Periodontal Maintenance				
Periodontal Surgery				
Periodontal Scaling and Root Planing				
General Anesthesia when dentally necessary				
MAJOR SERVICES				
Implants (One per tooth in 5 plan years for natural teeth lost while covered by plan)	Not Covered	Not Covered	60% of Allowance	60% of Allowance
Crowns/Inlays/Onlays (Replacement once every 5 plan years)				
Bridges and Dentures (Initial placement for natural teeth lost while covered by plan)				
Bridges and Dentures Replacement (One every 5 plan years)				
ORTHODONTICS: Diagnostic, Active Retention Treatment				
Adults	Not Covered	Not Covered	50% of Allowance	50% of Allowance
Children	Not Covered	Not Covered	50% of Allowance	50% of Allowance
Orthodontic Lifetime Maximum	Not Covered	Not Covered	\$2,000	\$2,000
Benefits Payment Basis	A participating general dentist or specialist has agreed to accept negotiated fees as payment in full for services provided to plan members.	A non-participating general dentist or specialist has NOT agreed to accept the negotiated fees as payment in full. You may be responsible for any difference in cost.	A participating general dentist or specialist has agreed to accept negotiated fees as payment in full for services provided to plan members.	A non-participating general dentist or specialist has NOT agreed to accept the negotiated fees as payment in full. You may be responsible for any difference in cost.

VISION PRICE TAGS

Your vision benefits are provided through **VSP Vision Care**.

Use providers in the VSP network to obtain the highest level of benefits. Visit vsp.com to find or confirm in-network providers.

Members are permitted services based upon the plan year of July 1 to June 30. Effective July 1 of each plan year, members have the ability to schedule eligible services.

This chart is an overview of the vision coverage. Visit vsp.com for a detailed description of the Vision Care plan benefits.

VSP does not provide identification cards. In-network providers automatically submit electronic claims on your behalf.

EMPLOYEE STATUS		VISION CARE BASIC	VISION CARE ENHANCED
EMPLOYEE	Annual	\$77.04	\$155.88
	Biweekly	\$2.96	\$6.00
EMPLOYEE PLUS CHILD(REN)	Annual	\$165.24	\$334.68
	Biweekly	\$6.36	\$12.87
EMPLOYEE PLUS SPOUSE	Annual	\$153.96	\$311.76
	Biweekly	\$5.92	\$11.99
FAMILY	Annual	\$264.36	\$534.60
	Biweekly	\$10.17	\$20.56

SUMMARY OF BENEFITS	VISION CARE - BASIC		VISION CARE - ENHANCED	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
WellVision Exam	Once every plan year: \$0 copay	Up to \$45 reimbursement	Once every plan year: \$20 copay	Up to \$45 reimbursement
Routine Retinal Screening	Up to \$39 copay	NA	Up to \$39 copay	NA
PRESCRIPTION LENS				
Single Vision, Lined Bifocal and Lined Trifocal. Impact Resistant Glasses for dependent children.	Copay combined with exam covered in full every plan year	Single Vision - up to \$30 Lined Bifocal - up to \$50 Lined Trifocal - up to \$65	Copay combined with exam covered in full every plan year	Single Vision - up to \$30 Lined Bifocal - up to \$50 Lined Trifocal - up to \$65
Standard Progressive	Covered in full every plan year	Up to \$50 reimbursement	Covered in full every plan year	Up to \$50 reimbursement
Premium Progressive	\$95 to \$105	Up to \$50 reimbursement	\$20	Up to \$50 reimbursement
Custom Progressive	\$150 to \$175	Up to \$50 reimbursement	\$20	Up to \$50 reimbursement
Tints/Photochromic	NA	NA	Covered in full	NA
Scratch Resistant Coating	NA	NA	Covered in full	NA
FRAMES	Once EVERY OTHER plan year	Once EVERY OTHER plan year	Once EVERY plan year	Once EVERY plan year
Frames	\$130 frame allowance	Up to \$70 reimbursement	\$170 frame allowance	Up to \$70 reimbursement
Featured Frame Brands	\$180 frame allowance	NA	\$220 frame allowance	NA
VisionWorks	\$180 frame allowance	NA	\$220 frame allowance	NA
Costco	\$70 frame allowance	NA	\$95 frame allowance	NA
Additional Frame Savings	20% off amount over allowance	NA	20% off amount over allowance	NA
Additional Pairs of Glasses/Sunglasses	20% savings, including lens enhancements, extra \$50 to spend on featured brands	NA	20% savings, including lens enhancements, extra \$50 to spend on featured brands	NA
	CONTACT LENSES ARE IN LIEU OF LENSES AND FRAMES		ENHANCED PLAN MEMBERS MAY RECEIVE CONTACT EXAM AND LENSES EVERY PLAN YEAR	
Contact Lenses Exam (Fitting and Evaluation)	Copay not to exceed \$60	Up to \$105 reimbursement for Contacts	Copay not to exceed \$60	Up to \$105 reimbursement for Contacts
Contact Lenses	\$130 allowance		\$170 allowance	
Medically Necessary Contact Lenses	\$0 Copay	Up to \$210 reimbursement	\$20 Copay	Up to \$210 reimbursement
PRIMARY EYE CARE				
Retinal Screening for Diabetic Members*	\$0 Copay *Limitations and coordination with medical coverage may apply	NA	\$0 Copay*Limitations and coordination with medical coverage may apply	NA
Additional exams/services for members with diabetes, glaucoma, age-related macular degeneration*	\$20 per exam*Limitations and coordination with medical coverage may apply	NA	\$20 per exam*Limitations and coordination with medical coverage may apply	NA
Treatment/Diagnosis of eye conditions, including pink eye, vision loss and cataracts*	\$20 per exam*Limitations and coordination with medical coverage may apply	NA	\$20 per exam*Limitations and coordination with medical coverage may apply	NA
Laser VisionCare Correction	Average 15% off the regular price or 5% off the promotional price available from contracted facilities.			



Financial worries, aging parents, job stress, and health issues—everyone faces challenges from time to time. The Duquesne University EAP benefits, sponsored through Lytle EAP, offers confidential, free solutions to assist you and your family members with these challenges. The EAP solutions include:

ANYTIME, ANYWHERE

Reducing barriers to access through technology. *Includes 24/7/365 Telephone support, Mobile App with Chat Functionality, Video Counseling and Web Portal.*

Access the portal via mylifeexpert.com. Click “create a new account with your company code” and insert: duquesne, then follow instructions included in your activation email.

