



BENEFITS OVERVIEW

| 2016-2017 |

Dear Colleagues,

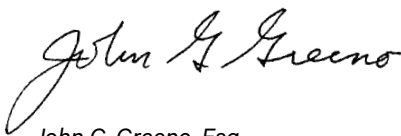
At Duquesne University, we are committed to offering our employees a comprehensive and affordable medical benefits plan, despite rising health care costs. The University, with the guidance of a benefits consultant and the Benefits Committee comprised of faculty, administrative, staff and union representatives,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

Follow these simple tips to get the most out of your benefit coverage and help save money on health care costs:

- Participate in the Wellness in Motion programs, including the Know Your Numbers campaign
- 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 eVisits/ TeleHealth options
- Visit an urgent care facility instead of the emergency room if you are not experiencing a true medical emergency
- Download vendor apps to your smartphone for access to important plan information, participating providers, recipes 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,



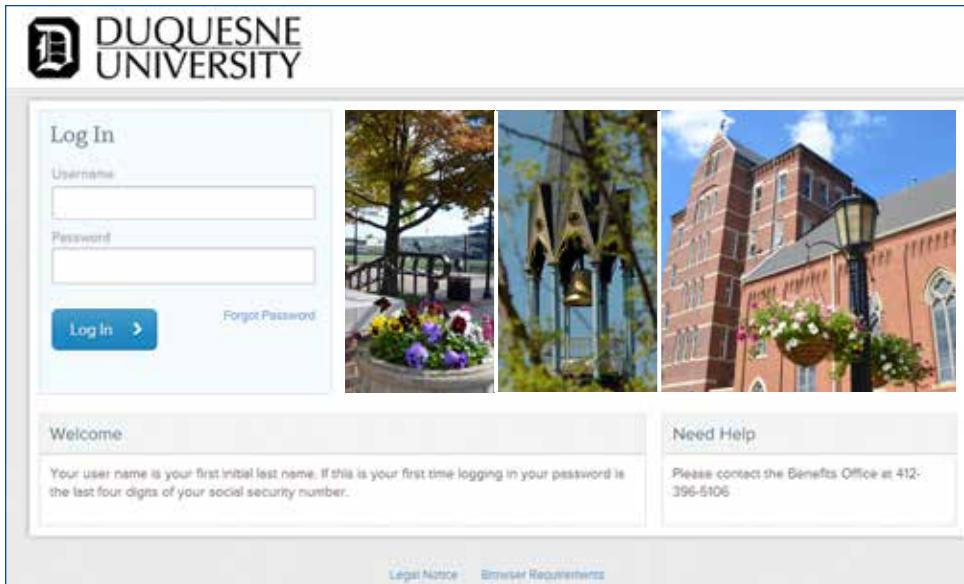
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Notice to Participants: The information contained in this enrollment guide represents only a portion of the actual provisions of the coverages mentioned. This document is not a contract. The complete terms and conditions concerning the discussed coverages 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.

ENROLLMENT PROCEDURE



1. **EVALUATE** your choices. Review this guide and contact the Benefits Office for an appointment at 412.396.5106. Compare your benefit options from all available sources.

2. **ENROLL ONLINE** through **bswift**, Duquesne's confidential, web-based benefits enrollment management system.

Connect to **bswift** at duq.edu/benefits.

LOG IN TO **bswift**

The benefits enrollment system **DOES NOT USE YOUR DORI** login and password.

- Enter your **Username**:
Your username is your **first initial and entire last name**.
For example, if your name is Robert Smith, the username would be 'rsmith.'
In the rare event that two or more people have the same name combination (e.g. Robert Smith and Rose Smith), you will need to contact the Benefits Office staff at extension 5106 for assistance.
- Enter your **Password**:
All passwords are set to the **LAST FOUR DIGITS** of your Social Security Number. The system will request a change to this password before you can begin the enrollment process.
- Select **Forgot Password** if you need assistance with your password.

3. **REVIEW** your selections carefully. Be sure your selections are what you wanted. Compare your paycheck against your online enrollment to verify your selections. **Federal guidelines only permit changes for a qualified life event after the enrollment period.**

4. **REMEMBER** to log into **bswift** anytime throughout the benefits plan year to review coverage, update life insurance beneficiaries or complete qualified life events.



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.

The **bswift** system is also available by downloading the application to your preferred mobile device.



askEMMA



- **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 profile via the providers' website.
- **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' website. Websites and customer service contact information are located on page 25.

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

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

MAKE THE MOST OF YOUR HEALTH DURING THIS PLAN YEAR!

- 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 the medical plan portals, save you money and help you avoid problems in the future.
- Actively participate in the disease management and coaching programs offered through The Center for Pharmacy Care and the medical plans. Refer to page 11 for information regarding \$0 cost if eligible for the Medication Therapy Management program.
- Stop using tobacco products. If you currently use or recently quit using tobacco or nicotine products, consider enrolling in the cessation or maintain tobacco free programs with the medical plans, or contact The Center for Pharmacy Care at 412.396.2155 for coaching assistance.
- Minimize your costs by using eVisits/TeleHealth, Urgent Care Centers and Medical Plan Health Information lines.

