

Duke Benefits

Summary Plan Description

- Welfare and Fringe Benefits Plan
- Cafeteria and Premium Conversion Plan
- Retiree Health Plan

This booklet contains summaries of the benefit plans, as of July 1, 2023, that apply to eligible Duke Employees, and is organized by subject and type of benefit.

The term “Duke” is used throughout this booklet. “Duke” refers to the University, Duke University Health System, Inc. and any other corporation or entity that adopts the Plan with the duly authorized approval of the Board of Trustees. When used in this Plan document, “Employer” shall refer to all of the foregoing collectively except where the context requires that such term refer to the corporation or entity that actually employs an individual.

Please note, the benefit program provided is based on an employee’s company code and job code as reflected in the HR benefits administration system (SAP). Duke employees holding more than one position classification receive the benefits associated with their primary position classification as reflected in SAP. For example, a housestaff member who also works within DHIP, receives benefits associated with their housestaff position classification.

The information contained in this booklet satisfies the requirements for summary plan descriptions provided under the Employee Retirement Income Security Act (ERISA) of 1974. If there is a conflict between this booklet and the official plan documents, the official plan documents will govern in all cases. Duke reserves the right at any time to change or terminate the benefit plans.

Please refer to Benefit Program Descriptions for information regarding benefit processing and claims and appeals procedures. With respect to any other questions, you may contact:

Human Resources Information Center (HRIC) Duke University

Phone: 919-684-5600

Email: benefits@duke.edu

Mailing Address: 705 Broad St., Box 90502, Durham, NC 27708-0502

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**Although included in the Summary Plan Description for comprehensiveness, this is not an ERISA plan and information is not included in the Plan's annual 5500 filing.*

DUKE HEALTH CARE PROGRAM

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DUKE HEALTH CARE PROGRAM

Introduction

Duke offers you and your eligible dependents coverage through the Duke Health Care Programs. The health care plans provide an extensive range of medical coverage including benefits for physician visits, prescription drugs, and behavioral health and substance abuse disorder treatment.

You may enroll in one of five different health care plans to meet your needs and the needs of your family. Pharmacy coverage and behavioral health and substance abuse disorder benefits are included in each of the health care plans.

Please read this Benefit Program Description together with the applicable member guide, which serves as your Summary Plan Description (SPD), carefully. It is designed to answer questions about your health care plan. If you require additional information, however, you should contact the administrator for your health care plan or the Human Resources Information Center (HRIC) at **919-684-5600**.

The term “Duke” is used throughout this booklet. “Duke” refers to the University, Duke University Health System, Inc. and any other corporation or entity that adopts the Plan with the duly authorized approval of the Board of Trustees. When used in this Plan document, “Employer” shall refer to all of the foregoing collectively except where the context requires that such term refer to the corporation or entity that actually employs an individual.

The benefit program provided is based on an employee’s company code and job code as reflected in the HR benefits administration system (SAP). Duke employees holding more than one position classification receive the benefits associated with their primary position classification as reflected in SAP. For example, a housestaff member who also works within DHIP, receives benefits associated with their housestaff position classification.

This plan is a welfare benefit plan, and therefore, it is not insured by the Pension Benefit Guaranty Corporation. While Duke expects to continue Duke Select, Duke Basic, Blue Care, Duke Options, and Duke USA indefinitely, it reserves the right to change the terms of Duke Select, Duke Basic, Blue Care, Duke Options, Duke USA, or the Prescription Drug Benefit Program or to terminate the plan in the future. Duke has the right to cancel your coverage.

Please see the “Important Summary for Employees Transitioning to the Duke Health Integrated Practice (DHIP) on July 1, 2023” in the “General Information About Your Benefits” section of this summary plan description for additional details.

Eligibility

You are eligible to participate in a Duke Health Care Program if you meet the payroll / benefit classifications for eligible employees and you are:

- A faculty employee holding a regular rank appointment who is receiving wages for Social Security purposes,
- A faculty employee holding other than a regular rank appointment and classified as a full-time or part-time member of the faculty scheduled to work at least 20 hours per week, who is receiving wages for Social Security purposes,
- A regular, full-time non-faculty employee scheduled to work at least 30 hours per week,
- A regular, part-time non-faculty employee scheduled to work at least 20 hours per week,
- A visiting faculty member required to be provided medical benefits by any federal immigration law or pursuant to an employment contract with Duke,
- A graduate resident trainee of Duke University Health System (i.e., housestaff who is scheduled to work at least 20 hours per week), or
- A postdoctoral scholar previously eligible for coverage.

Employees at a \$0 rate of pay or scheduled too few weeks per year (i.e., where weeks scheduled per year multiplied by hours scheduled is below 1,000) are generally not in a payroll / benefits eligible classification.

Eligible Dependents

An employee enrolled in the Plan may also enroll a dependent who is:

- The employee's spouse (marriage certificate may be required).
- The employee's Registered Same Sex Spousal Equivalent if registered with Duke HR prior to 1/1/2016.
- The employee's child up to age 26 ("child" includes biological children, foster and legally adopted children, children placed for adoption with the employee, stepchildren, children for whom the employee has been ordered by a court or administrative agency to provide health benefits under the Plan, and, if the employee has a Registered Same Sex Spousal Equivalent who is enrolled in the Plan as an eligible dependent of the employee, the children of the employee's registered Same Sex Spousal Equivalent).

In order to continue coverage of a mentally or physically disabled dependent child beyond their 26th birthday, all of the following criteria must be met:

- The child must be covered on a Duke health plan immediately prior to their 26th birthday;
- The disabling condition must exist on or prior to the 26th birthday;
- The parent must apply for the waiver prior to the child's 26th birthday;
- The mental or physical disability must be significant and render the child incapable of independent living and self-sustaining employment, and must be supported by medical records;
- The parent must provide annual evidence of continued incapacity upon request;

- There must not be a break in coverage after the 26th birthday under the parental policy.

PLEASE NOTE:

- Under no circumstances may employees enroll a sibling, cousin, parent or other dependent relative as a dependent.
- The University may require a birth certificate, marriage certificate, proof of joint residency, or the first two pages of your tax return in order to verify dependent status.
- A person who is enrolled in the Plan as an employee cannot also enroll as the dependent of another employee. Also, a person enrolled in the Plan as the dependent of one employee cannot also enroll as the dependent of another employee.
- Legal custody is insufficient. To cover a dependent child, you must be the legal guardian of the child.

PLEASE NOTE: Legal guardianship obtained outside of North Carolina must be consistent with North Carolina requirements.

Dependent Documentation

All employees covering dependents on the Duke Health Care Programs may be required to provide documentation to verify the eligibility of their dependents. A birth certificate, adoption papers, documentation of foster child, or legal guardianship papers must be available for children. Those covering stepchildren must show the birth certificate with the name of the spouse, and proof of marriage and current joint ownership of residence. Those covering a spouse must show either a copy of the first two pages of the most recent tax return (with income information removed), or a copy of the marriage certificate and current proof of joint ownership of residence, such as a utility bill (not cell phone) or lease agreement with both names.

Collective Bargaining Agreements

Group health benefits are a subject of good faith bargaining between Duke and:

- Duke University Press Workers Union;
- Local 26 Service Employees International Union Southern Region;
- Local 77 of the American Federation of State, County, and Municipal Employees;
- Local 465 of the International Union of Operating Engineers;
- Local 1328 Amalgamated Transit Union; and
- Local CLC / CTW of the Services Employees and International Union.

Any agreements between Duke University and an employee representative may be inspected at the office of the Employee / Labor Relations at the following address:

**Employee / Labor Relations
705 Broad St.
Durham, NC 27705**

Enrolling

You have 30 days from your date of employment or eligibility to enroll in a Health Care Program. If you do not enroll when you are first eligible (within 30 days of employment eligibility), you can enroll during the annual open enrollment period, or within 30 days of a qualifying life event. See also the General Information section for additional information on Qualifying Life Events.

There are several types of coverage for which you may enroll:

- Employee Only (Individual);
- Employee and Spouse;
- Employee and Child;
- Employee and Children; or
- Employee and Family.

Effective Date of Coverage

New or newly eligible employees of Duke University and Duke University Health System can elect coverage effective on the:

- First day of employment / eligibility with Duke (not eligible for University contribution), or
- First day of second month of employment / eligibility (eligible for University contribution if faculty, or non-faculty employee regularly scheduled to work 30 or more hours per week).

Eligible Employees may change coverage from Duke Select, Duke Basic, Blue Care, Duke Options, or Duke USA during open enrollment periods designated by Duke. Subscribers enrolled in Duke Select, Duke Basic, or Blue Care may also change to a national network PPO plan for which they are eligible in the event that they or a covered dependent move outside the service area for a period of three months or longer. Those changing plans for this reason must wait until open enrollment to change back to the previous plan if they or a covered dependent return to the area.

Employees who reside in North Carolina and are covering a dependent who resides outside of North Carolina, or who are covering a dependent attending college outside of North Carolina, should enroll in a national network PPO plan for which they are eligible in order to assure their family member is eligible for comprehensive plan benefits (i.e., not limited to emergency or urgent care).

When Coverage Ends

An employee's coverage will end for any of the following reasons:

- Subsequent to an election made by the employee during open enrollment;
- If the full amount of the employee's portion of the monthly premium is not timely or consistently paid; or
- When their work schedule is reduced below 20 hours per week, or the employee transfers to a benefits-ineligible position. The effective date for the coverage change will normally be the last day of the month after the work schedule or position change occurred.

Member Terminations

Your membership in the Plan, and coverage under the plan, may be terminated and written notice will be provided for any of the following reasons:

- Fraud or misrepresentation. This includes, but is not limited to, fraudulent statements or material misrepresentations of fact made on your enrollment application, including enrollment of ineligible dependents;
- Fraudulent use of services or facilities;
- Misuse of your identification cards. This includes, but is not limited to, allowing someone else to use your Plan identification card;
- Nonpayment of your contribution toward coverage under the Plan;
- Marriage of surviving spouse; or
- Eligibility for Medicare when continuing Plan coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

The Plan is entitled to recover all expenses it incurs (including the reasonable value of services received, reasonable attorney's fees and any incidental expenses) because of fraud, misuse or misrepresentation from the member who committed such fraud, misuse, or misrepresentation.

Spouse

A spouse must be removed from the Duke Health Plan on the day of divorce. A separated spouse continues to be eligible to be covered as a dependent under the plan.