PERSONAL ASSISTANT

The Personal Assistant helps individuals with their “to do” list. It can be difficult to find extra time in the day to manage everyday tasks. The EAP’s Personal Assistant helps lighten the load through researching the best options to benefit you and your loved ones.

SERVICES INCLUDE: Entertainment & Dining, Travel & Tourism, Household Errands, Service Professionals

COACHING

A coach works actively to help individuals assess their current situation then develop goals to meet their stated expectations. A coach is an accountability partner and helps individuals overcome obstacles to achieve goals.

COACHES HELP WITH: Life Transitions, Work/Life Balance, Goal Setting, Improving Relationships, & More.

MEDICAL ADVOCACY

Medical Advocacy is a new approach to maneuvering through the healthcare system. It offers strategies to promote employee health, productivity, and well-being by serving patient populations throughout the entire lifespan and by addressing health problems in every category of disease classification and in all disease stages.

HELP WITH: Insurance Navigation, Doctor Referrals, Specialist Referrals, Care Transition, Discharge Planning, Adult Care Coach

MENTAL HEALTH COUNSELING

When overwhelmed with personal, work or life stressors, mental health counseling can be a lifesaver. The EAP’s licensed master’s level counselors support you and your household members through difficult times providing confidential assistance 24/7.

HELP WITH: Family Conflict, Couples/Relationships, Substance Abuse, Anxiety, Depression

WORK AND LIFE RESOURCES

Navigating the practical challenges of life, while handling the demands of your job can be stressful. Work/Life resources and referral services are designed to provide knowledgeable consultation and customized guidance to assist with gaining resolution to everyday hurdles.

RESOURCES INCLUDE: Home Safe Services, Adoption, Elder/Adult Care, Parenting, Child Care, Special Needs Support, Wellness

LEGAL/FINANCIAL RESOURCES

Legal and Financial resources and referrals are available to connect employees with experienced, vetted professionals in their topical area of legal and financial needs.

RESOURCES INCLUDE: Divorce/Custody, Bankruptcy, Budgeting, Estate Planning/Wills, Personal Injury/Malpractice, Major Life Event Planning

HOME SAFE SERVICES

This program offers reimbursement for Uber/Lyft/Cab fare when an employee decides to call for a safe ride home when they find themselves too impaired to drive. The employee must obtain a receipt and mail to Lytle EAP Partners at 200 Cedar Ridge Drive, Suite 208, Pittsburgh, PA 15205. The receipt must contain “Duquesne University”, your name, address and telephone number. Reimbursement, limited to three times per year, up to \$50 will be mailed to your home. EAP publicity materials are sent along with the reimbursement check.

MetLife - metlife.com

BASIC EMPLOYEE TERM LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

Basic life insurance and Accidental Death and Dismemberment (AD&D) are automatically provided to eligible employees, at no cost, by Duquesne University. This coverage is equal to one times annual salary up to a maximum of \$300,000. Amount over \$50,000 is subject to imputed income as indicated during the enrollment process. Benefit reduces by 50% at age 70.

BUSINESS TRAVEL ACCIDENT INSURANCE

Business Travel Accident Insurance is automatically provided to eligible employees, at no cost, by Duquesne University. This coverage is equal to \$50,000 while traveling on business on behalf of the University.

EMPLOYEE OPTIONAL TERM LIFE INSURANCE

Employee optional life insurance provides additional protection for those who depend on you financially. Your need varies greatly upon age, number of dependents, dependent ages and your financial situation. The online enrollment system will indicate coverage available with the applicable premiums. You are responsible for the cost of the optional coverage you choose. *Proof of insurability and coverage limit may apply in some cases, which may result in the denial of coverage.*

SPOUSE AND CHILD OPTIONAL LIFE INSURANCE

If applicable, Spouse and Child optional life insurance will also be indicated with applicable premiums during your completion of the online enrollment process. You are responsible for the cost of the optional coverage you choose. *Proof of insurability and coverage limit may apply in some cases.*

BASIC LONG-TERM DISABILITY (LTD)

Basic Long-Term Disability (LTD) of 50% of base salary to a maximum benefit of \$5,000 per month is automatically provided to eligible employees after a 12-month waiting period. Long-term disability replaces a portion of your income if illness or accident prevents you from working for an extended period of time.

BUY UP LONG-TERM DISABILITY

Buy Up Long-Term Disability provides an additional 10% up to 60% of base salary to a maximum of \$12,000 per month. The online enrollment system will indicate coverage available with the applicable premiums. You are responsible for the cost of the optional coverage you choose.

Contact Duquesne University's Assistant Director, Benefits at 412.396.5105 to file an initial application for LTD benefits.



WILL PREPARATION SERVICE

Employees enrolled in the **Optional Term Life Insurance** policy are eligible to participate with the MetLife Will Preparation Services offered through Hyatt Legal Plans. Contact Hyatt Legal Plans at 1.800.821.6400 for additional information.

BENEFICIARIES

- **WHAT IS A BENEFICIARY?** Your beneficiary is who will receive payment from your life insurance and AD&D coverage.
- **DO YOU NEED TO NAME A BENEFICIARY?** If you don't name a beneficiary, your benefit will automatically go to your estate.

Even if you do not purchase optional coverage amounts, you need to name a beneficiary because the University provides free core life insurance and AD&D coverage.

Once you name a beneficiary during the online enrollment process, the designation will not change until you update. Thus if you marry, divorce or have a new child, it is your responsibility to update your life insurance beneficiaries via **bswift** as your life or family status changes.

If you purchase optional dependent life insurance for your spouse or child(ren), you are automatically the beneficiary for that plan.

The **bswift** online benefits enrollment system will automatically list "My Estate" as your beneficiary. You must select "add beneficiary" to enter the names and percentages of your beneficiaries.

Visit the website for additional information and rates: duq.edu/benefits



BENEFICIARIES

Naming your beneficiary, and keeping the information current, is an important aspect of managing your retirement account. A birth or marriage may have changed your thinking since you made your original choice. Or perhaps you never designated a beneficiary at all. Missing or outdated information can create significant costs and delays for those you leave behind.

This is a friendly reminder to make sure your beneficiary information reflects your current wishes.

It takes just a few minutes online.

The good news is that it's easy to name, change or confirm your beneficiaries.

Log in to your account at www.duq.edu/retirement.

Under My Account, select Change Beneficiaries from the Profile section.

From there, you can designate beneficiaries and select how much each should receive.