LEARN MORE ABOUT THE UNIVERSITY MEDICAL PLANS INCLUDING:

Telemedicine (referred to as eVisits by UPMC Health Plan and TeleHealth by Cigna)

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 Cigna OAP and UPMC EPO have a \$5 copay. Individuals enrolled with the high deductible health plans (HDHP) usually pay approximately \$40 per visit until they meet deductibles/coinsurance as outlined on page 6.

BENEFIT CHANGES OUTSIDE OF OPEN ENROLLMENT

When you enroll in health insurance, dental insurance, life insurance and/or the flexible spending accounts, your benefit elections remain in effect to the end of the plan year (June 30, 2017). 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 single health coverage to family 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 24 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 healthcare marketplace.

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

EMPLOYEE STATUS	Cigna High Deductible	University Contribution to Health Savings Account	UPMC High Deductible	University Contribution to Health Savings Account	Cigna OAP	UPMC EPO	Working Spouse Contribution
SINGLE							
Annual	\$549.00	\$450.00	\$549.00	\$450.00	\$1,961.00	\$2,172.00	None
Biweekly	\$21.12	\$17.31	\$21.12	\$17.31	\$75.42	\$83.54	None
EMPLOYEE PLUS SPOUSE OR CHILD							
Annual	\$877.00	\$550.00	\$877.00	\$550.00	\$3,046.00	\$3,689.00	\$1,200.00
Biweekly	\$33.73	\$21.15	\$33.73	\$21.15	\$117.15	\$141.88	\$46.15
FAMILY							
Annual	\$1,096.00	\$650.00	\$1,096.00	\$650.00	\$4,037.00	\$4,775.00	\$1,200.00
Biweekly	\$42.15	\$25.00	\$42.15	\$25.00	\$155.27	\$183.65	\$46.15

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 Cigna OAP or UPMC EPO plan, an additional pre-tax contribution of \$46.15 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 24 for additional information.

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

- You do not have a spouse
- You have enrolled in a High Deductible Health Plan, which does not require spousal contribution
- 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	Cigna and UPMC High Deductible Health Plans (HDHP)	Cigna Open Access Plus (OAP)	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. Cigna OAP 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?	Cigna Open Access Plus (OAP) and UPMC Health Plan Premium PPO Network	Cigna Open Access Plus (OAP)	UPMC Health Plan Exclusive Provider Organization (EPO)
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 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 OAP deductible.	The amount of the deductible is listed at the top of the plan design grid. Families and the Employee Plus Spouse or Child 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.	The UPMC EPO Plan does not have a 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 10% 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 \$15 copay for primary care and \$30 copay for a specialist doctor's office visit. Laboratory or imaging fees are subject to the deductible and coinsurance.	You pay a \$15 copay for primary care and \$30 copay for a specialist doctor's office visit. Laboratory or imaging fees are subject to 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 10% 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 the Duquesne University Pharmacy, CVS Caremark mail order or CVS retail stores. Copays are based upon the chart located on page 10. Once you meet your prescription out-of-pocket maximum as listed on page 10, 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: \$450 Single, \$550 Employee Plus Spouse or Child, \$650 Family. Limit = \$3,350 for individual and \$6,750 for family. 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 \$2,550 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 \$2,550 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 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

SERVICES	Cigna High Deductible Health Plan		UPMC High Deductible Health Plan		Cigna Open Access Plus Plan		UPMC Exclusive Provider Organization
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Network	Cigna OAP Plan		UPMC Premium PPO		Cigna OAP Plan		UPMC EPO 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.						No Deductible
Individual Deductible	\$1,500	\$3,000	\$1,500	\$3,000	\$250	\$750	None
Maximum Deductible Employee Plus Spouse or Child and Family	\$3,000 Family	\$6,000 Family	\$3,000 Family	\$6,000 Family	\$500	\$1,500	None
How do I know what my deductible will be?	<p>Families and the Employee Plus Spouse or Child 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 OAP deductible.</p>		<p>Families and the Employee Plus Spouse or Child 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 OAP deductible.</p>		<p>Families and the Employee Plus Spouse or Child 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>		The UPMC EPO plan does not have a deductible.
Plan Coinsurance	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. The out-of-pocket maximum limits how much you pay for your share.						
Employer-Paid Plan Coinsurance	90% after deductible until out-of-pocket limit is met, then 100%	70% after deductible until out-of-pocket limit is met, then 100%	90% after deductible until out-of-pocket limit is met, then 100%	70% after deductible until out-of-pocket limit is met, then 100%	90% after deductible until out-of-pocket limit is met, then 100%	70% after deductible until out-of-pocket limit is met, then 100%	90% until out-of-pocket limit is met, then 100%
Employee-Paid Coinsurance	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10%
Employee Out-of-Pocket Maximum Per Plan Year	The number below is after deductible has been met. All copays and coinsurance expenses contribute to this out-of-pocket maximum.				The number below is after deductible (if applicable) has been met. All medical copays and medical coinsurance expenses contribute to this medical out-of-pocket maximum. A separate out-of-pocket maximum applies to prescriptions.		
Individual	\$3,000	\$7,000	\$3,000	\$7,000	\$1,500	\$5,000	\$1,000
Employee Plus Spouse or Child	Family Only	Family Only	Family Only	Family Only	\$3,000	\$10,000	\$2,000
Family	\$3,850	\$14,000	\$3,850	\$14,000	\$3,000	\$10,000	\$2,000
Primary Care Physician	No Primary Care Physician is Required						
Physician Office Visit	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	\$15	You pay 30% after deductible	\$15
Specialist Office Visit	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	\$30	You pay 30% after deductible	\$30
eVisits and TeleHealth	You pay 10% after deductible. Call MDLive at 1.888.726.3171.		You pay 10% after deductible.		\$5 Call MDLive at 1.888.726.3171.		\$5
Pre-Existing Conditions Limitations	No pre-existing conditions limitations						