Dependent Children

Dependent children become ineligible at the end of the month they turn age 26, unless approved for disabled status prior to their 26th birthday.

Stepchildren

Stepchildren who have not been adopted by the employee will lose eligibility in the event of divorce from or death of the child's biological parent.

Ineligible Dependent

A dependent deemed ineligible after review of documentation will be removed from the plan. There are no COBRA rights, and it is not considered a qualifying event for enrollment in the Health Exchange Plan under the Affordable Care Act.

Termination of Coverage

Members may not terminate coverage under the Plan except during the annual open enrollment period or within 30 days of a valid and sufficiently documented qualifying event.

Subject to your continuation rights under COBRA, your Plan coverage will terminate if you lose your eligibility to be a member, or if the employee through whom you are enrolled in the Plan loses their Plan coverage. If you cease to be eligible to participate in the Plan because of an amendment to the Plan by Duke University, your coverage will terminate the date the amendment to the Plan takes effect.

Coverage for all the members enrolled through an employee who loses their eligibility because of a Plan amendment will terminate the date the amendment takes effect. Coverage for all Plan members will terminate as of the date Duke terminates the Plan.

PLEASE NOTE: If an enrolled employee dies, the Plan will determine whether the deceased employee qualified for retiree health benefits at the time of death. If the individual was eligible, then the surviving members enrolled through that employee may continue coverage as long as they meet the requirements to be eligible dependents. The eligible dependent who is the deceased employee's spouse, or if there is no surviving spouse, the eldest eligible dependent (or their legal guardian if they are a minor or legally incapacitated) shall be responsible for taking any actions regarding the Plan which the employee would have been required to take. No additional dependents can be enrolled in the Plan subsequent to the death of the employee. Eligibility for continued coverage as a surviving spouse (including covered dependent children) ends with remarriage. Eligibility for dependent children terminates at age 26. There is no waiver under this surviving dependent provision for continued enrollment of a disabled dependent beyond the age of 26. Dependent children must be enrolled under the contract of the spouse if at the time of the employee's death, both parents are employed by Duke and the spouse is benefits eligible.

Continuation of Coverage

COBRA Continuation

For information concerning COBRA continuation rights, please consult the sections Termination of Coverage and COBRA Continuation Coverage.

Employee Continuation of Coverage in Retirement

To continue to receive the health insurance plan in retirement, you must meet the following participation criteria at the time of retirement:

1. You must be enrolled under the health plan as the subscriber; AND
2. You must be receiving the Duke contribution as an active employee immediately preceding your retirement in order to be eligible to receive a Duke contribution in retirement; AND;
3. You must meet the applicable eligibility requirement for Duke University or Duke University Health System as listed in Additional Eligibility Requirements Duke University (Company Code 10 in SAP) and Additional Eligibility Requirements for Duke University Health System (DUHS) (All Other Company Codes) below.

PLEASE NOTE: Health insurance may also be continued for your spouse or Registered Same Sex Spousal Equivalent and/or eligible dependent children who are covered at the time of your retirement. If your spouse or Registered Same Sex Spousal Equivalent and/or eligible dependent children are not enrolled at the time of retirement, they will not be eligible to be enrolled in the future. If a retired employee has a marriage that occurred after January 1, 2020, the retired employee will have a one-time opportunity to add their spouse to health coverage within 30 days of the marriage date. If the retired employee acquires a new dependent as a result of a marriage, birth or adoption that occurred on or after January 1, 2020, the retired employee will have a one-time opportunity to add the new dependent to health coverage within 30 days of the marriage, birth or adoption.

Additional Eligibility Requirements for Duke University (Company Code 10 in SAP)

You must meet the Rule of 75, which became effective July 1, 1990. The Rule of 75 requires that your age plus years of continuous service with Duke at retirement must be equal to or greater than 75.

If you have transferred to Duke University from the Duke University Health System, you will not immediately fall under the eligibility rules for Duke University. You must work at least five (5) continuous years in a full-time, benefits-eligible capacity for Duke University after the date of transfer in order to be eligible for Duke University rules; otherwise, the Duke University Health System rules apply.

Additional Eligibility Requirements for Duke University Health Systems (DUHS) (All Other Company Codes)

Employees hired on or after July 1, 2002 are eligible for retiree health coverage if they meet the following criteria:

- Have 15 years of continuous service in a benefits-eligible classification after age 45 — retiree pays 100% of the premium.
- DUHS employees approved for group long term disability benefits hired after July 1, 2002, may retain their health coverage until age 65, as currently permitted, but will not receive credit for years of continuous service while on disability.

Employees employed by DUHS prior to July 1, 2002 are eligible for retiree health coverage if they meet one of the following criteria:

- Met the Rule of 75 (your age + years of continuous service = 75) as of July 1, 2002.
- If Employee had at least 15 years of continuous service (but did not meet the Rule of 75) as of July 1, 2002, then the employee is grandfathered under the Rule of 75 eligibility provision.
- If Employee is at least 60 years of age, with 10 or more years of continuous service (but did not meet the Rule of 75) as of July 1, 2002, then the employee is carried over under the Rule of 75 eligibility provision.

All other employees employed by DUHS prior to July 1, 2002 are eligible for retiree health coverage at the time of retirement if they meet one of the following eligibility criteria:

- Have 15 years of continuous service in a benefits-eligible classification after age 45 — DUHS will pay a portion of the premium. An employee will not receive credit for years of continuous service while on disability.

OR

- Met the Rule of 75 — Retiree pays 100% of the premium.*

* Federal legislation effective for calendar year 2025 will favorably impact the 2025 Duke Plus premium for Health System retirees participating in Duke Plus who are ineligible for Duke's contribution towards the premium. Federal subsidies in 2025 will offset a portion of the premium paid by these retirees in 2025. Duke reserves the right to change, amend or terminate any benefit plan or program at any time and for any reason, with respect to both current employees and retirees, including eligibility to participate as well as Duke's contribution towards the premium.

If you have transferred to the Duke University Health System from Duke University, you will remain under Duke University eligibility rules if at the time of the transfer you met the “Rule of 75” or had 15 or more years of continuous service as of July 1, 2002. Otherwise, the Duke University Health System rule of 15 years of continuous service after age 45 applies.

PLEASE NOTE: If a faculty or staff member meets the retiree health eligibility requirements and retires (early or normal), the retiree may suspend health or dental coverage and contributions at any time while employed and receiving benefits elsewhere provided the coverage is an employer group plan and the retiree is the employee. Coverage under another plan available to the individual as a retiree of another employer, through a spouse’s active or retiree plan, through an individual Marketplace Exchange plan, or from service with the military does not count as employee coverage under another employer sponsored plan.

Re-enrollment in the health or dental plan must occur within 60 days of the termination of the other employer sponsored coverage, or within 60 days of the death of the Duke retiree (for a spouse who was covered on the date of the employee’s retirement from Duke). Proof of continuous coverage through another employer plan where the retiree was the employee will be required. If the individual attempts to re-enroll after this 60-day period, the individual must pay the full premium (including the employer share) retroactive to the termination of the prior employer coverage (with the former employee as the subscriber) and up to the time of re-enrollment. Thereafter, the individual shall pay the employee / retiree share. Only those dependents covered while under a Duke Health Plan at the time of retirement are eligible for re-enrollment.

PLEASE NOTE: Employees that transitioned from the PDC to DUHS / DHIP on July 1, 2023 are eligible to have their PDC continuous service date count towards the 15 years of service after age 45 requirement to be eligible to participate in retiree health (or dental) for DUHS employees, but it does not count towards the subsidy of retiree premiums applicable for DUHS employees (ex. those hired prior to July 1, 2002.) Please see the “Important Summary for Employees Transitioning to the Duke Health Integrated Practice (DHIP) on July 1, 2023” in the “General Information About Your Benefits” section of this summary plan description for additional details.

PLEASE NOTE: Duke’s Retiree Health Program is not a vested benefit program. This means that Duke could choose to discontinue or change this program at its discretion and reserves this right.

Medicare

The Federal Government provides medical and pharmacy benefits for people age 65 and older through Medicare Part A, Part B, and Part D. Part A coverage includes payment for inpatient hospital expenses; Part B helps to pay for physician’s services, outpatient hospital care and other medical services not covered by Part A; and Part D covers prescription drugs. Parts A, B, and D are subject to deductibles and coinsurance. Contact the Social Security Administration for Medicare enrollment information.

PLEASE NOTE: For Medicare to be effective when you wish to retire, you must enroll several months in advance of your retirement date. You will be responsible for any expenses that should have been paid by Medicare if your Medicare enrollment is delayed because the retiree health plan is designed to pay secondary to Medicare.

Medicare Entitlement While Actively at Work

Members (and their spouses) who are actively at work and plan to continue working after age 65, should contact the Social Security Administration to enroll in Medicare Part A and to defer Part B within 3 months of turning 65. At the time of retirement from Duke, you will be given a form allowing you and your spouse, age 65 or older, to enroll in Medicare Part B without a penalty (you must do this several months in advance of your

retirement date). Your health plan will continue as primary coverage for members continuing as active employees after age 65. Your health plan will also continue as primary for the spouse, age 65 or older, of an active employee, whether or not they are enrolled in Medicare, as long as they are not enrolled in another group health benefits plan.

Early Retirees and/or Their Spouses

The Duke Health Plan will continue to remain as primary coverage for employees who retire before age 65 and are classified as early retirees. At age 65 or if eligible for Medicare prior to age 65 due to disability, enrollment in Medicare Part A and Part B is required as Medicare becomes your primary coverage. Medicare enrollment must be elected up to 3 months in advance of turning age 65 so that full coverage takes effect as of the retiree's 65th birthday, given that Medicare may make effective dates later when someone enrolls in the month of and the 3-month period following their 65th birthdate. When you turn age 65, you may continue group health coverage through Duke under the Duke Plus Plan administered by UMR. For more information, please contact the Human Resources Information Center at **919-684-5600** or UMR at:

UMR Inc.
PO Box 8052
Wausau, WI 54402
866-318-DUKE (866-318-3853)
umr.com

Retirees Age 65 or Older

Enrollment in Medicare Part A and Part B is required for retirees or their spouses age 65 or older or when eligible due to disability. During the Medicare enrollment period you should enroll in coverage 2 to 3 months BEFORE turning age 65. As a retiree age 65 or older, Medicare is your primary coverage. If you qualify for retiree health benefits, you may continue group health coverage through Duke under the Duke Plus Plan administered by UMR. For more information, please contact the Human Resources Information Center at **919-684-5600**.

