

# The Supplemental Life Insurance Plan

The Supplemental Life Insurance Plan is a voluntary, employee-paid life insurance plan through which you can purchase additional amounts of life insurance for yourself, and cover your spouse or same-sex spousal equivalent and your eligible dependent children.

## Eligibility for Coverage

You are eligible to enroll in this plan if you are an active employee, faculty member, or House Staff member regularly scheduled to work at least 20 hours per week.

Employees covered by a collective bargaining agreement (unless coverage was mutually agreed to in the bargaining agreement) are not eligible for this plan.

## When Coverage Begins

You may enroll in the plan at any time, however, you will be considered a “late entrant” if you enroll more than 60 days after your date of eligibility. Your coverage amount of up to two times annual pay (up to a maximum of \$500,000) is effective as of the day your completed enrollment form is received by the plan administrator (Marsh), if you have enrolled within 60 days of your eligibility and otherwise meet the eligibility criteria. If you are a late entrant, coverage will begin the first day of the month following the underwriter’s approval. Your dependent’s eligibility effective date is the day your dependent’s completed enrollment form is received by the plan administrator, if you have enrolled your dependent within 60 days of initial eligibility or within 31 days if he or she is a newly eligible dependent.

Coverage that does not require evidence of insurability and underwriter’s approval is effective the date the application is received. Otherwise, the effective date of your coverage is the latest of:

- Your benefits eligibility date, or
- The first day of the calendar month in which the first payroll deduction for your coverage occurs.

Your coverage remains effective as long as the premium is received, either via payroll deduction or direct payment to Marsh.

The effective date of dependent benefits is the latest of:

- Dependent benefits eligibility date,
- The effective date of your personal benefits, or
- The first day of the calendar month in which the first payroll deduction for dependent benefits occurs.

If you are absent from work due to injury, sickness, temporary layoff, or leave of absence, coverage for you and/or your dependents will begin the first day of the month you return to active employment (subject to eligibility and underwriting requirements). If you do not return to work within 90 days from the date you enrolled in the plan, contact the program coordinator to complete a new enrollment form.

## When Coverage Ends

Your coverage and your covered dependents’ coverage will end if any of the following events occurs:

- You stop making the required contributions,
- Your dependents reach age 19 or age 26 if a full-time student,
- You reach age 95, or
- The plan terminates.

## Qualified Issue

### What is Qualified Issue?

Qualified issue for insurance coverage means that you must satisfactorily answer two questions:

- 1) Have you been hospitalized during the preceding 90 days (not including well-baby deliver)?
- 2) Have you previously submitted a Supplemental Life enrollment form for yourself and had coverage denied?

Coverage for a same-sex spousal equivalent requires that the person be at least age 18, unmarried and not related to you by blood, and that you have been in a committed relationship and living together in the same residence for at least 12 months prior to enrolling in the program. Completion of a MetLife domestic partner affidavit is required. Contact Marsh@WorkSolutions at (800) 552-9670 for the form.

## Evidence of Insurability

Evidence of insurability is required if you:

- Apply for coverage more than 60 days after the date you are first eligible,
- Apply for coverage for your newly eligible spouse or same-sex spousal equivalent more than 31 days after they are first eligible,
- Apply for coverage for your newborn child after 45 days of their date of birth, or
- Elect coverage of more than two times your annual pay (up to \$500,000) or more than \$10,000 for your spouse or spousal equivalent.

An evidence of insurability form can be obtained from the program coordinator, Marsh@WorkSolutions, by calling (800) 552-9670 or logging on to [www.personal-plans.com/duke](http://www.personal-plans.com/duke).

### What is evidence of insurability?

A statement of your, your dependent's, or your spouse's or same-sex spousal equivalent's medical history used to determine if you, your dependent, or your spouse or same-sex spousal equivalent are approved for coverage.

## Paying for Coverage

You pay the full cost of Supplemental Life Insurance coverage using after-tax dollars withheld from your paycheck through regular payroll deductions.

The cost for your coverage and your spouse or same-sex spousal equivalent's coverage is based on the level of coverage elected, age, and smoker status.

Your premium will be automatically adjusted each year to reflect changes in age and any changes in your annual coverage amount. Coverage for your dependent children is \$1 per month, regardless of the number of children you cover.

You must notify the program administrator, Marsh@WorkSolutions by calling (800) 552-9670, that your covered dependents are no longer eligible. Your premium will be reduced following proper notification to the program administrator effective the first of the month following the month of notification.

# The Supplemental Life Insurance Plan

## Benefit Coverage

You can select coverage amounts of one to eight times your annual pay, up to \$100,000 for your spouse or spousal equivalent, and \$10,000 for each dependent child. Employee coverage is required in order for a dependent to participate. Coverage amounts will be rounded up to the next higher \$10,000 of your multiple of pay. For example, if you choose coverage of three times your annual pay, and your annual pay is \$17,100, your coverage would equal \$60,000 [ $\$17,100 \times 3 = \$51,300$ , rounded up to \$60,000].

In order to receive coverage, you must be actively at work and able to perform normal activities on both the date the application for benefits is completed and the effective date of coverage for anyone you choose to cover under the plan. Coverage for the plan must not have been previously denied.