SERVICES	Cigna High Deductible Health Plan		UPMC High Deductible Health Plan		Cigna 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	ALL PREVENTIVE CARE IS COVERED AT 100% PLAN PAYMENT PER ESTABLISHED GUIDELINES. Preventive Services will be covered in compliance with the requirements under the Affordable Care Act (ACA). Please refer to medical plan portals 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. Watch DU Daily and DORI for your opportunity to participate in wellness initiatives sponsored by the Office of Human Resources through the Mylan School of Pharmacy and Department of Recreation.						
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 10% after deductible		You pay 10% after deductible		\$125 per visit (payment waived if admitted)		\$125 per visit (payment waived if admitted)
Urgent Care Facility	You pay 10% after deductible		You pay 10% after deductible		\$30		\$30
Hospital Services - Inpatient/Outpatient	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10% Private room if medically necessary and appropriate.
Private room stays may result in extra charges.	Private room stays may result in extra charges.		Private room if medically necessary and appropriate.		Private room stays may result in extra charges.		Private room if medically necessary and appropriate.
Maternity Services							
First Office Visit					\$30		\$15
Subsequent Pre-Natal Visits	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	100%	You pay 30% after deductible	100%
Hospital Delivery Services					You pay 10% after deductible		You pay 10%
Infertility Counseling Testing					You pay 10% after deductible		You pay 10%
Assisted Fertilization Procedures	Not Covered						
Medical/Surgical Services (except office visits)	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10%
Chiropractic Services	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	\$30	You pay 30% after deductible	\$30
Limit per benefit period	25 visits						

SERVICES	Cigna High Deductible Health Plan		UPMC High Deductible Health Plan		Cigna Open Access Plus 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 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10%	
	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10%	
Rehabilitation Therapy	MUST HAVE AN APPROVED TREATMENT PLAN							
Physical and Occupational Therapy	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	\$30	You pay 30% after deductible	\$15	
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 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	\$30	You pay 30% after deductible	\$15	
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 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	\$30	You pay 30% after deductible	\$15	
Limit per benefit period	Covered up to 24 visits per benefit period		Covered up to 30 visits per benefit period		Covered up to 24 visits per benefit period		Covered up to 30 visits per benefit period	
Durable Medical Equipment and Prosthetics	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10%	
Skilled Nursing Facility Care	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10%	
Limit per benefit period	Covered up to 100 days per benefit period							
Home Health Care	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10%	
Limit per benefit period	No Limit		60 days		No Limit		60 days	
Private Duty Nursing	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10%	
	Based on Medical Necessity Provisions							
Allergy Serums, Treatments and Injections	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10%	
Emergency Transportation	You pay 10% after deductible. Non-emergency (transportation from hospital back to home) is generally not covered.						You pay 10%	
Dental Services Related to Accidental Injury	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10%	
Diabetes Treatment	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10%	
Home Infusion Therapy	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10%	

SERVICES	Cigna High Deductible Health Plan		UPMC High Deductible Health Plan		Cigna Open Access Plus 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 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10%
Cardiac Rehabilitation	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	\$30	You pay 30% after deductible	You pay 10%
Limit per benefit period	36 days		12 weeks		36 days		12 weeks
Hospice Care	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10%
Transplant Services	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	Inpatient covered at 100% at Lifesource center, otherwise same as plan's inpatient hospital facility benefit. Travel maximum of \$10,000 per transplant if using Lifesource facility.	Not Covered	You pay 10%
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 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10%
Outpatient	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	\$30 per visit	You pay 30% after deductible	\$30 per visit
Substance Abuse Services							
Inpatient Detoxification	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10%
Inpatient Rehabilitation	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 10%
Outpatient Rehabilitation	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible	\$30 per visit	You pay 30% after deductible	\$30 per visit
Nationwide Out-of-Area Care	You pay 10% after deductible Cigna Open Access Plan network available nationwide	You pay 30% after deductible Cigna Open Access Plan network available nationwide	You pay 10% after deductible for urgent and emergent care while traveling. Contact UPMC Health Plan or Assist America to find a provider.		You pay 10% after deductible Cigna Open Access Plan network available nationwide	You pay 30% after deductible Cigna Open Access Plan network available nationwide	Covered only for urgent and emergent 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 Cigna. 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 Cigna. 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.