Disabled

If you or your spouse is disabled, under age 65, and have been entitled to Social Security disability benefits for 24 months, you are eligible for Medicare coverage. You are required to enroll in Medicare Part A and Part B when first eligible. Medicare is your primary coverage. You may continue group health coverage through Duke under the Duke Plus Plan administered by UMR. For more information, please contact the Human Resources Information Center at **919-684-5600** or UMR at the address and telephone number noted previously.

End Stage Renal Disease

For members or their covered family members entitled to Medicare solely because they have end stage renal disease, your Duke health plan will be the primary coverage for no fewer than nine, but no more than 33 months, starting with the earlier of (a) the month in which a regular course of dialysis is initiated, or (b) in the case of an individual who receives a kidney transplant, the first month in which the individual becomes entitled to Medicare.

Thereafter, if you or your spouse continues active employment at Duke, you may continue group health coverage under your Duke Health Plan, but must enroll in Medicare Parts A and B when eligible. For those on disability, please see the previous section entitled "Disabled."

Coordination with Medicare

Unless prohibited by 42 U.S.C., Section 1395y (b) (1) (A) (pertaining to discrimination against the working aged with respect to entitlement of benefits under group health plans), if you and/or your spouse are eligible for Medicare but fail to apply, the Plan will provide supplemental benefits only, i.e., Medicare benefits — Part A and Part B — will be taken into account when calculating benefits. You must still make all copayments or co-insurance payments required by the Plan in addition to paying any costs Medicare would have covered if you had enrolled in Medicare as required.

Termination of Coverage

Member Terminations

Your membership in the Plan, and coverage under the Plan, may be terminated and written notice will be provided for any of the following reasons:

- Fraud or misrepresentation. This includes but is not limited to fraudulent misrepresentation of fact made on your enrollment application, including enrollment of ineligible dependents;
- Fraudulent use of services or facilities;
- Misuse of your identification cards. This includes but is not limited to allowing someone else to use your Plan identification card;
- Nonpayment of your contribution toward coverage under the Plan;
- Marriage of a surviving spouse; or
- Eligibility for Medicare when continuing Plan coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

The Plan is entitled to recover all expenses it incurs (including the reasonable value of services received, reasonable attorney's fees, and any incidental expenses) because of fraud, misuse or intentional misrepresentation from the member who committed such fraud, misuse or intentional misrepresentation.

PLEASE NOTE: Any member whose coverage is terminated for the reasons indicated in the preceding section ("Member Terminations") may permanently lose eligibility to remain or enroll in Duke health plans in the future. If an enrolled active employee dies, eligibility as a surviving dependent is based on the eligibility of the deceased employee for continuing health benefits in retirement. The eligible deceased employee's dependents covered at the time of death may continue in effect as if the employee were not deceased. The eligible dependent who is the deceased employee's spouse, or if there is no surviving spouse, the eldest eligible dependent (or their legal guardian if they are a minor or legally incapacitated) shall be responsible for taking any actions regarding the Plan which the employee would have been required to take. No additional dependents can be enrolled in the Plan subsequent to the death of the employee. Eligibility for continued coverage as a spouse ends with remarriage. Eligibility for dependent children terminates at age 26 or upon remarriage of the surviving spouse, whichever comes first.

Extended coverage for disabled dependents terminates with the death or remarriage of the surviving spouse or age 26, whichever comes first.

Continuation of Coverage

For more information concerning COBRA continuation rights, please consult the sections Termination of Coverage and COBRA Continuation Coverage.

Review of Eligibility Determinations Requests for Review

The initial decision affecting your eligibility to become a member under the Plan (either as an eligible employee or dependent) is made by the Plan Administrator. If you (or any person claiming eligibility for coverage as your dependent) are determined not to be eligible to become a member, you may file a written request for review of that decision. Such requests should specifically identify the decision to be reviewed. Upon completion of the review, you will be sent a notice containing: a) the Plan Administrator's decision concerning the eligibility determination you asked to be reviewed; b) if the eligibility determination is upheld in whole or in part, the reasons for upholding the disputed determination; c) reference to the Plan provisions on which the Plan Administrator based their decision in whole or in part, to the Staff Fringe Benefits Committee.

Timetable for Eligibility Review Decisions

Generally, the eligibility review decisions are made within 45 days of receipt of the claim by the Plan Administrator, but in some cases special circumstances may exist which necessitate extending the period of time for making the claims decision. If additional time is required, you will be sent a notice before the 45-day period is up explaining why more time is needed ("extension notice.") In cases where you receive a notice that more time is needed, the decision will be made within 45 additional days — that is, within a total of 90 days.

Duke Health Care Programs and Duke Long Term Disability Plan

Employees participating in a Duke Health Plan at the time of approval for Long Term Disability benefits may continue to participate while on an active claim with the Duke Long Term Disability Plan provided the following qualifications are met:

- The individual must be participating (in a fully paid-up status) in a Duke Health Plan / Dental Plan on their last day worked.
- Premiums must be paid in a timely manner, or deducted from the LTD check. If Duke Program coverage is terminated for non-payment or premium, there is no reinstatement.
- There must not be a break in coverage under the disabled individual's Duke Health Plan / Dental Plan. If a disability claim is denied and subsequently approved through the appeal process, "no break in coverage" rules still apply. In order for coverage to continue, there must be no break in coverage. If coverage was not maintained, retroactive premiums from the date coverage ended to the date coverage is to be reinstated must be paid.
- No additional family members may be added to the coverage once the individual is approved for Long Term Disability unless it is a HIPAA qualifying life event.
- If a disabled employee has a marriage that occurred after January 1, 2020, the disabled employee will have a one-time opportunity to add their spouse and any dependents acquired as a result of the marriage to health coverage within 30 days of the marriage date.
- When a family member is removed from coverage, they may not re-enroll.
- Once eligible for Medicare, the individual must notify Duke University Benefits and immediately enroll in Medicare Parts A and B. Those who do not enroll in Medicare Part B in a timely manner will be responsible for payment of those claims that would have been attributable to Medicare Part B. (This is also true for a covered spouse who is or becomes eligible for Medicare.)
- All persons participating in the Duke Long Term Disability Plan will be enrolled in the Duke Plus Plan once they or a family member become Medicare eligible.

- If the individual dies while on Duke Long Term Disability, health coverage for family members will depend on the eligibility of the deceased individual for retiree health benefits. If the decedent was eligible at the time of death, the covered family members may continue under the survivor benefits. COBRA will be available to those who are not eligible.

Cost of the Plan

The cost of the coverage in the plan is funded by contributions from employees and Duke if you are scheduled to work 30 or more hours per week. From time to time, Duke in its sole discretion will determine the level of University and employee contributions. Presently, Duke makes contributions to the plan on behalf of plan members who are faculty employees holding regular rank appointments and receiving wages for Social Security purposes, and other full-time non-faculty employees who are scheduled to work at least 30 hours per week. In addition, Duke presently makes contributions on behalf of certain visiting faculty members, postdoctoral scholars, and graduate resident trainees in the Duke University Health System. Those employees eligible for an employer contribution will receive the contribution effective the first of the month after the date of employment or eligibility.

Different contribution rates are applied for the different coverage categories. A copy of the current contribution schedules for the five health care plans is available from the HRIC or on the web at hr.duke.edu/benefits. Your contributions are paid on a before-tax basis where permitted under federal and state law. Postdoctoral scholars' contributions are made on an after-tax basis through payroll deduction.

Special Enrollment for Loss of Coverage or New Dependents

The Health Insurance Portability and Accountability Act (HIPAA) allows eligible employees and their dependents to request enrollment in the plans no later than 30 days after a loss of other group coverage or a birth, marriage, adoption, or placement for adoption. See the HIPAA Special Enrollment section under "Duke University General Information about Your Benefits" for more information.

Designation of Primary Care Provider

You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Duke Human Resources at **919-684-5600**. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Duke Health Plans or from any other person (including a primary care provider) in order to obtain obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Duke Human Resources at **919-684-5600**.

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your doctor, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or

issuer may not, under federal law, require that a doctor or other health care provider obtain certification for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain certification.

Mastectomy Benefits

In accordance with the Women’s Health and Cancer Rights Act of 1998, the Duke Health Plans provide for the following services related to mastectomy surgery:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance without regard to the lapse of time between the mastectomy and the reconstructive surgery; and
- Prosthesis and physical complications of all stages of the mastectomy, including lymphedemas.

The benefits described above are subject to the same copayment or coinsurance and limitations as applied to other medical and surgical benefits provided by Duke Health Plans.

GINA Notice

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to a request for medical information. “Genetic Information,” as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Medicaid and the Children’s Health Insurance Program (CHIP)

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 you 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 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, dial **877-KIDS NOW (877-543-7669)** or access 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 live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is updated frequently. You should contact your state for further information on eligibility.

To see if any more states have added a premium assistance program since July 31, 2023 or for more information on special enrollment rights, you can contact either the U.S. Department of Labor Employee

Benefits Security Administration at dol.gov/ebsa, 866-444-3272 or the U.S. Department of Health and Human Services Centers for Medicare & Medicare Services at cms.hhs.gov, 877-267-2323 (ext. 61565).

