DUFlex Flexible Benefits Plan

Summary Plan Description

Effective July 1, 2016

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Plan Contacts

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

Contact	Reasons to Access
Plan Administrator Duquesne University of the Holy Spirit Human Resource Management 600 Forbes Avenue Pittsburgh, PA 15282	Verify your eligibility. Review your benefits. Get answers to most questions. Get information about employee contributions.

Claims Administrators

Cigna (High Deductible Health Plan, Open Access Plus, PPO)

Your Health and Welfare Benefits

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

Medical/prescription drug/substance abuse/mental health benefits/Health Savings Account (HSA).

Dental benefits.

Vision benefits.

Long term disability (LTD) insurance.

Life insurance.

Accidental death and dismemberment insurance.

Business Travel Accident.

Dependent Care Flexible Spending Account (FSA).

Health Care Flexible Spending Account (FSA).

Limited Flexible Spending Account (vision and dental expenses only).

Employee Vacation Purchase (Employee Vacation Administrative Policy).

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dollars, and depending on the employee's enrollment choices, the credits can be used on a pre-tax basis to purchase certain benefits. Any credits not used to purchase pre-

Health Care Flexible Spending Account

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

Generally, eligible medical expenses are expenses that you, your spouse or your dependent (determined as

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

Dependent Care Flexible Spending Account

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

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

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

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

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

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

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

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

Health Savings Account (HSA)

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

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

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

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

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

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

If You Become Ineligible

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

If You Become Disabled

If you should become disabled, you may be able to continue your eligibility for some or all of the health and welfare benefits under the plan. Please refer to the Duquesne University Administrat 0 Tc 0 Tw 5.855 beco3 0 Td (0

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

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

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

Child means a natural child, a legally adopted child who is under age 18 at the time of the adoption, a child placed with you for adoption who is under age 18 at the time of the placement, a foster child (if the child is an "eligible foster child", as defined in the Internal Revenue Code, and the child is not a ward of the state) or a stepchild. Child also includes any other person whose welfare is your legal responsibility under a legal guardianship, written divorce settlement, written separation agreement or a court order.

Spouse means the legal spouse under the laws of the state where the marriage was performed, provided that a state-issued marriage certificate is obtained. The Plan Administrator will require documentation proving a legal marital relationship.

If you are an employee that is married to another University employee, you may enroll as an employee or a dependent under the Plan, but you cannot enroll as both a dependent and an employee. Eligible dependents may be enrolled under one employee's coverage only under the Plan.

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

State Eligibility Laws

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

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

Effective Date of Your Coverage

New Employees

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

Current Employees

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

Changing Your Coverage During the Year

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

Qualified Change in Status

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

You get married, divorced, or your marriage is annulled.

You have a baby, adopt, or have a child placed in your care for adoption.

Your dependent dies.

Your dependent gains or loses eligibility status.

You or your dependent moves to a new place of residence outside of your present coverage area.

You or your dependent has a change in employment status, such as:

- Switching from full-time to part-time employment (or vice versa).
- Beginning or ending employment (this provision does not apply if rehired within 30 days).
- Experiencing a strike or a lockout.
- Commencing or returning from an unpaid leave of absence.
- Changing your worksite to a location that offers different benefits than are currently available to you.

You experience a significant change in cost of benefits or coverage.

Special Enrollment Rights

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

Non-enrolled employee: If you are eligible but not enrolled, you can enroll.

Non-enrolled spouse: If you are enrolled, you can enroll your spouse when you marry. In addition, you can enroll your spouse if you acquire a child through birth, adoption, or placement for adoption.

New dependents/spouse of a non-enrolled employee: If you are eligible but not enrolled, you can enroll your spouse or child who becomes your eligible dependent as a result of the event. However, you also must enroll.

Other Changes in Circumstance

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

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

You or your dependent becomes eligible for or loses Medicaid coverage.

You elected “no coverage” because you had coverage elsewhere (for example, under a spouse’s plan) and that other coverage experiences a substantial change or ends:

- The coverage must end because of a loss of eligibility, such as a divorce, termination of employment, the other employer stops contributing to the other plan or the cost of coverage through the other

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

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

Contact the Plan Administrator for more details about FMLA leave.

Benefits Coverage Wh

Termination of Coverage

Employees

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

You terminate employment (in which case participation shall cease in accordance with the terms of Related Documents, individual plans, programs, insurance contracts, and benefit components).

You cease to be an employee who is eligible for coverage.

If permitted by law, you report for active duty as a member of the armed forces of any country.

If participant contributions are required, you cease making contributions to the plan.

One or more benefits under the plan are terminated by action of the University.

Dependents

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

You terminate employment (in which case participation shall cease in accordance with the terms of Related Documents, individual plans, programs, insurance contracts, and benefit components).

You cease to be an employee who is eligible for coverage.

If permitted by law, your dependent reports for active duty as a member of the armed forces of any country.

If participant contributions are required, you cease making contributions to the plan.

A dependent ceases to qualify as a dependent.

One or more benefits under the plan are terminated by action of the University.

Coverage under the plan may also be terminated for any individual (or any employee or dependent covered under the same family coverage as that individual) who engages in fraud or who makes a material misrepresentation of fact relating to the coverage. For example, if someone knowingly files a claim for benefits

Continuation of Coverage

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

Coverage Continuation Rights Under COBRA

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

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

COBRA Qualified Beneficiaries

Employee. You become a COBRA qualified beneficiary if you lose your health coverage under the plan because of

When COBRA Coverage Is Available

The plan offers COBRA coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of your employment, the reduction in your work hours, or your death, the University will notify the Plan Administrator of the qualifying event.

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

How COBRA Coverage Is Offered

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

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

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

How Long COBRA Coverage Lasts

You or your covered dependent fails to make contributions by the due date as required.

The University stops providing health benefits to any employee.

COBRA

Disagreements about benefit eligibility or benefit amounts can arise. The

HIPAA Privacy Rights

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

The information is created or received by a health care provider, the plan, or the health carrier (i.e. covered entity).

The information includes specific identifiers that identify you or could be used to identify you.

The information relates to one of the following:

- Providing health care to you.
- Your past, present, or future physical or mental condition.
- The past, present, or future payment for your health care.

The Notice of Privacy Practices for the plan contains a complete explanation of your rights under the HIPAA Privacy Rule. The notice describes how Protected Health Information may be used and disclosed, and how you can get access to that I9(u)-1tm(nf)-13.5 (u t1-8(t)-13ica t512.3(e 0.(2)d (or)Tj3.1(nc)-8(l)-8um(e 04u)-1tm(nf))-3

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

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

You have the right to request that the plan restrict uses and disclosures of your Protected Health Information to carry out payment or health care operations.

You have the right to request that the plan communicate with you in a certain way if you feel that the disclosure of your Protected Health Information could endanger you.

You have the right to inspect and obtain a copy of your Protected Health Information.

If you believe that the Protected Health Information the plan has about you is inaccurate or incomplete, you have the right to request a correction.

You have a right to request a list of disclosures made by the plan of your Protected Health Information, other than those disclosures for which an accounting is not required.

You have a right to request and receive a paper copy of the Notice of Privacy Practices for the plan, even if you have received this notice previously or agreed to receive this notice electronically.

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

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

University's Right to Use Your Social Security Number for Adminil(he 2(p)T27(niD 1 TJ 0 Tc 0 Tw a