If you prefer, you can complete a paper form and return it by mail. To have a form mailed to you, call TIAA at 800-842-2252. For your protection, TIAA cannot change your beneficiary over the phone.

If you make a change, you'll receive confirmation by mail. And you can change your beneficiary again at any time.

The beneficiary information captured as part of the online benefits enrollment is only for your Duquesne University life insurance. You must contact TIAA or any other personal accounts you may have to update their beneficiary information.

As a Duquesne University employee, a key part of your compensation and future security is your retirement plan. Regardless of your age, the time for thinking about retirement is now. With careful planning, you can help make your retirement years a more comfortable and secure time of life for you and your family.

Eligible University employees can voluntarily elect to defer a portion of their salary to the Duquesne University sponsor Duquesne University 403(b) Retirement Plan with TIAA to supplement their retirement savings.

EMPLOYEE CONTRIBUTIONS

The Duquesne University Retirement Plan is a defined contribution plan that helps you save for retirement. Employees can begin participation in the plan with their own voluntary contributions on the first day of the month following or coinciding with their hire date. Additional information regarding the retirement plan Universal Availability can be found at duq.edu/retirement and also on page 32 of this Overview Guide.

Changes to voluntary retirement plan deductions can be made at any time using the online website at duq.edu/retirement or by calling TIAA at 1-800-842-2252. Voluntary deductions can be made on a pre-tax basis or an after-tax basis by selecting the Roth 403(b) option.

The Internal Revenue Code limits the total amount of contributions that may be made to all retirement plans you have across all employers. The online enrollment process provides the opportunity to review and elect your voluntary contribution as either a specific percentage or the yearly maximum contribution.

For 2023 you can contribute up to \$22,500 per year.

If you are age 50 or older anytime in 2023, you can contribute an additional \$7,500 to your tax-deferred account, for a maximum of \$30,000.

Each participant gets one limit for contributions to all 403(b) plans, so if you are also a participant in a 403(b) plan of another employer, your combined contributions to that plan and to the Duquesne University Plan in 2023 are generally limited to \$22,500. If you do participate in more than one 403(b) plan, you are responsible for tracking and reporting the amount of all of your contributions to the plans so that the total amount of all your contributions to all plans in which you participate do not exceed the limit.

EMPLOYER CONTRIBUTIONS

The Duquesne University Plan helps you save even more for retirement by providing matching funds to your own contributions if you are an eligible employee. Both University and employee contributions are immediately vested, and the plan is 100% portable if you leave. Vested means you are eligible to receive both your and the University's contributions if you terminate employment.

You are eligible to receive the matching funds the first day of the month following your one-year anniversary. This one-year waiting period may be waived if you have previously worked at a qualifying educational institution and complete a Prior Year of Service form upon employment.

Depending upon the terms of your employment, you may be required, as a condition of your employment, to contribute 5% of your eligible salary after fulfilling certain age and service requirements on a pre-tax basis.

UNDERSTANDING RETIREMENT PLAN FEES

You can enhance your retirement savings by understanding how investment fund fees affect returns. All investment funds have fees for services associated with that particular fund that offset the amount of earnings applied to a participant's account. Fees can vary among investment options due to risks and complexities of the fund's investment strategy and the services provided to the plan. Differences in fees and expenses may significantly change the amount in a retirement account over many years of savings.

A Department of Labor Fee Disclosure Notice is sent annually to eligible participants to provide information on these investment fund fees and assist participants in making meaningful comparisons of their investment alternatives. The Notice includes historical performance, comparable benchmark performance, shareholder type fees, and expenses and investment restrictions.

HOW TO OBTAIN BENEFITS

Contact your retirement plan vendor to request no more than two outstanding loans, request a hardship withdrawal, request a distribution if you have attained age 59 ½ or to request disability distribution. Contact TIAA approximately three months before your retirement date to ensure paperwork and distribution options are properly completed.

457(B) DEFERRED COMPENSATION PLAN

The University also offers a 457(b) plan for a select group of employees based on income levels. This plan permits additional savings in addition to the 403(b) voluntary contributions. There is no University contribution to this plan. While the fund line up is the same as the 403(b), this plan has different definitions regarding withdrawals and distributions. Enrollment in this plan is completed by individual appointment with our TIAA counseling representative.



RETIREMENT PLAN COUNSELING

As a participant in the Duquesne University Retirement Plan, you have access to personalized, confidential advice on the plan's investment options from HB Retirement or TIAA advisors. This service is available as part of your retirement program at no additional cost to you.

These appointments provide an excellent opportunity for you to discuss your particular accounts on a range of topics, including payroll deductions, investments, allocations, transfers, tax-deferred savings, death benefits and retirement options.

Even if you are not approaching retirement, be sure to take advantage of the individual appointments and online planning tools.

HB RETIREMENT

Jack Ryan and Gabe Antoni of HB Retirement offer on-campus, online and telephone counseling sessions. You can schedule an in-person meeting by calling Sierra Christian at **412-754-3574** or emailing smchristian@hbretirement.com. You can also schedule an online meeting by selecting the appropriate link for Jack Ryan or Gabe Antoni.

- Jack Ryan: go.oncehub.com/JackRyan1
- Gabe Antoni: go.oncehub.com/GabrielAntoni

TIAA

Schedule an in-person or virtual session online by visiting TIAA.org/schedulenow or calling **800-732-8353**, weekdays, 8 a.m. to 8 p.m. (ET).

UNIVERSITY FAMILY-FRIENDLY BENEFITS

The University offers family-friendly benefits for all employees, including:

- 10 regular vacation days at the onset of employment
- 6 family sick days
- Paid maternity and parental leave
- Generous time off schedule for various holidays and holy days of obligation

For more information about the University's family-friendly TAP policies please review:

- TAP No. 14: Holidays/Holy Days of Obligation
- TAP No. 15: Sick Leave, Short- and Long-Term Disability Benefits
- AP No. 17: Vacation

THE ADMINISTRATIVE POLICIES (TAPS)

Full detailed information for all University policies are available for review at duq.edu/taps.

TAP NO. 13: TUITION REMISSION

Eligible employees may take advantage of full, basic tuition remission to further their own education. Depending on an employee's status, full- or partial-basic tuition remission is also available to eligible spouses and dependent children, providing they meet the admission requirements of the University. **All Duquesne University tuition remission forms must be completed (with estimated credits per term) and submitted by the established deadlines. Forms not submitted by the deadline are subject to a five percent benefit reduction.**

TUITION EXCHANGE

All tuition exchange forms must be completed and received by the Benefits Office no later than November 15 of the year preceding enrollment. Participating tuition exchange schools may be found at tuitionexchange.org and cic.org. Refer to TAP NO. 13 located at duq.edu/TAPS for additional information.