ALABAMA: Medicaid

myalhipp.com

855-692-5447

ALASKA: Medicaid

The AK Health Insurance Premium Payment Program

myakhipp.com

866-251-4861

CustomerService@MyAKHIPP.com

Medicaid Eligibility: health.alaska.gov/dpa/Pages

ARKANSAS: Medicaid

myarhipp.com

855-MyARHIPP (855-692-7447)

CALIFORNIA: Medicaid

Health Insurance Premium Payment (HIPP) Program: dhcs.ca.gov/hipp

Phone: 916-445-8322

Fax: 916-440-5676

hipp@dhcs.ca.gov

COLORADO: Health First Colorado (Medicaid Program) and Child Health Plan Plus (CHP+)

Health First Colorado: healthfirstcolorado.com

Health First Colorado Member Contact Center: 800-221-3943 / State Relay 711

CHP+: hcpf.colorado.gov/child-health-plan-plus

CHP+ Customer Service: 1-800-359-1991 / State Relay 711

Health Insurance Buy-In Program (HIBI): hcpf.colorado.gov/health-insurance-buy-program

Customer Service: 855-692-6442

FLORIDA: Medicaid

flmedicaidprecovery.com/flmedicaidprecovery.com/hipp

877-357-3268

GEORGIA: Medicaid

GA HIPP: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp

GA HIPP Phone: 678-564-1162, Press 1

GA CHIPRA: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra

GA CHIP Phone: 678-564-1162, Press 2

INDIANA: Medicaid

Healthy Indiana Plan (for low-income adults 19-64): in.gov/fssa/hip

Healthy Indiana Plan Phone: 877-438-4479

All Other Medicaid: in.gov/medicaid

All Other Medicaid Phone: 800-457-4584

IOWA: Medicaid and CHIP (Hawki)

Medicaid: hhs.iowa.gov/programs/welcome-iowa-medicaid

Medicaid Phone: 800-338-8366

Hawki: dhs.iowa.gov/Hawki

Hawki Phone: 800-257-8563

HIPP: hhs.iowa.gov/hipaa

HIPP Phone: 888-346-9562

KANSAS: Medicaid

kancare.ks.gov

Medicaid Phone: 800-792-4884

HIPP Phone: 800-967-4660

KENTUCKY: Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP):

chfs.ky.gov/agencies/dms/member/Pages/kihipp

KI-HIPP Phone: 855-459-6328

KI-HIPP Email: KIHIPPPROGRAM@ky.gov

KCHIP: kidshealth.ky.gov/Pages

KCHIP Phone: 877-524-4718

Kentucky Medicaid: chfs.ky.gov/agencies/dms

LOUISIANA: Medicaid

Medicaid: medicaid.la.gov

Medicaid Phone: 888-342-6207

LaHIPP: ldh.la.gov/lahipp

LaHIPP Phone: 855-618-5488

MAINE: Medicaid

Enrollment: mymaineconnection.gov/benefits/s/?language=en_US

Enrollment Phone: 800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium Forms: maine.gov/dhhs/ofi/applications-forms

Private Health Insurance Premium Phone: 800-977-6740

TTY: Maine relay 711

MASSACHUSETTS: Medicaid and CHIP

mass.gov/masshealth/pa

Phone: 800-862-4840

TTY: 711

masspremassistance@accenture.com

MINNESOTA: Medicaid

mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp

800-657-3739

MISSOURI: Medicaid

dss.mo.gov/mhd/participants/pages/hipp.htm

573-751-2005

MONTANA: Medicaid

dphhs.mt.gov/MontanaHealthcarePrograms/HIPP

800-694-3084

HSHIPPProgram@mt.gov

NEBRASKA: Medicaid

ACCESSNebraska.ne.gov

Toll-free Phone: 855-632-7633

Lincoln Phone: 402-473-7000

Omaha Phone: 402-595-1178

NEVADA: Medicaid

dhcfp.nv.gov

800-992-0900

NEW HAMPSHIRE: Medicaid

dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program

Phone: 603-271-5218

HIPP toll free number: 800-852-3345, ext. 5218

NEW JERSEY: Medicaid and CHIP

Medicaid: **state.nj.us/humanservices/dmahs/clients/medicaid**

Medicaid Phone: 609-631-2392

CHIP: **njfamilycare.org/index.html**

CHIP Phone: 800-701-0710

NEW YORK: Medicaid

health.ny.gov/health_care/medicaid

800-541-2831

NORTH CAROLINA: Medicaid

medicaid.ncdhhs.gov

919-855-4100

NORTH DAKOTA: Medicaid

hhs.nd.gov/healthcare

844-854-4825

OKLAHOMA: Medicaid and CHIP

insureoklahoma.org

888-365-3742

OREGON: Medicaid

healthcare.oregon.gov/Pages/index.aspx

800-699-9075

PENNSYLVANIA: Medicaid and CHIP

HIPP Program: pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html

CHIP: dhs.pa.gov/CHIP/Pages/CHIP.aspx

CHIP Phone: 800-986-KIDS (5437)

RHODE ISLAND: Medicaid and CHIP

eohhs.ri.gov

855-697-4347, or 401-462-0311 (Direct Rlte Share Line)

SOUTH CAROLINA: Medicaid

scdhhs.gov

888-549-0820

SOUTH DAKOTA: Medicaid

dss.sd.gov

888-828-0059

TEXAS: Medicaid

hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program

800-440-0493

UTAH: Medicaid and CHIP

Medicaid: medicaid.utah.gov

CHIP: chip.utah.gov

Phone: 877-543-7669

VERMONT: Medicaid

dvha.vermont.gov/members/medicaid/hipp-program

800-250-8427

VIRGINIA: Medicaid and CHIP

FAMIS Select: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select

Health Insurance Premium Payment Program: coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs

Medicaid / CHIP Phone: 800-432-5924

WASHINGTON: Medicaid

hca.wa.gov

800-562-3022

WEST VIRGINIA: Medicaid and CHIP

WV Bureau for Medical Services: dhhr.wv.gov/bms

WV HIPP: mywvhipp.com

Medicaid Phone: 304-558-1700

CHIP Toll-free Phone: 855-MyWVHIPP (855-699-8447)

WISCONSIN: Medicaid and CHIP

dhs.wisconsin.gov/badgercareplus/p-10095.htm

800-362-3002

WYOMING: Medicaid

health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility

800-251-1269

Qualified Medical Child Support Orders (QMCSO)

A copy of the procedure for QMCSOs can be obtained without charge from the Plan Administrator. Contact the Plan Administrator:

**Health Care Plan Administrator Duke Benefits
705 Broad St., Box 90502
Durham, NC 27708**

Subrogation and Reimbursement

While the benefits provided under the health care plan are designed to reimburse you and your covered dependents for certain health care expenses arising from any injury, illness, or sickness, the plan will not be responsible for payment of any health care expenses arising from any injury, illness, or sickness suffered by you or a covered dependent if a third party or organization may be responsible for the injury, illness, or sickness. It is Duke's intention that the plan only will advance those health care expenses for you or a covered dependent with the understanding and expectation that the plan will be repaid in full through the plan's subrogation and reimbursement rights described in this section.

Coverage under the plan for you and your dependents is subject to two conditions. First, if you or a covered dependent should be injured or suffer an illness or sickness for which a third party or organization may be liable or responsible, the plan is automatically subrogated to all rights of recovery which you or a covered dependent may have against such third person or organization for the full amount of any benefits the plan pays. This means that the plan may use your right to recover money from that other person or organization (including any insurance company insuring such third person or organization) to the extent of the benefits the plan may pay for you or your covered dependent.

Second, in addition to the plan's right of subrogation, if you, a covered dependent, and/or an attorney acting on behalf of you or such covered dependent actually recover money from a third person or organization (including an insurance company insuring such third person or organization) for any injury, illness, or sickness for which benefits have been provided under the plan, you, your covered dependent, and/or any attorney representing you and/or your covered dependent are required to reimburse the plan first, from the amount recovered, the amount of benefits the plan has paid for you or your covered dependent. This means that you, your covered dependent, and/or any attorney representing you and/or your covered dependent also must pay to the plan the amount of money recovered through judgment or settlement from the third person or organization (including an insurance company insuring such third person or organization), up to the amount of benefits paid or provided by the plan. This reimbursement requirement applies to any and all medical expenses related to such injury, illness, or sickness regardless of whether such expenses are incurred and/or paid prior to or after the time you, your covered, dependent, and/or any attorney representing you and/or your covered dependent recovers any amount of money from the third person or organization.

The plan's rights of subrogation and reimbursement comes first even if:

- You, your covered dependent, and/or your attorney do not receive from the third party or organization (or any insurance company insuring such third person or organization) all of the damages you claim to have suffered;

- The payment you, your covered dependent, and/or your attorney receive is for, or described as for, your damages and/or expenses (such as for personal injuries, pain and suffering, or attorney's fees) other than health care expenses; or
- The covered dependent recovering the money is a minor.

You, your covered dependent, and/or your attorney must fully assist and cooperate with the Plan Administrator in protecting the subrogation and reimbursement rights of the plan. You, your covered dependent, and/or attorney are required to promptly furnish to the Plan Administrator or its designated agent all information concerning any rights of recovery or recoveries from the other persons or organizations. Before the plan will pay any health care expenses for you or your covered dependent, a subrogation and reimbursement agreement must be completed and signed by you, your covered dependent, and/or your attorney and submitted to the Plan Administrator. The plan is entitled to enforce its subrogation and reimbursement rights even if you, your covered dependent, and/or your attorney do not submit a completed subrogation and reimbursement agreement.

You, your covered dependent, and/or your attorney must notify the Plan Administrator before filing any suit or settling any claim so as to enable the Plan Administrator to participate in the suit or settlement to protect and enforce the plan's rights. The plan shall be responsible only for those reasonable attorneys' fees and expenses to which the Plan Administrator or its agent agrees to in writing.

The Plan Administrator in its sole discretion may withhold or deduct from the payment of any future benefits for you or your covered dependents, or suspend or terminate the provision of payment of any future benefits for you or your covered dependents, in order to protect the subrogation and reimbursement rights of the plan.

Please understand that the purposes of the plan's subrogation and reimbursement rights is not to penalize you or a covered dependent who may suffer an injury, illness, or sickness as a result of a third-party person or organization. Instead, these rights help Duke University control health care costs under the plan and lessen the need to increase contributions paid by all eligible employees for health care coverage.

Your Health Care Plan Options

Duke Select, Duke Basic, Blue Care HMOs; Duke Options and Duke USA PPOs

Duke offers a choice of five health care plan options to best suit the needs of you and your family:

- Duke Select HMO (Health Maintenance Organization),
- Duke Basic HMO,
- Blue Care HMO,
- Duke Options PPO (Preferred Provider Organization), or
- Duke USA PPO.

Your HMO Options:

Duke Select, Duke Basic and Blue Care

Duke offers three HMOs: Duke Select and Duke Basic (administered by Aetna), and Blue Care (administered by BlueCross BlueShield of NC). In these HMOs, you may, but are not required to, select a primary care physician (PCP) from a plan's list of network providers. You will pay a flat charge — or copayment — for most services when you visit a network provider. Routine, preventive services are covered under these plans in

accordance with the preventive care recommendations and guidelines specified under the provisions of the Patient Protection and Affordable Care Act. Recommendations and guidelines may be updated periodically; for frequencies and limits, please contact Aetna or BCBS, or review updates posted on healthcare.gov.