PRESCRIPTION DRUG PLAN

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 6, is provided using your Cigna HDHP or UPMC HDHP medical plan card. Refer to your medical plan customer service number for additional information.

Cigna OAP 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%.

	Cigna Open Access Plus Plan	UPMC Exclusive Provider Organization
Prescription Drug Card	CVS Caremark will mail a separate card for participants. Visit the prescription plan online to compare pricing, track mail orders and review accounts. CVS Caremark www.caremark.com • 1.877.347.7444	
Prescription Out-of-Pocket Maximum	All prescription copays contribute to the prescription drug out-of-pocket maximums.	
Individual	\$4,850	\$5,600
Employee Plus Spouse or Child	\$9,700	\$11,200
Family	\$9,700	\$11,200
Retail - One Month Supply - Prescriptions written for non-chronic, short-term conditions		
Generic	\$4 for prescriptions filled at Duquesne University Pharmacy. \$8 maximum at all other locations.	
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	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 in one of the following three ways: Duquesne University Pharmacy, CVS Caremark mail order services, Target or a CVS retail store.	
Generic	\$12 for prescriptions filled at Duquesne University Pharmacy. \$16 maximum at all other locations.	
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. 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.

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 below.
- Set up a health care flexible spending account to use pre-tax dollars to pay for your prescriptions. Remember that you can list your DBI 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 three ways:

- Duquesne University Pharmacy via campus delivery or through walk-in services, 412.246.0963
- CVS Caremark mail order services, 1.877.347.7444
- 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!

DUQUESNE UNIVERSITY PHARMACY

Duquesne University Pharmacy is available at [412.246.0963](tel:412.246.0963) to answer any questions regarding your prescription medications. They also offer:

- A \$4 Generic Drug Program
- Maintenance medication for 90-day supplies
- Free, confidential prescription delivery to your office
- Easy prescription transfer

Hours: 9:00 a.m. – 5:00 p.m. | Monday through Friday

MEDICATION THERAPY MANAGEMENT PROGRAM | \$0 copayment for select medications!

MEDICATION THERAPY MANAGEMENT

The Center for Pharmacy Care also offers a Medication Therapy Management Program for employees with specific conditions, including high cholesterol, depression, chronic pain management, asthma, hypertension (high blood pressure) and diabetes. As a participant in this program, you will receive:

- An initial health assessment
- 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
- Employees enrolled in the University CVS Caremark prescription plan will have a \$0 copayment for select medications for the following covered prescriptions:
 - Cholesterol
 - Depression
 - Chronic pain management

- Hypertension (high blood pressure)
- Diabetes (open to all family members)
- Asthma
 - For employees with spouse and children enrolled in the University CVS Caremark prescription plan, a \$10 copayment for their covered asthma prescriptions.

TO SCHEDULE AN INITIAL CONFIDENTIAL, FREE MEDICATION ASSESSMENT,

contact The Center for Pharmacy Care at 412.396.2155. Remember, in addition to free, confidential education and counseling, Duquesne University will pay the full cost of prescriptions for the above conditions for employees covered through our CVS Caremark prescription plan under the Cigna OAP and UPMC EPO plans.



A Healthy Lifestyle Program for Employees



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

Employees enrolled in Medicare 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 health-care expenses.

The features include:

- Your deposits are tax-free and your money grows, year after year, tax free until you use it.
- You own the account and decide how to invest and grow your money—even when you leave or retire.
- You can withdraw funds anytime to pay for eligible medical expenses including deductibles, co-insurance, prescriptions, vision and dental care.
- At age 65 or after, you can withdraw funds without penalty and use them for whatever you want.
- 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:
 - \$3,350 for Single;
 - \$6,750 for Employee plus Spouse or Child and Family; and
 - Any participant who turns 55 or older during the plan year may also contribute an additional \$1,000.
- Use the medical plan websites to locate information regarding the cost and quality of treatment options, doctors and hospitals to assist with planning.
- 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 Cigna High Deductible Health plan or UPMC High Deductible Health plan will use Healthcare Bank with Discovery Benefits, Inc. for the Health Savings Account deposits.
- Duquesne University pays the monthly administrative fee for the Health Savings Account **at Healthcare Bank with Discovery Benefits, Inc.** while you are an active employee.