PAID MATERNITY AND PARENTAL LEAVE

The University offers 100% Paid Maternity and Parental Leave of absence for eligible employees. Paid Maternity Leave allows the birth parent, four consecutive weeks of 100% paid leave to be used immediately following the birth of a child. Paid Parental Leave allows for two consecutive weeks of 100% paid leave that can be used within 12 months of the birth or the placement of a child for adoption, foster care or legal guardianship. Please refer to TAP 23 for more details. Employees covered by a collective bargaining agreement should refer to their current contract.

TIME OFF AND LEAVES OF ABSENCE

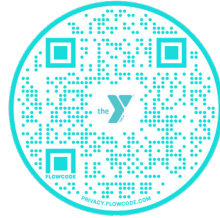
As a Duquesne University employee, your benefits package includes time off programs. Your time off depends on your employment status.

Information regarding these programs can be found online within various Administrative Policies which are located at duq.edu/TAPS.

Employees covered by a collective bargaining agreement should refer to their current contract.

YMCA CHILD DEVELOPMENT CENTER DUQUESNE UNIVERSITY

Infant, Toddler, Preschool Child Care
12 Washington Place, Suite 110
Pittsburgh, PA 15219
412-852-4909



Contact the YMCA to schedule a tour, to learn more about the University discount and to review available openings.

OMEGA FEDERAL CREDIT UNION

Omega Federal Credit Union serves over 500 member companies and has over 80 years of excellent customer service. A credit union is a not-for-profit financial cooperative owned by its members. Surplus earnings are returned to the members in the form of higher savings rates, lower loan rates and low or no fee products and service. Visit their website for additional information, including an application form.

DUQUESNE UNIVERSITY RETIREES ASSOCIATION (DURA)

DURA provides retired Duquesne University faculty and staff with opportunities to stay connected to the University, and enjoy social, recreational, and educational activities.

LIBERMANN LUNCHEONS

Campus Ministry invites administrators, faculty, and staff. to their Libermann Luncheons. The lunches feature guest speakers and are usually held in the Africa Room at noon during the fall and spring semesters. Contact campus ministry at 412-396-6021 for additional information.

MYLEAD

MyLEAD stands for Maximize your Learning, Education and Development. Visit MyLEAD for additional information regarding our Pathways to Professional Success training program and other learning and development opportunities.

DUQUESNE UNIVERSITY ATHLETIC DEPARTMENT

Employees are eligible to buy one, and get one free season tickets for football, Men's Basketball and Women's Basketball. Contact the Dean Honda Ticket Office or ticketsservices@duq.edu for additional information.

PNC WORKPLACE BANKING

Contact PNC Workplace Banking for information regarding the dedicated PNC WorkPlace banking team.

DUQUESNE UNIVERSITY POWER CENTER

Explore our 80,000 square foot recreation and fitness facility featuring a full array of intramural leagues and sports, over 60 group fitness classes weekly, a full cardio fleet, multiple weightlifting options, an indoor track, club sports, and more. There are many ways to enhance your wellbeing at the Power Center.

ENTERPRISE RENTAL CAR DISCOUNTED RATES

As an University employee, you have access to discounted rates toward rental car needs through our partner at Enterprise. This perk can be used for both personal and business purposes, with ability to status match creating opportunity for free upgrades and much more. For more information on how to use this discounted program, please contact Procurement & Payment Services (purchasing@duq.edu)

WANT TO SAVE TIME AND MONEY? THEN TELEMEDICINE MAY BE FOR YOU!

Telemedicine is referred to as eVisits by UPMC Health Plan and Well360 by Highmark.

Telemedicine is a convenient and affordable option that allows you to talk with a doctor 24 hours a day, 7 days a week who can diagnose, recommend treatment and prescribe medication (when appropriate) for many of your medical issues.

Conditions commonly treated through Telemedicine include:

- Acne
- Bladder infection/Urinary tract infection
- Bronchitis
- Cold/flu
- Diarrhea
- Fever
- Migraine/headaches
- Pink eye
- Rash
- Sinus problems
- Sore throat
- Stomach ache
- Sunburn and more



Individuals enrolled with Highmark PPOBS and UPMC EPO have a \$5 copay. Individuals enrolled with the high deductible health plans (HDHP) usually pay approximately \$45 per visit until they meet deductibles/coinsurance as outlined on page 8.

Your eligibility for benefits (and that of your enrolled dependents) ceases at the end of the month in which your employment is terminated or if the benefits program is discontinued. Insurance coverage for dependents will also terminate at the end of the month in which your dependent is no longer eligible.

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) gives employees and their qualified beneficiaries the opportunity to continue benefit coverage under the employer’s medical, dental and vision plans, and flexible spending accounts when a “qualifying event” would normally result in the loss of eligibility. Examples include termination of employment, death of the employee, reduction in work hours, divorce or loss of eligibility by a dependent child.

The plans available through COBRA continuation coverage are the same plans currently offered by the University; however, you or your dependent(s) must pay the full cost of the health, dental and vision plan, plus an administrative fee. COBRA premiums are due monthly, and failure to pay on time will result in loss of coverage.

Length of COBRA Continuation Coverage

Coverage may continue for differing lengths of time depending upon the reason for eligibility.

- Up to 18 months if loss of coverage is due to termination of employment or reduction in work hours
- Up to 36 months for dependents if loss of coverage is due to death, divorce or a dependent child’s loss of eligibility
- Up to 29 months if the individual is disabled at the time of eligibility for continued coverage or is disabled within 60 days of eligibility for continued coverage

Notifying Benefits Office of a Qualifying Life Event

To apply for COBRA coverage, when a divorce is final, a dependent child no longer meets age and/or dependency eligibility requirements as outlined in each specific plan, or a marriage or birth/adoption of child, update information using the online bswift system per instructions on page 33.

Within 14 days, the Benefits Office will provide you and/or your qualified dependent pertinent information on the application procedure and eligibility for continuation of coverage through COBRA.