Duke Select, Duke Basic, and Blue Care are open-access plans. You do not need a referral from your PCP to see a network specialist. If you enroll in an HMO, the plan will not pay for care from an out-of-network provider except for care in an emergency department, urgent care provider or behavioral health and substance use disorder provider.

PLEASE NOTE: As part of our effort to provide the health care you and your family need, Duke Select and Duke Basic use a custom network that is unique to Duke. These two plans are only offered to employees living in ZIP codes beginning with the following numbers — 272, 273, 275, 276, and 277. To participate in Blue Care, you must reside in North Carolina. If you move outside of these ZIP codes, you may not continue your enrollment in Duke Select or Duke Basic, and must change to Blue Care or Duke Options.

All Duke Basic members will receive an annual contribution to a health care reimbursement account* based on the level of coverage selected:

- \$200 for Individual
- \$300 for Employee / Child
- \$400 for Employee / Children
- \$400 for Employee / Spouse
- \$500 for Family

PLEASE NOTE: Additional contributions will not be made if dependents are added during the plan year or if the same persons or portions of the family unit terminate and re-enroll under a separate contract during the same plan year. If you terminate employment and are rehired within the same calendar year, you will not receive a second health care reimbursement account contribution for Duke Basic.

***PLEASE NOTE:** If your spouse has an HSA, you are not eligible for this sum as a pre-tax benefit. Contact the Human Resources Information Center at **919-684-5600** if your spouse has an HSA and you elect Duke Basic coverage.

As noted above, if you are enrolled in the Duke Basic health plan, you will receive a contribution from the University to your Health Care Reimbursement Account. Eligible health care expenses are reimbursable until the last day of the following month after your last day worked, to coincide with the end date of your Duke Basic coverage. The University's contribution to a Health Care Reimbursement Account is not a guaranteed benefit, and Duke reserves the right to modify this contribution with proper notification.

Away Coverage

Subscribers and their dependents that are out of town, on sabbatical, away at college, summer camp or otherwise not in the Duke Select / Basic area should purchase additional health insurance coverage for non-emergency care services or consider enrolling in Duke Options or Duke USA. All treatment covered under Duke Select / Basic is provided in the Duke Select / Basic network by in-network providers. Services needed for follow-up care for injuries and illnesses outside of the network are not eligible for coverage under this plan. Blue Care provides coverage throughout North Carolina. Emergency / urgent care and behavioral health /

substance abuse are the only out-of-network benefits provided under the Duke Select / Basic and Blue Care programs.

See also the Business Travel Assistance section of the Summary Plan Description for additional information about coverage when traveling on Duke business, as well as the CIGNA Medical Benefits Abroad coverage described below in this section.

Duke Options PPO

Duke offers you Duke Options PPO (administered by BlueCross BlueShield of NC). This plan does not require that you select a PCP. Duke Options has a national network of physicians and hospitals and a network of international hospitals, so if you or a family member travel often or lives elsewhere, you should consider enrolling in this plan to ensure you have access to providers outside of North Carolina. If you use a network provider, you will be responsible for a lower portion of the bill than you would if you used an out-of-network provider. Routine, preventive services are covered under this plan in accordance with the preventive care recommendations and guidelines specified under the provisions of the Patient Protection and Affordable Care Act.

Recommendations and guidelines may be updated periodically; for frequencies and limits, please contact Aetna or BCBS, or review updates posted on healthcare.gov.

Duke USA PPO

Duke offers the Duke USA PPO (administered by BlueCross BlueShield of NC) as an alternative to the Duke Options PPO plan. Eligibility for the Duke USA plan is limited to employees who reside outside of a ZIP code beginning with 272, 273, 275, 276, or 277 (i.e., outside of the Duke Basic/Duke Select service areas). The Duke USA plan has higher deductibles, higher out-of-pocket maximums, and different coinsurance than the Duke Options plan. Certain benefits covered under the Duke Options plan are not included in the Duke USA plan, so carefully choose the coverage that is appropriate for you and your dependents.

A full description of each plan's covered benefits is published in the Member Guides. Member Guides are accessible at hr.duke.edu/medical or may be requested from the Human Resources Information Center at 919-684-5600.

Duke Plus Retiree Health

For employees who are eligible to continue Duke health insurance as a retiree and who are age 65 or older or otherwise Medicare eligible, or who have dependents who are Medicare eligible, Duke offers the Duke Plus Retiree Health Plan (administered by UMR). This plan does not require that you select a PCP. Duke Plus has a national network of physicians and hospitals, but also provides out-of-network benefits if you elect to use a provider who does not participate in the network. For those individuals who are Medicare eligible, any provider who accepts Medicare is considered an in-network provider. This plan also includes Medicare Part D compliant prescription drug coverage for those who are Medicare eligible.

Coverage While Traveling Abroad

Duke offers eligible employees and their dependents supplemental Cigna Medical Benefits Abroad coverage for unexpected injuries and illnesses that may occur while traveling internationally on Duke business for six months or less. This coverage is administered by Cigna Global Health and provides access to pre-screened health care professionals or facilities located internationally. Enrollment in the coverage is automatic for all benefits-eligible employees. See the Business Travel Assistance section of this document for more information.

Personal Assistance Service

Duke offers benefits-eligible employees scheduled to work at least 20 hours per week and their dependents access to the Personal Assistance Service (PAS) at no charge. The PAS staff of licensed professionals offer confidential assessment, short-term counseling (up to 8 sessions per year), and referrals to help resolve a broad range of personal, work, and family problems. PAS is a resource that can be used as needed, on a voluntary basis and if a referral to an outside source is made, some services may be covered in part by your health care insurance. More information is available at pas.duke.edu. Please note that PAS is not an ERISA program, and enrollment in Duke's health plan is not required to be eligible to use these services.

Summary of Benefits

Benefits provided by the plans are described in detail in the member documents entitled "Duke Select — Member Schedule of Benefits," "Duke Basic — Member Schedule of Benefits," "Benefit Booklet — Blue Care," "Benefit Booklet — Duke Options," and "Benefit Booklet — Duke USA." A copy of the member document is available on the Duke HR website (hr.duke.edu/benefits), may be requested through the Human Resources Information Center **919-684-5600**, or may be requested through Aetna or BlueCross BlueShield of NC Member Services. The "Member Schedule of Benefits" for each of the health plans is incorporated in this Summary Plan Description.

How To File a Claim

Medical Claims and Claims Review Procedures for the Plan

The medical and behavioral claims and claims review procedures for Duke Select, Duke Basic, Blue Care, Duke Options, and Duke USA are described in the Member Schedule of Benefits.

Please see the Pharmacy Benefits in the Summary Plan Description for information related to pharmacy claim appeals.

Authority of the Staff Fringe Benefits Committee and the Plan Administrator

Both the Staff Fringe Benefits Committee (the Committee) and the Plan Administrator have the duty and discretionary authority to interpret and construe the provisions of the program, subject to the objective terms of the plans and the claims and claims review procedures described in the member document.

Interpretations and determinations made by the Staff Fringe Benefits Committee and the Plan Administrator will be applied uniformly to all persons similarly situated and will be binding and conclusive upon each eligible employee and dependent who is covered under the plans and any other interested person. Such interpretations and determinations made by the Committee and the Plan Administrator will be overruled by a court of law only if the Committee and the Plan Administrator are found to have acted arbitrarily and capriciously in interpreting and construing the provisions of the plans.

Other Information

See the "General Information" section of this booklet for:

- A summary of your rights under the Employee Retirement Income Security Act of 1974 (ERISA);
- Information about COBRA continuation coverage; and
- Administration and other general information about this plan.

Pharmacy Benefit

Your prescription drug benefit program is administered by Express Scripts and is available to Duke employees and retirees (and their eligible dependents) covered by Duke Select, Duke Basic, Blue Care, Duke Options, Duke USA, and Duke Plus health care plans.

This plan is a welfare benefit plan, and therefore is not insured by the Pension Benefit Guaranty Corporation. While Duke expects to continue Duke Select, Duke Basic, Blue Care, Duke Options, Duke USA, and Duke Plus indefinitely, it reserves the right to change the terms of Duke Select, Duke Basic, Duke Options, Blue Care, or the Prescription Drug Benefit Program or to terminate the plan in the future. Your coverage may be cancelled by Duke Select, Duke Basic, Duke Options, or Blue Care.

Injectable Fertility Drugs

PLEASE NOTE: Injectable fertility drugs are not reimbursed according to the standard pharmacy benefit copayment. They are covered by Duke Select and Duke Options at 75% for those employees or their spouses with at least two years of service with Duke based on the most recent continuous service date on file and only if treatment is received at Duke Fertility. Members who permanently reside outside of North Carolina are not required to have services provided through Duke Fertility, but must be under the care of a participating BlueCross BlueShield fertility specialist and fertility drugs are subject to prior authorization.

PLEASE NOTE: Prescription drug costs incurred for Fertility Services do not accrue towards the Plans' out-of-pocket maximums.

Maintenance Drug Pharmacy Program

For your ongoing prescription drug needs, use either the Express Scripts home delivery pharmacy or the Duke Pharmacies — located at Duke Outpatient Pharmacy, Duke Specialty Pharmacy at the Cancer Center, Duke Raleigh Hospital Plaza Pharmacy, Campus Center Pharmacy at the Student Wellness Center, Duke Regional Hospital Outpatient Pharmacy, Duke North Pavilion Retail Pharmacy or Duke Children's Health Center (CHC) Retail Pharmacy — if you are taking a maintenance medication to treat a long term health condition, such as high blood pressure, asthma, or diabetes. This does not include controlled substances.

Those who need specialty drugs must purchase them through either the Duke Pharmacies or Express Scripts' specialty pharmacy, Accredo. Specialty drugs that are needed immediately may be purchased at any retail pharmacy.

PLEASE NOTE: Certain specialty medications require a member's participation in the SaveOnSP program, detailed later in this section.

Using Mail Order:

Employees may purchase three months of maintenance drugs at the standard copay. After the third fill, maintenance drugs not filled through the mail or Duke Pharmacies will require a 50% co-insurance for all plans except Duke Basic, where the use of mail or Duke Pharmacies are mandatory. If you use Express Scripts mail order:

- You can order your refills online at [express-scripts.com](https://www.express-scripts.com) or phone in your order toll-free to **800-717-6575**
- Telephone consultations with a registered Express Scripts pharmacist are available around the clock by calling **800-717-6575**, and
- Use EasyRxSM to order new or refill existing prescriptions. Follow the steps below.