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

- \$450 per year for Single subscribers
- \$550 per year for Employee plus Spouse or Child subscribers
- \$650 per year for Family subscribers

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. Discovery Benefits, Inc. (DBI) administers this plan for the University. Use the calculators, list of eligible expenses and planning tools available on the DBI website at discoverybenefits.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 DBI debit card or via electronic claim submission.

- The plan year to incur expenses is extended through September 15, 2017.
- Deadline to submit eligible claims for reimbursement is December 31, 2017.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

- You may contribute from \$130 to \$2,550 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 Discovery Benefits, Inc. (DBI).

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. DBI 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 discoverybenefits.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, 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, 2017.
- Deadline to submit eligible claims for reimbursement is December 31, 2017.

ELIGIBLE EXPENSES

Care of a qualified dependent is only eligible if the care enables you (or you and your spouse) to work, look for work, or go to school full time. 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.

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
SINGLE	Annual	\$219.36	\$374.04
	Biweekly	\$8.44	\$14.39
EMPLOYEE PLUS SPOUSE OR CHILD	Annual	\$449.04	\$762.60
	Biweekly	\$17.27	\$29.33
FAMILY	Annual	\$734.40	\$1,239.36
	Biweekly	\$28.25	\$47.67

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
Single	\$50	\$50	\$50	\$50
Employee Plus Spouse or Child	\$100	\$100	\$100	\$100
Family	\$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 <i>(Two times per plan year)</i>	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 <i>(One time per plan year for child under age 19)</i>								
Sealants <i>(One per molar in 3 years for child under age 14)</i>								
Full Mouth X-Rays <i>(One per 3 plan years)</i>								
Bitewing X-Rays <i>(Two sets per plan year)</i>								
Space Maintainers <i>(Non-orthodontic for child under age 19)</i>								
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 <i>(Root Canal)</i>								
Repairs of CIO, Dentures and Bridges								
Simple Extractions								
Periodontal Maintenance								
Periodontal Surgery								
Periodontal Scaling and Root Planing	Not Covered	Not Covered	60% of Allowance	60% of Allowance				
General Anesthesia when dentally necessary								
MAJOR SERVICES								
Implants <i>(One per tooth in 5 plan years for natural teeth lost while covered by plan)</i>								
Crowns/Inlays/Onlays <i>(Replacement once every 5 plan years)</i>	Not Covered	Not Covered	60% of Allowance	60% of Allowance				
Bridges and Dentures <i>(Initial placement for natural teeth lost while covered by plan)</i>								
Bridges and Dentures Replacement <i>(One every 5 plan years)</i>								
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.				

Your vision benefits are provided through **VSP (Vision Service Plan)**. Use providers in the VSP network to obtain the highest level of benefits. Visit vsp.com to find or confirm in-network providers.

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

VISION PRICE TAGS

EMPLOYEE STATUS		VSP CHOICE BASIC	VSP CHOICE ENHANCED
SINGLE	Annual	\$65.04	\$131.64
	Biweekly	\$2.50	\$5.06
EMPLOYEE PLUS SPOUSE OR CHILD	Annual	\$130.08	\$263.28
	Biweekly	\$5.00	\$10.13
FAMILY	Annual	\$209.52	\$423.72
	Biweekly	\$8.06	\$16.30

SUMMARY OF BENEFITS	VSP CHOICE BASIC		VSP CHOICE ENHANCED	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Exams	Once every plan year	Once every plan year	Once every plan year	Once every plan year
Lenses	Once every plan year	Once every plan year	Once every plan year	Once every plan year
Frames	Once every other plan year	Once every other plan year	Once every plan year	Once every plan year
Contacts	In lieu of lenses and frames	In lieu of lenses and frames	Once every plan year	Once every plan year
WellVision Exam	Covered in full	\$45 Allowance	\$20	\$45 Allowance
Single Vision	Covered in full	\$30 Allowance	Covered in full	\$30 Allowance
Lined Bifocal	Covered in full	\$50 Allowance	Covered in full	\$50 Allowance
Lined Trifocal	Covered in full	\$65 Allowance	Covered in full	\$65 Allowance
Lenticular	Covered in full	\$100 Allowance	Covered in full	\$100 Allowance
Tints/Photochromic	NA	NA	Covered in full	NA
Scratch Coating	NA	NA	Covered in full	NA
Progressive Lenses	NA	\$50 Allowance	\$20	\$50 Allowance
Frames	Covered in full up to retail allowance of \$130 20% off any amount above the retail allowance	\$70 Allowance	Covered in full up to retail allowance of \$170 20% off any amount above the retail allowance	\$70 Allowance
	CONTACT EXAM AND LENSES ARE IN LIEU OF LENSES AND FRAMES		ENHANCED PLAN MEMBERS MAY RECEIVE CONTACT EXAM AND LENSES EVERY PLAN YEAR	
Contact Lenses Exam	Copay not to exceed \$60	\$105 Allowance for Exam and Contacts	Copay not to exceed \$60	\$105 Allowance for Exam and Contacts
Contact Lenses	\$130		\$170	
Medically Necessary Contacts	Covered after copay	\$210 Allowance	Covered after copay	\$210 Allowance
Additional Pairs of Glasses/Sunglasses	20% off unlimited additional pairs of prescription glasses and/or non-prescription sunglasses	NA	20% off unlimited additional pairs of prescription glasses and/or non-prescription sunglasses	NA
ID Cards	No ID card is required for services. In-network providers electronically submit claims on your behalf.			
Service Frequency	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.			
Laser VisionCare Program	Discounts average 15% to 20% off or 5% off a promotional offer for laser surgery, including PRK, LASIK and Custom Lasik from VSP contracted facilities.			
TruHearing MemberPlus Program	Savings of up to 50% on hearing aids, yearly comprehensive exams for \$75, fitting/programming/adjustment visits, three-year repair warranty and 48 batteries per purchased hearing aid. May add up to four guests (parents, grandparents, siblings) for \$71 each. Sign up via vsp.truhearing.com and call 1.877.396.7194 to schedule an appointment.			
Provider Choice	VSP Vision Care offers in-network benefits through 49,000 VSP preferred providers nationwide. Even though Walmart and Sam's Club are considered out-of-network providers, they have a national agreement with VSP to permit electronic claims submission.			
Customer Service	vsp.com	1.800.877.7195	imember@vsp.com	Download vsp app