COBRA RATE MEDICAL | HIGHMARK

EMPLOYEE STATUS	HIGHMARK HIGH DEDUCTIBLE	HIGHMARK PPOBS
PARTICIPANT		
Monthly	\$674.62	\$732.85
PARTICIPANT PLUS CHILD(REN)		
Monthly	\$1,214.29	\$1,319.12
PARTICIPANT PLUS SPOUSE		
Monthly	\$1,484.14	\$1,612.25
FAMILY		
Monthly	\$2,023.82	\$2,198.52

COBRA RATE MEDICAL | UPMC

EMPLOYEE STATUS	UPMC HIGH DEDUCTIBLE	UPMC EPO
PARTICIPANT		
Monthly	\$674.62	\$732.85
PARTICIPANT PLUS CHILD(REN)		
Monthly	1,214.29	\$1,319.12
PARTICIPANT PLUS SPOUSE		
Monthly	\$1,484.14	\$1,612.25
FAMILY		
Monthly	\$2,023.82	\$2,198.52

COBRA RATE DENTAL

EMPLOYEE STATUS	METLIFE PDP BASIC	METLIFE PDP ENHANCED
PARTICIPANT		
Monthly	\$18.65	\$37.10
PARTICIPANT PLUS CHILD(REN)		
Monthly	\$42.67	\$83.41
PARTICIPANT PLUS SPOUSE		
Monthly	\$38.37	\$75.07
FAMILY		
Monthly	\$62.81	\$122.06

COBRA RATE VISION

EMPLOYEE STATUS	VSP BASIC	VSP ENHANCED
PARTICIPANT		
Monthly	\$6.55	\$13.25
PARTICIPANT PLUS CHILD(REN)		
Monthly	\$14.05	\$28.45
PARTICIPANT PLUS SPOUSE		
Monthly	\$13.09	\$26.50
FAMILY		
Monthly	\$22.47	\$45.44

REQUIRED NOTICES | General Notice of COBRA Continuation Coverage Rights

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

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

When is COBRA continuation coverage available? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Patricia Lee, Assistant Director, Benefits Duquesne University, Benefits Office, 600 Forbes Avenue, Pittsburgh, PA 15282.

How is COBRA continuation coverage provided? Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an

independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage.

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must provide this notice to: Patricia Lee, Director, Benefits Duquesne University, Benefits Office, 600 Forbes Avenue, Pittsburgh, PA 15282.

Second qualifying event extension of 18-month period of continuation coverage. If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of the month after your employment ends; or the month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit medicare.gov/medicare-and-you.

If you have questions. Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit HealthCare.gov.

Keep your Plan informed of address changes. To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. Plan administrator contact information: Patricia Lee, Director, Benefits Duquesne University, Benefits Office, 600 Forbes Avenue, Pittsburgh, PA 15282

SUMMARY OF BENEFITS AND COVERAGE (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available when completing enrollment via bswift and on the benefits office website at duq.edu/work-at-du/benefits/requirednotices. **A paper copy is also available, free of charge, by calling the Benefits Office at 412.396.5106.**

SUMMARY PLAN DESCRIPTIONS (SPD)

As required under the Employee Retirement Income Security Act (ERISA), all employees and their covered dependents must be given access to a copy of the Summary Plan Description (SPD) for the employees welfare benefit plans.

The SPD outlines the eligibility, schedule of benefits and covered/excluded items of the benefit plans offered by Duquesne University.

These documents can be viewed during the online enrollment process, on the Benefits website at duq.edu/requirednotices, or by **requesting a paper copy, free of charge by calling the Benefits Office at 412.396.5106.**

WELLNESS PROGRAM

The Duquesne University Wellness in Motion program is a voluntary wellness program available to all benefits eligible employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in Wellness in Motion you will be asked to complete a voluntary health risk assessment that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for cholesterol and blood glucose levels. You are not required to complete the health risk assessment or to participate in the blood test or other medical examinations. However, employees and their eligible spouses who choose to participate in Wellness in Motion will receive \$300 each. Although you are not required to complete the health risk assessment or participate in the biometric screening, only employees and their eligible spouses who do so will receive \$300 each. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting your medical plan provider at the phone number on the back of your ID Card. The information from your health risk assessment and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as The Center for Pharmacy Care counseling. You also are encouraged to share your results or concerns with your own doctor. Please refer to page 29 for additional information regarding the "Notice of Health Information Practices."

MOTHERS' AND NEWBORNS' HEALTH PROTECTION ACT

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).

WOMEN'S HEALTH AND CANCER RIGHTS ACT ANNUAL NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits contact your provider at the phone number on the back of your ID card.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Offer Free Or Low-Cost Health Coverage To Children And Families

If you or your dependents are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer sponsored health coverage, but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at askebsa.dol.gov or by calling toll-free 866.444.EBSA (3272).

MEDICARE PART D CREDITABLE COVERAGE NOTICE

Group medical plans with prescription drug coverage sponsored by the University for eligible active employees meet the standards for creditable coverage required by federal regulations and guidelines.

HIPAA SPECIAL ENROLLMENT RIGHTS NOTICE

If you are declining enrollment for medical benefits for yourself or your eligible dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in the medical benefits provided under this Plan if you or your eligible dependents lose eligibility for that other coverage. However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days plan after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

To request special enrollment or obtain more information, contact the Benefits Office at 412.396.5106 or complete your enrollment via the bswift self-service website at duq.edu/benefits.

NOTICE OF HEALTH INFORMATION PRACTICES

This notice describes how patient health information (PHI) about you may be used and disclosed and how you can get access to this health information. Please read it carefully and ask any questions.

WHAT IS HEALTH INFORMATION:

Each time that a service is rendered or a procedure is done, even as simple as a routine blood pressure check, data and information are collected. This is health information or what is commonly referred to as information for or in the medical record or the patient record. Accurate, credible, and timely data and information are used by this organization, covered entity, as the basis for planning your care, as a means of having multiple healthcare providers know about your current health status, for health insurance, as a health legal document, as a record for billing purposes, as a source of data for research, planning, and marketing, as a source of required information for public health officials, and as a means to continue to improve the care that we provide. At this organization, we have always, and will continue to protect the privacy of your health information and the dignity of you as an individual. On July 6, 2001, the U.S. Federal Government passed compliance regulations that mandate all healthcare facilities, health plans, and clearinghouses to protect health information and inform consumers of the healthcare information practices of the facility. Overtime amendments and additions have been made and are incorporated into this Notice.