Ordering new prescriptions

Your doctor may e-prescribe ongoing medications for a 90-day supply plus refills, if appropriate. You may need to give your doctor your Express Scripts ID number. When ordering medications through Express Scripts, you will need to provide your credit card number for billing, mail your prescription if your doctor has provided a paper script, send the required copayment, and use the order form / envelope provided. If you have any questions, please call Member Services at **800-717-6575**.

PLEASE NOTE: The Express Scripts mail order pharmacy does not hold prescriptions. When the doctor calls in or e-prescribes the drug, it is filled. If you do not want a prescription immediately, request a paper prescription and mail in the prescription when desired.

Refilling your medication

A few simple precautions will help ensure you do not run out of your prescription. Reorder your prescription on or after the refill date indicated on the refill slip or on your medication container. You may also reorder when you have fewer than 25% of medication left.

Refills online: Log on to the website at express-scripts.com. Have your member ID number, the prescription number (the 12-digit number on your refill slip), and your credit card ready when you log on. Credit card and personal information are secure on this site.

Refills by phone: Have your member ID number, refill slip with the prescription number, and your credit card ready.

Refills by mail: Use the refill and order forms provided with your medication. Mail them with your copayment to:

**Express Scripts Rx Services
P.O. Box 650322
Dallas, TX 75265-9946**

Delivery of Medication

Prescription orders receive prompt attention and, after processing, are usually sent by U.S. mail or UPS within one week. Your enclosed medication will include instructions for refills, if applicable. Your package also may include information about the purpose of the medication, correct dosage, and other important details. Special packaging is used for medications that require special handling, such as refrigeration.

Paying for your Medication

You may pay by check, money order, HealthEquity FSA Card, or credit card. If you prefer to pay for all orders by credit card, you may enroll in the automated payment plan by calling **800-948-8779**. Participation in the automated payment plan is optional.

PLEASE NOTE: The pharmacist's judgment and state and federal law govern the dispensing of certain controlled substances and other prescribed drugs and may, for instance, limit their allowed quantities.

Federal law prohibits the return of dispensed controlled substances. Controlled substances are medications that are habit forming and are restricted to a six-month supply.

Retail Network Pharmacy Program

Immediate prescription drug needs may be filled at a participating retail pharmacy.

If you use a participating retail network pharmacy:

Present your prescription drug ID card and prescription(s) at the pharmacy. The retail pharmacist will confirm your eligibility for benefits, and you will be told the copayment / deductible you are required to pay.

A claim form for prescriptions filled at a participating retail network pharmacy is not needed. Your claim is processed onsite at the time the medication is dispensed.

To find the participating retail network pharmacies nearest you, visit the website at [express-scripts.com](https://www.express-scripts.com) and use the interactive pharmacy locator. You may also use the voice-activated Pharmacy Locator System by calling Member Services at **800-717-6575**.

If you use a non-participating pharmacy:

You must pay 100% of the prescription price at the time of purchase and submit a claim form to Express Scripts for reimbursement. After you have paid for a prescription filled at a non-participating pharmacy, submit a completed claim form to Express Scripts. The prescription receipt must be attached to the form. To obtain claim forms, visit [express-scripts.com](https://www.express-scripts.com) or call Member Services at **800-717-6575** to use the automated ordering system. You may also access the claim form on the Duke website at hr.duke.edu/forms.

You will usually be reimbursed within 21 days of submitting the claim form. You will be reimbursed the discounted amount that would have been charged by a participating pharmacy, less the required copayment.

Pharmacy Program Features

Express Scripts and your health plan may use the health and prescription information you provide solely to administer your benefit program. In addition, Express Scripts may use this information and prescription data from claims submitted nationwide for reporting and analysis without identifying individual patients. Information may be shared with your health plan and your health plan's contractors as necessary to administer your health plan benefit program.

Express Scripts has a strong commitment to your privacy. Effective administrative and technical safeguards have been established to protect the confidentiality of your prescriptions and other information and to prevent unauthorized access to or disclosure of this information.

When your prescriptions are filled at one of the Express Scripts Rx mail service pharmacies, the pharmacists use the health and prescription information they have on file for you to consider many important clinical factors including drug selection, dosing, interactions, duration of therapy, and allergies. They also have available information received from your retail pharmacy.

Express Scripts may contact your doctors to discuss certain clinical factors and benefit management matters. If your doctor authorizes a change in your prescription, Express Scripts will send a confirmation letter to you and your doctor. You will only be dispensed the medication authorized by your doctor.

Drug Utilization Review:

In order to ensure safe and appropriate use of medication under the drug utilization review program, prescriptions filled through the mail service pharmacy or a retail network pharmacy are examined for potential problems based on your personal medication profile. Drug utilization review is especially important if you or your covered dependents take many medications or see more than one doctor. If there is a question about your prescription, your pharmacist may contact your doctor before dispensing the medication.

Education and Safety

You will receive information about critical topics such as drug interactions and possible side effects with every new prescription. By visiting [express-scripts.com](https://www.express-scripts.com), you may access additional health-related information.

Health Management

Based on your prescription and health information, you may be invited to participate in one or more health management programs. Program participants generally receive educational mailings and toll-free phone access to registered pharmacists. In some programs, participants also may receive follow-up calls from pharmacists.

Generic Drugs

Generic medications contain the same active ingredients as their brand name equivalents and are subject to the same U.S. Food and Drug Administration (FDA) standards for quality, strength, and purity as their brand name counterparts. Generic drugs usually cost less than brand name drugs, so asking your doctor to prescribe generic drugs when possible may be cost efficient.

Sometimes your doctor may prescribe a medication to be dispensed as written when a preferred brand-name or generic drug is available. As part of your prescription drug program, the pharmacist may discuss with your doctor whether a generic drug might be appropriate for you. Although your doctor always makes the final decision on your medication, you may request to keep the original prescription.

The National Preferred Formulary

Your prescription drug program includes a formulary feature. A formulary is a list of commonly prescribed medications that are preferred based on their clinical effectiveness and lower plan cost. The list includes medications from most major pharmaceutical manufacturers. The National Preferred Formulary is managed by Express Scripts and may be updated throughout the plan year.

Visit the Express Scripts website at express-scripts.com to view the formulary. Use of a formulary drug is voluntary. However, you will pay less if you need a brand-name drug and use a drug on the formulary. Sometimes your doctor may prescribe a non-formulary medication when a formulary brand-name drug is available. In such cases, your doctor may specify that the prescription be dispensed as written. As part of your prescription drug program, the pharmacist may ask your doctor whether an alternative formulary drug might be appropriate for you. If your physician agrees, your prescription will be filled with the alternative drug. Your doctor always makes the final decision on your medication. Only the medication authorized by your doctor can be dispensed.

Managed Rx Coverage / Prior Authorization

Your prescription drug program provides coverage for some drugs only if they are prescribed for certain uses, durations, or quantities. For this reason, some drugs must receive authorization before they can be covered under your benefit plan. If the drug you have been prescribed must be pre-authorized, your pharmacist will tell you. You may ask that your pharmacist contact your physician to request that he or she initiate a review. It may shorten the review time, however, if you contact your physician directly and request that he or she call Express Scripts at **800-753-2851** to initiate the review, which typically takes two business days. The patient and physician will be notified when the review is complete. If your medication is not approved for plan coverage, you will have to pay the full cost of the drug. You may appeal the decision. For more information on appeals, see "The Express Scripts Prior Authorization and Appeal Process" later in this section, or call Member Services at **800-717-6575**.

Step Therapy

For several therapies, participants are required to try the generic or target formulary drug before the plan will pay for more expensive alternatives. This is known as step therapy. Your physician can contact Express

Scripts if you find that your medication requires step therapy. The phone number is **800-753-2851** to initiate the review of a step therapy medication.

Express Scripts, a national pharmacy benefit manager, provides pharmacy benefits for each of Duke's medical plans. Copayments and deductibles vary depending on the type of medicine prescribed (generic, brand or non-formulary), the length of the prescription, and the place of purchase.

Copayment & Deductible Structure for Retail Pharmacies (up to 34-day supply)*

An annual \$100 deductible per person applies to brand and non-formulary prescriptions filled at retail pharmacies. This deductible means each person covered by the medical plan must satisfy the \$100 deductible for brand and non-formulary drugs purchased at a retail pharmacy before the plan begins to pay benefits under a copayment structure. The \$100 deductible applies to short term drugs purchased at the Duke onsite pharmacies. The deductible is waived only for long term drugs. There is no deductible for generic drugs (except for Duke Basic).

The **retail copayment structure** for short term medications and controlled substances is listed below.

- Generic: \$15 or cost of the drug if less than \$15 (no deductible, except for Duke Basic)
- Brand: \$50 (after meeting annual \$100 deductible per person)
- Non-formulary: \$70 (after meeting annual \$100 deductible per person)

After your third purchase of the same medication, your prescription may be considered to be a long term medication and you will pay a higher cost if you continue to purchase it at a retail pharmacy. Specifically, you will pay 50% of the total cost of the prescription, subject to a minimum and maximum. The minimum is \$10 for generic; \$70 for brand; and \$85 for non-formulary drugs. The maximum is \$30 for generic; \$165 for brand; and \$180 for non-formulary drugs.

To avoid paying more for your long term medications, use the Express Scripts Mail Order Pharmacy or participating onsite Duke Pharmacies (Duke Outpatient Pharmacy, Duke Specialty Pharmacy at the Cancer Center, Duke Raleigh Hospital Plaza Pharmacy, Campus Center Pharmacy at the Student Wellness Center, Duke Regional Hospital Outpatient Pharmacy, Duke North Pavilion Retail Pharmacy or Duke Children's Health Center (CHC) Retail Pharmacy). In addition to reduced copays, the \$100 deductible for brand and non-formulary maintenance drugs will be waived (except for Duke Basic) if you use Express Scripts mail order or a Duke onsite pharmacy. (See the chart at the end of this section for details.)

Persons who take drugs classified as a "specialty drug" must purchase them at either Express Scripts' specialty pharmacy, Accredo, or the Duke Pharmacies. Specialty acute drugs may still be purchased at a retail pharmacy.

***Reminder:** Participants in the Duke Basic medical plan have an annual \$100 deductible for all prescription drugs and are required to use the mail order program or participating onsite Duke Pharmacies after the third purchase of a long term medication.