Coverage is guaranteed for up to two times annual pay to a maximum of \$500,000 if you meet the eligibility requirements, are actively at work, and request coverage within 60 days after your date of hire. Coverage of up to eight times your annual pay can be selected, to a maximum of \$2.5 million, but requires completion of additional medical questionnaires and screenings.

If you elect coverage for your spouse or same-sex spousal equivalent of up to \$10,000, the plan requires that he or she must not have been previously denied coverage, must not have been hospitalized during the past 90 days, and must be able to perform normal activities on the date you elect coverage. Coverage is guaranteed within your first 60 days of eligibility or within 31 days of your marriage if these requirements are met. Coverage of up to \$100,000 is available for your spouse or same-sex spousal equivalent but requires additional medical screening.

Coverage also may be purchased for your unmarried child (including your legally adopted child or step-child) who is under age 19 (or under age 26 if a full-time student), but not less than 14 days old, and who is dependent on you for support. Additional underwriting requirements require that the child must not have been hospitalized during the past 90 days and

must be able to perform normal activities on the day you sign the application. You may enroll your newborn child within 45 days of birth.

## Automatic Increase

Your employee coverage will increase as your annual pay increases. If your coverage increases to the next \$10,000 increment level, your premium will increase respectively.

If your annual pay in effect as of July 1 makes you eligible for additional coverage, your coverage may be automatically increased on January 1. You must be actively at work for the increased coverage amount to be effective.

Automatic increases are calculated once each calendar year.

## Accelerated Death Benefit

If you or your covered spouse is diagnosed with a medical condition that limits life expectancy to 12 months or less, you may request an accelerated payment of death benefit equal to 80% of the life insurance coverage amount. The minimum payment is \$10,000 and the maximum payment is \$500,000. You must continue to pay premiums on the remaining life insurance coverage.

## Continuation of Coverage

When you terminate or go on a leave of absence, you may continue your coverage by paying premiums directly to the plan coordinator, if you have had coverage for at least two years and the group plan is still in effect. You may keep this coverage until you reach age 95.

If your dependent children lose eligibility due to age or marriage, they may convert their coverage up to a \$50,000 policy without having to provide evidence of insurability. This option is not available for a mentally or physically disabled child. Coverage for a mentally or physically disabled child may be continued at the \$10,000 level as a rider to an adult certificate.

The child may request conversion to an individual certificate by notifying Marsh @WorkSolutions and completing an enrollment form in accordance with the terms of your certificate. The request must be made within 90 days of the date the child becomes ineligible. Marsh @WorkSolutions does not send out notification of ineligibility. Please call Marsh @WorkSolutions for the required enrollment form.

## Claims Information

In the event of your death, your beneficiary must make written claim for benefits and provide proof of death in accordance with the underwriter's guidelines. Your beneficiary must file a claim within 90 days after your death.

Follow the steps below to file claims for benefits:

1. Request a claim form from Marsh @WorkSolutions.
2. Complete the claim form.
3. Attach any required documentation and proof of the loss for which the claim is being made.
4. Submit the completed form and documentation within the time required by the plan to:

**Marsh @WorkSolutions**  
**P.O. Box 9122**  
**Des Moines, IA 50306-9122**  
**(800) 552-9670**

Once your claim is received, if approved, it will be processed for payment. If sufficient information is not received to process your claim, your beneficiary will be notified in writing of what additional information is needed.

The underwriter determines whether the claim is allowed. If a claim is denied in whole or in part, the underwriter will notify you and explain its procedure for reviewing a denied claim.

The underwriter will have the sole responsibility for the review and final decision on any denied claim and is the named fiduciary for purposes of review and final decision.

## Appeals of Eligibility, Right to Participate, and Other Claims Not Directly Related to Benefit Payments

With respect to all other eligibility claims or issues, including the right to participate under the plan, claims and proof of claims must be filed in writing with the Plan Administrator in accordance with the procedures and guidelines established from time to time by the Staff Fringe Benefits Committee. Send your claim to:

**Supplemental Life Insurance Plan Administrator**  
**Duke Benefits**  
**705 Broad St.**  
**Box 90502**  
**Durham, NC 27708**

The Plan Administrator will review your claim and you will be notified of the decision within 90 days after the claim is received. In the event of special circumstances requiring an extension of time, you or your beneficiary will receive written notice of the extension prior to the expiration of the initial 90-day period.

If you disagree with the decision, you may appeal the decision by notifying the Staff Fringe Benefits Committee in writing within 60 days of the date you receive notice of denial. Send appeals to:

**Staff Fringe Benefits Committee**  
**Duke Benefits**  
**705 Broad St.**  
**Box 90502**  
**Durham, NC 27708**

You will be able to examine all pertinent materials and submit comments in writing. Your appeal will be decided within 60 days of when it is received or 120 days in special situations. The Staff Fringe Benefits Committee's decision is final and conclusive.

If you are dissatisfied with the Staff Fringe Benefits Committee's decision after you have pursued these steps, you have the right to file a lawsuit in state or federal court. You may not file a lawsuit before 90 days have passed after you file your claim or later than three years after the loss due to death occurred.