THE CONSUMER'S HEALTH INFORMATION RIGHTS:

This facility maintains a medical record for you containing medical information concerning you. With this in mind, you have the right to:

- Request a restriction on use and disclosure of health information, although the facility is not required to comply except as follows. A covered entity must agree to the request of an individual to restrict disclosure of PHI about the individual to a health plan if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law and the PHI pertains solely to a healthcare item or service for which the individual or another on behalf of the individual, other than the health plan, has paid the covered entity in full. A covered entity may terminate a restriction by informing the individual except for the above. (45CFR164.522)
- Obtain a copy of this notice
- Inspect, have access to, and receive a copy of your medical record (45CFR 164.524) A fee for labor and materials can be assessed.
- Amend your medical record (45 CFR 164.528)
- Obtain an accounting of disclosures of your medical record (45 CFR 164.528)
- Request your medical record by alternative means or location. You are entitled to receive electronic copies of PHI only if that PHI is already maintained in electronic format. The method of electronic transmission, the sending and receiving, must be deemed secure.
- Revoke your authorization to use or disclose your health information except to the extent that action has already been taken

THIS ORGANIZATION'S RESPONSIBILITIES:

This organization's mission of quality service and respect of the individual has always taken into account protecting health information privacy. Our responsibilities are to:

- Maintain the privacy of your health information
- Provide you this notice of health information practices
- Notify you if we are unable to satisfy a request or a restriction.
- Accommodate all reasonable requests while maintaining quality care and respect for you
- Make you aware of all health information practice policy changes
- We will not use or disclose your PHI your approval except as stated in this notice.

- When PHI is disclosed as above, it will be disclosed at the minimum necessary level.
- Account for how patient data are being used.
- Notify affected individuals following a breach of unsecured protected health information

TO REQUEST FURTHER INFORMATION OR ASK QUESTIONS:

If you would like further information or have questions, this organization employs a HIPAA Compliance Officer who can be reached at 412-396-1387.

If you believe that your privacy rights have been violated, you can file a complaint with the Compliance Officer or with the Secretary of Health and Human Services. There will be no penalty or retaliation for filing a complaint.

Examples of Permitted Types of Uses and Disclosures of Health Information:

This organization may use or be required to use your health information without your authorization or consent for normal business activities as follows:

For Care and Treatment: Health information obtained by a healthcare practitioner such as a physician, nurse, or therapist, will be entered into your medical record and used to determine a plan of care. For example, healthcare members will write and read what others have written such that your care can be coordinated and everyone is aware of how you are responding to your treatment plan. In addition, your health information may go with you such that future healthcare providers will have a record of your care. Your health insurer may disclose health information to the sponsor of the plan.

For Billing and Payment: In addition to demographic information, information on a bill sent to an insurer may include health information. This health information is restricted to that which is needed for the financial transactions.

For Healthcare Operations: In order to provide quality care and for payment, this organization may use your health information, for example, to analyze the care, treatment, and outcomes of your medical case and of others. This health information will be used to continually improve the care of the services that are provided. If a health plan receives protected health information for the purpose of underwriting, premium rating, or other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and if such health insurance or health benefits are not placed with the health plan, such health plan may only use or plan, such health plan may only use or disclose such protected health information for such purposes or as may be required by law, subject to the prohibition at 164.502 (a)(5)(i) with respect to the genetic information included in the protected health information.

In accordance with 164.504(f), the group health plan, or a health insurance issuer or HMO with respect to a group health plan, may disclose protected health information to the sponsor of the plan with the exception of genetic information as above.

For Directory Purposes: Where applicable, we will use your name, location, general medical condition, and religious affiliation for directory purposes unless you instruct us not to. This health information is only for the use of clergy and to people who ask for you specifically by full name (although religious affiliation will not be given to the latter).

For Business Associates: In order to provide quality services, this organization requires business services such as pharmacy, health insurance, clinic services, information technology, vendors, etc.. These services will have use of your health information at the minimum necessary level as it pertains to their service delivery. Also, business associates and their subcontractors must follow Federal standards for protecting your health information and sign a business associate agreement. In addition, the business associates must follow the HIPAA Privacy Rule, the Security Rule as specified in the Health Information Technology for Economic and Clinical Health Act (HITECH)/Energy and Commerce Recovery and Reinvestment Act, Subtitle D, Section 4401, and 45CFR164.502(a)(5)(ii)(A).

For Clergy: Where applicable, unless you specify that you object, health information such as your name and general medical condition will be given to clergy for professional purposes only.

For Notification: We may use or disclose health information, such as your general condition, to notify or assist in notifying a family member or person responsible for your care.

For Communication: We may use or disclose health information relevant to your care to family member's or those that you deem responsible for your care on a need to know basis.

For Research: We may disclose health information to researchers if they have appropriate consent forms and the research has been approved by our institutional review board. The researchers will be held to this facility's health information privacy standards.

For Funeral Directors: We may disclose health information to funeral directors in accordance with state laws and for professional purposes only.

For Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or organizations involved in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

For Marketing Purposes: Where applicable, we may contact you to provide information on appointment reminders or alternative treatments and services that may benefit you given your medical condition. In addition, a covered entity or business associate shall not directly or indirectly receive remuneration in exchange for any protected health information of an individual unless the covered entity obtained from the individual, in accordance with section 164.508 of title 45, Code of Federal Regulations, a valid authorization that includes a specification of whether the protected health information can be further exchanged for remuneration by the entity receiving protected health information of that individual. Exceptions under HITECH include, when the purpose of the exchange is for research, public health, treatment, health care operations, providing an individual with a copy of their protected health information, and for remuneration that is provided by a covered entity to a business associate for activities involving the exchange of protected health information that the business associate undertakes on behalf of and at the specific request of the covered entity pursuant to a business associate agreement. The price charged must reflect not more than the costs of preparation and transmittal of the data for such purpose.

For Fundraising: We may contact you for fundraising efforts conducted for this organization's benefit. Per 45CFR164.514(f)(1)(i-vi), the PHI used without an authorization is limited. You also have the right to opt out of receiving any further fundraising communication, and to opt back in.

For the Food and Drug Administration: As requested or required by the FDA, we may disclose health information relative to an adverse health condition related to food, food supplements, product and product defects related to food, or post marketing surveillance information to allow product recalls, repairs, or replacements.

For Workers Compensation Issues: In compliance with Worker's Compensation laws, health information may be revealed to the extent necessary to comply with the law and your individual case.

For Public Health Requirements: As required by law, health information may be disclosed to public health or legal authorities for the jurisdiction of disease, injury, disability prevention or control and to assist in disaster relief efforts. In addition, about information disclosure at a school in regards to an individual who is a student or a perspective student, if the PHI that is disclosed is limited to proof of immunization.