Copayment Structure for Express Scripts Mail Order Pharmacy or Participating Onsite Duke Pharmacies (up to 90-day supply)

You will save time and money by filling your recurring, long term medications through the mail order program or participating onsite Duke Pharmacies. Medications provided by pharmaceutical manufacturers in unbreakable packaging may require dispensing in quantities of less than 90 days. When possible, your

prescription should be written for a 90-day supply because a prescription for less than 90 days will still be charged a 90-day copayment.

The Express Scripts Prior Authorization and Appeal Process

Express Scripts provides clinical coverage review services for members of the Duke Health Care Programs. The preferred method to request an initial clinical coverage review is for the prescriber or dispensing pharmacist to call the Express Scripts Coverage Review Department at **800-753-2851**.

Alternatively, the prescriber may submit a completed coverage review form online at: express-scripts.com/corporate/prior-authorization-resources

Requests may also be mailed to:

**Express Scripts
Attn: Prior Authorization Department
PO Box 66571
St. Louis, MO 63166-6571**

Mail Service coverage review requests are automatically initiated by the Express Scripts Home Delivery pharmacy as part of filling the prescription.

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of the request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes a situation is urgent, the expedited review must be requested by the provider by phone at **800-753-2851**.

How To Request a Level 1 Appeal or Urgent Appeal After an Initial Coverage Review Has Been Denied

When an initial coverage review has been denied, a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied and a brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements / letters, bills or any other documents

Clinical appeal requests:

Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St. Louis, MO 63166-6587
Phone: 800-935-6103
Fax: 877-852-4070

Standard pre-service appeals are completed no later than 15 days from receipt. Post-service appeals are completed no later than 30 days from submission. Urgent appeals are completed within 72 hours, and the decisions made are final and binding. There is only one level of review for urgent appeals.

How To Request a Level 2 Appeal After a Level 1 Appeal Has Been Denied

When a Level 1 appeal has been denied a request for a Level 2 appeal may be submitted by the member or authorized representative within 90 days from receipt of the notice of the Level 1 appeal adverse benefit determination. To initiate a Level 2 appeal, the information listed above for a Level 1 appeal must be included and sent to the same address.

Express Scripts completes appeals based on business policies that are compliant with state and federal regulations. Appeal decisions are made by an Express Scripts Pharmacist, Specialist, and panel of clinicians or an independent third-party utilization management company.

Contact Express Scripts

express-scripts.com

Member Services at **800-717-6575**

(TTY 800-759-1089) 24 hours a day, seven days a week.

Visit the website anytime to learn about patient care, refill your mail service prescriptions, check the status of your mail service pharmacy order, request claims forms and mail service order forms, view the National Preferred™ Formulary, or find a participating retail pharmacy near you.

Pharmacy Benefits Comparison Chart

	At a participating retail pharmacy	Through the Express Scripts mail order pharmacy or participating onsite Duke pharmacies
Amount	Up to a 34-day supply	90-day supply
Generic No deductible except for participants covered by Duke Basic. ¹	First three purchases (any medication): \$15 (or cost of drug if less) After third purchase (long term medication): 50% ² Cost of drug to max. \$30	\$25 (or cost of drug if less)
Brand Annual \$100 per person retail deductible applies. No deductible for 90-day supply through mail order or Duke Pharmacies except for Duke Basic participant.	First three purchases (any medication): \$50 After third purchase (long term medication): 50% ² Min. \$70, Max. \$165	\$130
Non-formulary Annual \$100 per person retail deductible applies. No deductible for 90-day supply through mail order or Duke Pharmacies except for Duke Basic participant.	First three purchases (any medication): \$70 After third purchase (long term medication): 50% ² Min. \$85, Max. \$180	\$180

¹ Participants in the Duke Basic Medical Plan have a \$100 deductible for all prescription drugs, including generic, mail order, and Duke Pharmacy prescriptions.

² The copayment (50% of the total cost of the medication) will also be subject to the following minimum and maximum copayments. The minimum is \$10 (or cost of drug is less) for generic; \$70 for brand; and \$85 for non-formulary drugs. The maximum is \$30 for generic, \$165 for brand; and \$180 for non-formulary drugs. This does not apply to Duke Basic participants because they are required to use mail order of Duke Pharmacies for long term medication.

What Drugs Are Covered and What Drugs Are Not?

Covered

- Legend drugs (federal law requires these drugs be dispensed by prescription only)
- Insulin
- Disposable insulin syringes / needles
- Blood glucose testing strips, glucometers
- Legend contraceptives; injectable contraceptives
- Any other drug which, under the applicable state law, may only be dispensed upon the written prescription of a physician or other lawful prescriber

- Growth hormone (limited to patients who qualify under the Express Scripts guidelines.)
- Retin A® (through age 35, over age 35 with approval through prior authorization)

Not Covered

- Compounded drugs
- Anorexiant (drugs for weight reduction) including Lonamin®, Pondimin®, Redux®, Meridia®, Xenical®, Qsymia, Saxenda, Wegovy, or other drugs prescribed for the primary purpose of weight reduction
- Non-legend drugs other than those listed under “What Drugs Are Covered?”
- Viagra®, Muse®, Cavereject®, Levitra®, Cialis®, or other drugs approved for erectile dysfunction
- Renova®
- Growth hormone for short stature
- Rogaine®, Propecia® (or similar products whose sole purpose is to stimulate or promote hair growth)
- Drugs labeled “Caution — limited by federal law to investigational use,” or experimental drugs
- Infertility drugs unless authorized by a provider in Duke Fertility when covered under Duke Options or Duke Select, and receiving services from Duke Fertility. (Duke Options members who reside outside of North Carolina may use a participating provider other than Duke Fertility.)
- Drugs which are purchased outside of the United States and do not have FDA approval
- Biological sera, blood or blood plasma, or products derived from blood or blood products
- Medical devices and appliances (except glucometers prescribed by your physician)
- Charges for the compounding of any drug that are in addition to negotiated fees
- Over-the-counter items
- Take-home drugs from an inpatient facility
- Replacement of drugs that have been lost, stolen, or destroyed
- Drugs prescribed by a provider for himself/herself or his/her immediate family

Specialty Medications under the SaveOnSP Program

Duke Health Care Programs include a specialty pharmacy copayment assistance program that may apply to certain specialty drugs. Under this program, known as SaveOnSP, the cost of the drugs included under the copayment assistance program are reimbursed by the manufacturer at no cost to the participant and therefore the cost of the drugs does not apply towards satisfying the out-of-pocket maximum or deductible. A listing of these medications may be accessed online at hr.duke.edu/benefits/medical/pharmacy, or may be requested by calling the Human Resources Information Center at **919-684-5600**, emailing benefits@duke.edu, or contacting Express Scripts at **800-717-6575**. This list is reviewed and updated at least annually.

Medications covered under the SaveOnSP Program are filled through an approved specialty pharmacy (either Accredo or Duke Pharmacies). Participation in the SaveOnSP Program is voluntary, but members who choose

not to enroll may be responsible for a higher coinsurance amount, and the cost of medications will not count towards the pharmacy plan deductible or out-of-pocket maximums.

Enrollment in the SaveOnSP program takes place via telephone. To enroll, contact SaveOnSP at **800-683-1074**.

For additional information or questions about the program, contact the Human Resources Information Center at **919-684-5600**, email benefits@duke.edu, or contact Express Scripts at **800-717-6575**.

Duke Preferred Drug List Exclusions

A listing of drugs that are excluded from coverage under the Duke Pharmacy Benefit Program is updated at least annually and is posted online at hr.duke.edu/benefits/medical/pharmacy/covered-drugs. You may also request a copy of the “National Preferred Pharmacy Exclusions” by contacting the Human Resources Information Center at **919-684-5600**, emailing benefits@duke.edu, or by contacting Express Scripts at **800-717-6575**.

Special Services

Express Scripts provides the services listed below to meet the special needs of members. Contact Express Scripts’ Member Services at **800-717-6575** in order to:

- Reach a registered pharmacist for consultation regarding a prescribed medication;
- Request that a mail order prescription include labels in Braille; or
- Request that pharmacy plan information be provided in an alternative format, such as Braille, large print, or audio cassette.

It is intended that the Duke Health Care Programs qualify as “accident and health plans” and as “self-insured medical expense reimbursement plans” under the federal tax laws. This Benefit Program Description, which is a part of the Duke University Welfare and Fringe Benefits Plan along with the applicable Member Guides, shall constitute the written plan document for the Duke Health Care Programs. It is further intended that benefits payable under the Duke Health Care Programs be eligible for exclusion from gross income.

Duke reserves the right to amend or terminate these benefits or your eligibility for benefits (including an amendment to reduce benefits or eliminate benefits or any changes to the premium or contribution rates) for all participants or for a specific class of participants, including current or former employees, under the Duke Health Care Programs. The written plan documents for the Duke Health Care Programs are not employment contracts or any type of employment guarantee.

DUKE DENTAL PROGRAM

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DUKE DENTAL PROGRAM

Introduction

Coverage for the Duke Group Dental Insurance Program is provided and underwritten by Ameritas Life Insurance Corp. The Duke Dental Program offers you a choice of three options, depending on the level of coverage you and your family may need. All options cover Type 1 (preventive), Type 2 (basic), Type 3 (major), and Type 4 (periodontics / endodontics), but they differ in how they pay for covered services.

The PPO option requires that you use a network provider in order to fully realize the benefits of the Plan. If you select the PPO option and use an out of network provider, the amount the Plan pays will be based on discounted network charges and you will be responsible for any charged amount over that allowance.

If you select Plan A, you have the freedom to visit any licensed dentist of your choice. You may also choose to use a network provider. Using a network provider will limit your out-of-pocket costs. Also, if you utilize a network provider, the deductible is waived for all covered procedures.

Plan B provides a very nominal benefit and payments are based on a fixed schedule of fees.

You can find a PPO network provider by calling Ameritas at **800-755-8844** or by visiting [explore.ameritas.com/duke](https://www.ameritas.com/duke).

The term "Duke" is used throughout this booklet. "Duke" refers to the University, Duke University Health System, Inc. and any other corporation or entity that adopts the Plan with the duly authorized approval of the Board of Trustees. When used in this Plan document, "Employer" shall refer to all of the foregoing collectively except where the context requires that such term refer to the corporation or entity that actually employs an individual.