Knowing important numbers like your blood pressure, cholesterol, glucose (blood sugar) and body mass index (BMI) will help you learn about your risk for developing chronic conditions and create an action plan to control your risk factors to live a long, healthy life.

In addition to the health benefits of participating, you can also earn money! Each eligible employee will receive a \$250 participation reward!

EARN \$250

- Open to Duquesne University employees enrolled in a University medical plan. If your spouse is also a Duquesne University employee enrolled in our plan, then only one per household is eligible for the campaign.
- All employee information is confidential.
- Complete a Know Your Numbers general health screening of:
 - Body mass index (BMI)
 - Cholesterol level
 - Blood pressure
 - Blood glucose level
- Complete Wellness Profile via online tool offered through your health insurance plan. It's helpful to have your screening numbers to complete the Profile.
- **Deadline is June 30, 2017.**

OBTAIN YOUR SCREENINGS

- Contact The Center for Pharmacy Care at 412.396.2155 for free screenings.
- Personal physician visits, health clinic and community screenings are acceptable. These screenings may require a copay. Documentation forms for screenings outside of The Center for Pharmacy Care are available at duq.edu/benefits.

HOW \$250 WILL BE PAID

- The \$250 reward is taxable income.
- **Employee must be an active member of the medical plan when payment is being processed.**
- Completion of screenings and online wellness profiles by the deadline of September 30, 2016 will result in \$250 being added to the first pay of November 2016.
- Completion of screenings and online wellness profiles by the deadline of December 31, 2016 will result in \$250 being added to the first pay of February 2017.
- Completion of screenings and online wellness profiles by the deadline of March 31, 2017 will result in \$250 being added to the first pay of May 2017.
- Completion of screenings and online wellness profiles by the deadline of June 30, 2017 will result in \$250 being added to the first pay of August 2017.
- **All screenings and Profiles must be completed by June 30, 2017.**



The bottom-line for the **KNOW YOUR NUMBERS CAMPAIGN**

- You are eligible again this year, even if you participated last year!
- Avoid the last minute rush — schedule your screenings now!

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 \$75,000. 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.

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 additional benefits of 60% of base salary to a maximum of \$10,000 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 the Disability Claims Manager at 412.396.6677 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

Please refer to **The Administrative Policies (TAPs)** for additional information. These documents are available on our website at duq.edu/taps

VACATION PURCHASE

If you are a full-time, non-faculty employee of the University, you may purchase up to five additional vacation days. Vacation is purchased in units of one full day. The cost indicated on your enrollment information is determined by dividing your base annual salary by 260. For example, \$26,000 divided by 260 is \$100 per day. Purchasing two vacation days would cost \$200, or approximately \$7.69 per pay (\$200 divided by 26 biweekly pays). Vacation purchase is completed with pre-tax dollars. **Purchased days must be used within the plan year or they are forfeited.** If you leave the University and have not used the purchased time, you will be reimbursed on a pro-rated basis. There is no opportunity to sell vacation days back to the University.

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 on the Office of Human Resources website.

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

The Administrative Policies (TAPs)

duq.edu/about/administration/policies/taps

You can view your current leave balance on the **DORI** system by accessing:

- Self Service → Employee → Leave Balances

TUITION REMISSION/TUITION EXCHANGE

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 deadline are subjected to a five percent benefit reduction.**

All tuition exchange forms must be completed and received by the Benefits Office no later than December 1 of the student's senior year of high school. Participating tuition exchange schools may be found at tuitionexchange.org and cic.org.