For Correctional Institutions: Should you be an inmate in a correctional institution, health information may be disclosed to the institution or its agents

which would be necessary for your health and safety and the health and safety of other individuals.

For Law Enforcement Agencies: Health information may be disclosed to law enforcement agencies for purposes required by law or subpoena.

For Judicial and General Administrative Proceedings: Patient health information may be released per minimum necessary requirements for proceedings.

For Healthcare Oversight: Patient health information may be used by health oversight agencies for activities such as audits, inspections, and licensure activities.

For Specialized Government Functions: In the event that appropriate military authorities require information, it may be released at the minimum necessary level.

For Victim of Abuse, Neglect, and Domestic Violence: Information may be released to social service agencies or protective services in order to protect an individual.

For Emergency Circumstance: If the opportunity to agree or object to the use or disclosure of PHI cannot practically be provided because of your incapacity or in an emergency circumstance, the covered entity may, in the exercise of professional judgment, determine whether the disclosure is in the best interest of the individual and if so disclose only the PHI that is directly relevant to the person's involvement with the individual's care or payment.

Examples of uses and disclosures that require an authorization such as psychotherapy notes [where deemed appropriate], participation in research, and marketing that involves financial remuneration, are to be made with your written authorization and you may revoke such authorization at any time as provided by 164.508(b)(5). Other uses and disclosures not described in the notice will be made only with your written authorization.

Examples of uses and disclosures requiring an opportunity for the individual to agree or to object include the following:

A covered entity may disclose, with your agreement, to a family member, other relative, a close personal friend, or any other person identified by you, the PHI directly relevant to such person's involvement with your healthcare treatment or payment related to your healthcare episode.

When an individual is deceased, a covered entity may disclose to a family member, or other persons who were involved in the individual's care or payment for health care prior to the individual's death, protected health information of the individual that is relevant to such person's involvement, unless doing so is inconsistent with any prior expressed preference of the individual that is known to covered entity.

Any other uses and disclosures not specified in this Notice will be made only with an authorization from you.

NOTICE OF AVAILABILITY OF SEPARATE PAYMENTS FOR CONTRACEPTIVE SERVICES

Duquesne University has certified that its group health plan qualifies for an accommodation with respect to the federal requirement to cover all Food and Drug Administration-approved contraceptive services for women, as prescribed by a health care provider, without cost sharing. This means your Duquesne University medical plan and/or prescription drug plan will not contract, arrange, pay, or refer for contraceptive coverage. Instead, the Duquesne University plans will provide separate payments for contraceptive services that you use, without cost sharing and at no other cost, for so long as you are enrolled in the University's medical plans. Duquesne University will not administer or fund these payments. If you have any questions about this notice, contact your medical plan and/or prescription drug plan provider.

YOUR RIGHTS AND PROTECTIONS AGAINST MEDICAL BALANCE BILLING

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. “Out-of-network” describes providers and facilities that haven't signed a contract with your health plan. An out-of-network provider may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out of network provider.

YOU ARE PROTECTED FROM BALANCE BILLING

You are protected from balance billing for:

Emergency services.

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out of network providers can't balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get care out of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out of network services toward your deductible and out of-pocket limit.

If you believe you've been wrongly billed, you may contact your health plan at the number on the back of your ID card.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

Duquesne University sponsors the Duquesne University 403(b) Retirement Plan (the "Plan"). Eligible University employees can voluntarily elect to defer a portion of their salary to the Plan to supplement their retirement savings.

ELIGIBILITY

Generally, all common law employees of the University who receive compensation reportable on a Form W-2 are eligible to participate in the Plan. The only employees not eligible to participate in the Plan are employees who are students who are not subject to FICA payroll taxes. Thus, all employees, aside from the students described above, are eligible to make voluntary contributions to the Plan. This includes part-time employees and adjunct faculty who are not eligible for any matching University contributions but are still eligible to make voluntary contributions to the Plan.

CONTRIBUTIONS

An employee can elect to defer a portion of their compensation to the Plan on a pre-tax or post-tax basis. With the pre-tax option, Federal income taxes are deferred on the contributions and any earnings thereon until distributed from the Plan. Distributions are taxed as ordinary income for Federal tax purposes. With the post-tax (or Roth) option, taxes are paid at the point of contribution, instead of paying them at the time of withdrawal.

Employees can invest their contributions to the Plan among the investment options offered by TIAA, the approved vendor under the Plan. Employees are 100% vested in their accounts under the Plan at all times.

CONTRIBUTION LIMITS

Annual contributions to the Plan are limited per IRS rules. For 2023 you can contribute up to \$22,500 per year.

If you are age 50 or older anytime in 2023, you can contribute an additional \$7,500 to your tax-deferred account, for a maximum of \$30,000.

Each participant gets one limit for contributions to all 403(b) plans, so if you are also a participant in a 403(b) plan of another employer, your combined contributions to that plan and to the Duquesne University Plan in 2023 are generally limited to \$22,500. If you do participate in more than one 403(b) plan, you are responsible for tracking and reporting the amount of all of your contributions to the plans so that the total amount of all your contributions to all plans in which you participate do not exceed the limit.

TO ENROLL

Eligible employees can begin participating in the Plan at any time. To enroll in the Plan, an employee must visit www.duq.edu/retirement to complete both (i) the TIAA online application process to open an account and (ii) an online request to elect the contribution amount. Contributions are designated as a percentage of salary. The employee's online request will apply only to amounts earned after enrolling in the Plan, and an employee's election will continue until the online request is modified or revoked by the employee.

TO MODIFY A DEFERRAL ELECTION

Employees must visit www.duq.edu/retirement at any time to increase, decrease or stop their voluntary contributions to the Plan.

APPROVED VENDOR

The current approved vendor under the Plan is TIAA. Employees should contact TIAA for information about the Plan investment options and services it offers.

This notice is provided as a source of information and does not constitute legal, tax, or other professional advice. If legal advice, tax advice, or other professional assistance is required, the services of a professional advisor should be sought. Every effort has been made to make this notice as thorough and accurate as possible. However, there are other legal documents, laws, and regulations that govern the operation of the Plan. It is understood that in the event of any conflict, the terms of the Plan document (available on line at www.hr.duq.edu), applicable laws, and regulations will govern.