For details about eligibility, please visit duq.edu/admissions-and-aid/financial-aid/programs/tuition-exchange.

EMPLOYEE ASSISTANCE PROGRAM | 1.800.327.7272

If you're struggling with a work or family issue, free confidential help is just a call away. You and your eligible dependents can receive help on issues such as:

- Marital or premarital problems
- Alcohol or drug abuse
- Interpersonal issues
- Conflict at work
- Depression or anxiety
- Stress management
- Family relationships
- Grieving a loss
- Financial, legal or consumer concerns
- Child and elder care resources
- Personal Health Partners



OUR EMPLOYEE ASSISTANCE PROGRAM offers Personal Health Partners to lend a hand with the many aspects of family health care. You and your family members have access to a Personal Health Partners specialist who can answer questions regarding specific treatment options, secure appointments with specialists and help answer questions related to insurance matters. Personal Health Partners case managers are experienced in coordinating with health insurance representatives, social workers, claim representatives, pharmaceutical companies, doctor's offices and nurses. The service is free to you and your family members including parents and parents-in-law. Call 1.800.327.7272 for assistance.

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.

EMPLOYEE CONTRIBUTIONS

The **Duquesne University Retirement Plan** is a tax-deferred defined contribution plan that helps you save for retirement. Eligible 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.

Changes to voluntary retirement plan deductions can be made at any time with the completion of a new Salary Reduction Agreement form.

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 will be waived if you have previously worked at a qualifying educational institution as a full-time administrator, a full-time faculty member or a full-time hourly position.

Employees contribute 5% of eligible salary on a voluntary basis and receive, if eligible, an additional 8% matching contribution from the University. You may always contribute more than 5%, but additional voluntary contributions are not matched.

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.

UNDERSTANDING RETIREMENT PLAN FEES

You can enhance your retirement savings by understanding how investment fund fees effect 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 every November 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

In general, you may not withdraw any of the funds in your retirement plan accounts as long as you are employed at the University. However, if eligible, you may 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 and are no longer eligible for University contributions, or request disability distribution.

Contact your retirement plan vendor approximately three months before your retirement date to ensure paperwork and distribution options are properly completed.

COUNSELING

Both Fidelity and TIAA offer ongoing opportunities for you to meet personally with one of the Participant Counselors. 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. Use the Appointment Scheduling numbers provided below to determine the date and time that works best for you.

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

RETIREMENT PLAN CONTACT INFORMATION

- **FIDELITY** | <https://nbacctopen.fidelity.com/>
Customer Service: 1.800.343.0860
Appointment Scheduling: 1.800.642.7131
F.L. Geary: 412.445.4080
- **TIAA** | <http://www1.tiaa-cref.org/tcm/duq/>
Customer Service: 1.800.842.2776
Appointment Scheduling
1.800.732-8353 or 1.877.209.3136
Mark Sekera: 412.365.3008
- **VALIC** | <http://www.valic.com/>
John Soika: 412.680.0494
(No longer accepting contributions)

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 24.

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 PRICE TAGS | CIGNA

EMPLOYEE STATUS	CIGNA HIGH DEDUCTIBLE	CIGNA OAP
SINGLE		
Monthly	\$424.85	\$529.50
EMPLOYEE PLUS SPOUSE OR CHILD		
Monthly	\$849.69	\$1,058.99
FAMILY		
Monthly	\$1,614.43	\$2,012.07

COBRA RATE MEDICAL PRICE TAGS | UPMC

EMPLOYEE STATUS	UPMC HIGH DEDUCTIBLE	UPMC EPO
SINGLE		
Monthly	\$424.85	\$560.94
EMPLOYEE PLUS SPOUSE OR CHILD		
Monthly	\$849.69	\$1,141.00
FAMILY		
Monthly	\$1,614.43	\$2,167.87

COBRA RATE DENTAL PRICE TAGS

EMPLOYEE STATUS	METLIFE PDP BASIC	METLIFE PDP ENHANCED
SINGLE		
Monthly	\$18.65	\$31.79
EMPLOYEE PLUS SPOUSE OR CHILD		
Monthly	\$38.17	\$64.82
FAMILY		
Monthly	\$62.42	\$105.35

COBRA RATE VISION PRICE TAGS

EMPLOYEE STATUS	VSP BASIC	VSP ENHANCED
SINGLE		
Monthly	\$5.53	\$11.19
EMPLOYEE PLUS SPOUSE OR CHILD		
Monthly	\$11.06	\$22.38
FAMILY		
Monthly	\$17.81	\$36.02

** Continuation Coverage Rights Under COBRA**

Introduction

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: Lisa Yakelis, Benefits Manager, 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: Lisa Yakelis, Benefits Manager, 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, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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 www.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 www.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 contact information: Lisa Yakelis, Benefits Manager
Duquesne University, Benefits Office
600 Forbes Avenue, Pittsburgh, PA 15282**

REQUIRED NOTICES

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 www.duq.edu/work-at-du/benefits/required-notice.

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.

Employees and/or their covered dependents are given three options to access/obtain a copy of an SPD

1. On-line enrollment. Links to the SPDs can be found while completing the enrollment process.
2. Benefits web site. Links to the SPDs are located at www.duq.edu/work-at-du/benefits/required-notice
3. You may also request a paper copy of an SPD from the Benefits Office at 412.396.5106.

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 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 **www.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.

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.

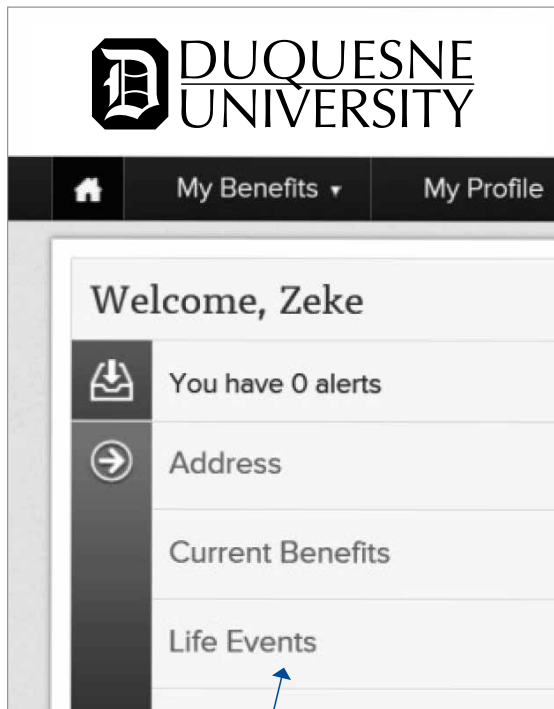
Thank you for reading the Notice of Health Information Practices.

Effective Date: 3/31/2013

Employees may use the **bswift** system to update information throughout the plan year due to qualified life events as defined on page 3.

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

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



2. **SELECT** Life Events
3. **SELECT** your specific Life Event
4. **INDICATE** the effective date
5. **ENTER** information as requested
6. **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 1
- **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	http://webcorp.axa-assistance.com USERNAME: axa PASSWORD: travelassist
CVS Caremark Prescription Drug Specialty Drug Management	1.877.347.7444 1.800.237.2767	www.caremark.com
The Center for Pharmacy Care <i>(Medication Therapy Management)</i>	412.396.2155	www.duq.edu/cpc
Cigna – Including 24 Hour Health Information Line	1.800.244.6224	www.cigna.com
Coldwell Banker Real Estate	1.800.998.7444	www.coldwellbanker.com
Dental – MetLife PDP Plus Network – Group #151368	1.800.942.0854	www.metlife.com/mybenefits
Duquesne University Pharmacy <i>(Free Prescription Delivery on Campus)</i>	412.246.0963	www.duqpharmacy.org
Employee Assistance Program (EAP) and Personal Health Partners	1.800.EAP.7272	www.lytleap.com MEMBER LOGIN: duquesne
Flexible Spending Accounts and Health Savings Accounts <i>Participant Services</i>	1.866.451.3399	customerservice@discoverybenefits.com www.discoverybenefits.com/participants
Fidelity Investments – Account #68969 <i>Appointment Scheduling</i>	1.800.343.0860 1.800.642.7131	www.netbenefits.com
HIPAA Rights Line	412.396.1387	
Little Giant Federal Credit Union On Campus – Room 109, Libermann Hall T & Th 9:00 a.m. to 4:00 p.m. Voice Response	(M-F) 412.771.6400 412.391.1340 412.771.1383	www.littlegiantfcu.org
MetLife (Life Insurance and LTD) – Group #151368	Life Insurance: 1.800.438.6388 LTD: 1.800.300.4296	www.metlife.com/mybenefits
MetLife Grief Counseling	1.855.609.9989	https://griefcounseling.harrisrothenberg.net/default.aspx USERNAME: MetLife PASSWORD: grief
Social Security Office	1.800.772.1213	www.ssa.gov
SEIU Pension Fund	1.800.458.1010	www.seiu.org
TIAA – Account Numbers RC405488 and RCP405488 <i>Appointment Scheduling</i>	1.800.842.2776 1.800.732.8353	www1.tiaa-cref.org/tcm/duq/
UPMC Health Plan UPMC MyHealth 24/7 Nurse Line	1.888.876.2756 1.866.918.1591	www.upmchealthplan.com
VSP Choice (Vision Service Plan) – Client #30039552	1.800.877.7195	www.vsp.com
Benefits Office	412.396.5106	www.duq.edu/benefits
Web Enrollment		www.duq.edu/benefits



Office of Human Resources
600 Forbes Avenue
Pittsburgh, PA 15282

FOR MORE INFORMATION

duq.edu/benefits | 412.396.5106