RETIREMENT PLAN COUNSELING

As a participant in the Duquesne University Retirement Plan, you have access to personalized, confidential advice on the plan's investment options from HB Retirement or TIAA advisors. This service is available as part of your retirement program at no additional cost to you.

These appointments provide an excellent opportunity for you to discuss your particular accounts on a range of topics, including payroll deductions, investments, allocations, transfers, tax-deferred savings, death benefits and retirement options.

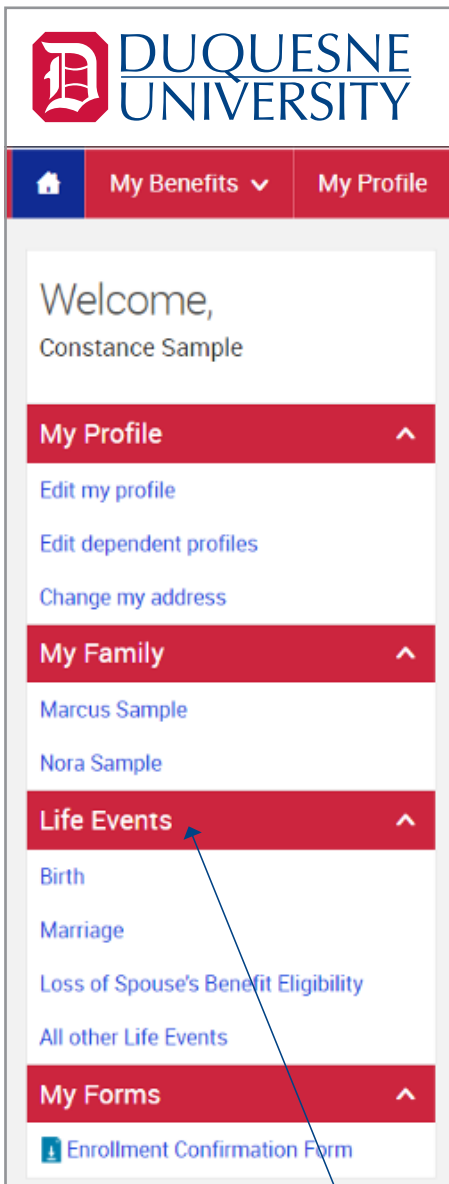
Even if you are not approaching retirement, be sure to take advantage of the individual appointments and online planning tools.

See additional scheduling information and telephone numbers on page 23.

Employees may use the **bswift** system to update information throughout the plan year due to qualified life events as defined on page 5.

These steps must be completed within 30 days of the event.

1. **LOG IN** to **bswift** using the instructions located on page 3.



2. **SELECT** your specific Life Event
3. **INDICATE** the effective date
4. **ENTER** information as requested
5. **CONFIRM** and Save Enrollment

The following items are needed before the Benefits Office can approve and process the qualified life event:

- **BIRTH** – copy of crib card then Birth Certificate upon receipt
- **DIVORCE** – copy of Divorce Decree
- **MARRIAGE** – copy of Marriage Certificate
- **EMPLOYMENT STATUS** – proof of gain/loss of coverage indicating effective date, specific coverage gained/lost (i.e., medical, dental, vision) and person(s) gaining/losing coverage

Follow these instructions to upload documentation to **bswift**:

- **SCAN** and save document to your computer
- **LOG IN** to **bswift** using the instructions located on page 3
- **SELECT** My Profile
- **SELECT** Employee File
- **SELECT** Add Employee File Document
- **TITLE** the document (i.e. Marriage Certificate, “Child’s Name” Birth Certificate, etc.)
- **SELECT** Document Type
- **SELECT** Browse to locate and select your scanned document
- **CLICK** Save

A confirmation email will be sent when the Benefits Office has completed the process.

Qualified life events must be reported within 30 days of the event.

Do not wait for documentation to begin this process.

Your enrollment will remain pending on **bswift** until the Benefits Office approves and processes.

CUSTOMER SERVICE CONTACTS

Axa Assistance <i>(Travel Assistance and Identity Theft Solutions)</i>	1.800.454.3679	metlife.com/travelassist
CVS Caremark Prescription Drug Specialty Drug Management	Customer Care Service via RxBenefits 1.877.352.7987 1.800.237.2767	caremark.com customercare@rxbenefits.com
The Center for Pharmacy Care <i>Medication Therapy Management</i> <i>Wellness in Motion Screenings and Immunizations</i>	412.396.2155	cpc@duq.edu
Highmark – Including 24 Hour Health Information Line	1.800.215.7865	highmarkbcbs.com
Coldwell Banker Real Estate	1.800.396.0960	realestateadvantageprogram.com
Dental – MetLife PDP Plus Network – Group #151368	1.800.942.0854	metlife.com/mybenefits
Employee Assistance Program (EAP) and Personal Health Partners	1.800.EAP.7272	mylifeexpert.com COMPANY CODE: duquesne
Enterprise Car Rental Discount		purchasing@duq.edu
Flexible Spending Accounts and Health Savings Accounts <i>wex Participant Services</i>	1.866.451.3399	customerservice@wexhealth.com www.wexinc.com/login/benefits-login/ Select Participants/Employees
HIPAA Rights Line	412.396.1387	
Howard Hanna Real Estate	412.784.3829	hannagoldadvantage.com Click "Register for benefits", then select Duquesne University
MetLife (Life Insurance and LTD) – Group #151368	Life Insurance: 1.800.438.6388 LTD: 1.800.300.4296	metlife.com/mybenefits
MetLife Grief Counseling	1.888.319.7819	metlifegc.lifeworks.com USERNAME: metlifeassist PASSWORD: support
Omega Federal Credit Union	1.800.496.8728	omegafcu.com
Social Security Office	1.800.772.1213	ssa.gov
SEIU Pension Fund	1.800.458.1010	seiu.org
TIAA – Account Number RC405488 <i>Appointment Scheduling</i>	1.800.842.2252 1.800.732.8353	duq.edu/retirement
UPMC Health Plan UPMC MyHealth 24/7 Nurse Line	1.888.876.2756 1.866.918.1591	upmchealthplan.com
YMCA Child Development Center Duquesne University Located at 12 Washington Place, Suite 110	412.852.4909	https://www.pittsburghymca.org/ DuquesneUniversity
VSP Vision Care – Client #30039552	1.800.877.7195	vsp.com
Benefits Office	412.396.5106	duq.edu/benefits



Office of Human Resources
600 Forbes Avenue
Pittsburgh, PA 15282



FOR MORE INFORMATION

duq.edu/benefits | 412.396.5106