The benefit program provided is based on an employee's company code and job code as reflected in the HR benefits administration system (SAP). Duke employees holding more than one position classification receive the benefits associated with their primary position classification as reflected in SAP. For example, a housestaff member who also works within DHIP, receives benefits associated with their housestaff position classification.

Duke Dental Program

Coverage and Limitations Comparisons

The following charts compare the three Duke Dental options — PPO Plan, Plan A and Plan B:

Preventive Services ¹ (Type 1)

Procedures	PPO Plan	Plan A	Plan B
2 Exams per year 2 Cleanings per year Space Maintainers X-Rays Fluoride treatment (for children under age 19)	MAC ² No deductible	100% of U&C ² No deductible	Benefits based on the schedule for Plan B No deductible

Basic Services (Type 2)

Procedures	PPO Plan	Plan A	Plan B
Extractions and fillings Full or partial denture repair Sealants Anesthesia (with surgical procedures)	Based on benefits payable levels No deductible Benefit Payable Levels ⁴ Level 1 80% of MAC ² Level 2 90% of MAC ² Level 3 100% of MAC ²	Based on benefits payable levels \$100 lifetime deductible per person ³ Benefit Payable Levels ⁴ Level 1 80% of U&C ² Level 2 90% of U&C ² Level 3 100% of U&C ²	Benefits based on the Schedule for Plan B \$50 calendar year deductible on Type 2 (basic) and Type 3 (major) procedures combined

¹ No benefits will be paid for expenses incurred by late entrants during the first twelve months an insured is covered, except for exams, cleanings, and fluoride applications. A late entrant is any person who did not enroll within 30 days after the date of employment or within 30 days from the date the person qualified for insurance, or any person who has elected to become insured again after terminating coverage.

² All payments are based on the maximum allowable charge (MAC) under the PPO Plan. Payments under Plan A are based on the usual and customary (U&C) charge. You are liable for charges over U&C. Payments under Plan B are based on a fixed schedule of fees.

³ The deductible is waived for all covered procedures if you utilize a participating network provider.

⁴ Level 1 applies during the first calendar year that you are insured. You must visit a dentist during each calendar year and have one covered procedure performed in order for Level 2 reimbursement to apply during the second calendar year and Level 3 reimbursement to apply each calendar year thereafter.

If during any calendar year you fail to visit a dentist or fail to have one covered procedure performed, Level 1 reimbursement will automatically reapply during the following calendar year and you must advance to Levels 2 and 3 as if you were newly insured.

Exception: If during any calendar year you have a break in continuous coverage of more than one month, Level 1 reimbursement will reapply for the balance of that calendar year and you must advance to Levels 2 and 3 as if you were newly insured.

Major Services (Type 3)

Procedures	PPO Plan	Plan A	Plan B
Pontics (false tooth) and bridges Crown and bridge repair Dentures and partial dentures Onlays	50% of MAC ¹ \$50 calendar year deductible per person on Types 3 and 4 procedures combined	50% of U&C ¹ \$75 calendar year deductible per person ²	Benefits based on the Schedule for Plan B \$50 calendar year deductible ² on Type 2 (basic) and Type 3 (major) procedures combined

Major Services (Type 4)

Procedures	PPO Plan	Plan A	Plan B
Periodontics Endodontics	65% of MAC ¹ \$50 calendar year deductible per person on Types 3 and 4 procedures combined	65% of U&C ¹ \$75 calendar year deductible per person on Type 3 and Type 4 procedures combined ²	Procedures covered in Type 2 (basic) Benefits based on schedule \$50 calendar year deductible ² on Type 2 (basic) and Type 3 (major) procedures combined

Maximum Deductibles

Procedures	PPO Plan	Plan A	Plan B
N/A	N/A	N/A	Three deductibles per family per year

Maximum Benefit

Procedures	PPO Plan	Plan A	Plan B
N/A	\$2,000 per person per year ³ Types 3 and 4 procedures combined	\$1,250 per person per year ³ Types 1, 2, 3, and 4 combined	\$1,000 per person per year ³ Types 1, 2, and 3 combined

Orthodontia

PLEASE NOTE: Benefits payable only if treatment begins after the participant becomes covered by the Duke Dental Plan.

Procedures	PPO Plan	Plan A	Plan B
All Plans (PPO, Plan A and Plan B) allow participants to see any dentist for Orthodontia services	2-year Treatment 50% of U&C ¹ No deductible \$1,000 lifetime max. per person (adults and children) Benefits paid on a quarterly basis	2-year treatment 50% of U&C ¹ No deductible \$1,000 lifetime max per person (adults and children) Benefits paid on a quarterly basis	2-year treatment 50% of U&C ¹ No deductible \$750 lifetime max. per person (adults and children) Benefits paid on a quarterly basis

PLEASE NOTE: If you have already achieved the highest benefit payable, Level 3, you will remain at that level as long as you continue to visit a dentist at least one time each calendar year and are continuously covered by the Plan.

¹ All payments are based on the maximum allowable charge (MAC) under the PPO Plan (except orthodontia which is paid based on U&C charges). Payments under Plan A are based on the usual and customary (U&C) charge. You are liable for charges over U&C. Payments under Plan B are based on a fixed schedule of fees.

² The deductible is waived for all covered procedures if you utilize a participating network provider.

³ Ameritas Dental Rewards®: Dental Plan members who filed a claim for at least one covered procedure in a calendar year and have less than \$500 in paid claim dollars in that year will be able to carry over funds for possible future use. Each member meeting the criteria can carry over \$250 of their unused Annual Maximum for future use.

⁴ See "How the Dental Plan Works" section for claims payment examples, sample procedures and a list of ineligible expenses.

Eligibility and Enrollment

You are eligible for dental coverage if you are a:

- Faculty employee holding a regular rank appointment who is receiving wages for Social Security purposes.
- Faculty employee holding other than a regular rank appointment and classified as a full-time or part-time member of the faculty scheduled to work at least 20 hours per week, who is receiving wages for Social Security purposes.
- Regular employee or Housestaff scheduled to work at least 20 hours per week.
- Postdoctoral scholar previously eligible for coverage.
- Employees at a \$0 rate of pay or scheduled too few weeks per year (Example: where weeks scheduled per year multiplied by hours scheduled is below 1,000) are generally not in a payroll / benefits eligible classification.

Eligible Dependents

The following dependents are eligible for enrollment in a Duke Dental Program:

- Your legal spouse;
- Your dependent child up to age 26 (“child” includes biological children, stepchildren, foster and legally adopted children, or children placed for adoption with the employee, children for whom the employee has been ordered by a court or administrative agency to provide health benefits under the Plan, and, if the employee has a Registered Same Sex Spousal Equivalent who is enrolled in the Plan as an eligible dependent of the employee, the children of the employee’s registered Same Sex Spousal Equivalent), who is under 26 years of age; and
- Your children who are mentally or physically disabled and incapable of self-support after age 26, as long as:
 - Their disability began before they turned age 26;
 - They had continuous coverage under a Duke Dental Plan prior to age 26; and
 - A dependent Statement of Health form is submitted to and approved by the Dental Plan prior to the 26th birthday.

Collective Bargaining Agreements

Group dental insurance benefits are a subject of good faith bargaining between Duke and certain employee representatives. The Plan is maintained pursuant to certain collective bargaining agreements. The agreements are available for your inspection in the Staff and Labor Relations Department of Duke’s Human Resources, **705 Broad Street, Durham, NC 27708.**

Enrolling

You have 30 days after the date of employment to enroll in the Group Dental Insurance Program.

If you do not enroll when you are first eligible (within 30 days after your date of employment or eligibility), you can enroll during the annual open enrollment period. You and your dependents will be late entrants and will only be covered for exams, cleanings, and fluoride applications during the first twelve months of coverage.

After the first twelve months, you will be entitled to full benefits as defined by the Group Dental Insurance Program.

Children enrolled during an open enrollment period within six months of turning age two are not subject to the late entrant penalty.

After you select between the three Plan options, there are several types of coverage in which you may enroll:

- Employee Only Coverage (Individual)
- Employee and Child
- Employee and Spouse
- Family

A person who is enrolled in the Plan as an employee cannot also enroll as the dependent of another employee. A person who is enrolled in the Plan as the dependent of one employee cannot also enroll as the dependent of another employee.

PLEASE NOTE: Once you enroll in a particular type of coverage, you cannot stop or change your election until the next annual open enrollment period, unless you experience a qualifying event. Qualifying events include, but are not limited to, birth, marriage, divorce, death of a spouse or child, or termination of employment. To participate, eligible dependents must enroll within 30 days of the qualifying event or they will be considered late entrants.

A calendar year, January 1 to December 31, is the basis for your deductibles, maximums, and coinsurance levels. During the first year you are insured, your calendar year is from your effective date through December 31 of that year.

Effective Date of Coverage

New employees of Duke University and Duke University Health System are eligible for coverage effective on the first of the month following your employment / eligibility date.

Late Entrant Restrictions

If you do not enroll within 30 days after your date of hire or eligibility, and enroll instead during the open enrollment period in the fall, you will be considered a "late entrant." As a "late entrant," your benefits during the first twelve months of coverage will be limited to preventive services: two preventive routine care exams (not including X-rays), two prophylaxis (routine) cleanings, and for children under age 19, one fluoride application. No other dental or orthodontia procedures or services will be covered during the first 12 months if a member is enrolled as a late entrant.

Periodontal procedures, including maintenance / cleanings, would not be covered during this 12-month period.

Once you have been enrolled in a Duke Dental Insurance Plan for at least 12 months, the insurance will also cover basic and major procedures, such as fillings, extractions, crowns, root canals, and periodontal treatment (including periodontal maintenance which applies toward cleaning frequency).

This 12-month waiting period does not apply:

- If you are switching from one Duke Dental Plan to another Duke Plan;
- If you add a child during an open enrollment period prior to his/her second birthday; or

- If you enroll an eligible dependent within 30 days of a qualifying event such as marriage or adoption.

PLEASE NOTE: Coverage must be continuous in order to avoid the late entrant restrictions. If you allow your Duke dental insurance to lapse and do not re-enroll in a Duke dental plan within 30 days of your return to work after an approved leave of absence, the late entrant provision will apply to your benefits when you re-enroll during open enrollment.

PLEASE NOTE: Employees that transitioned from the Primary Diagnostic Clinic (PDC) to DUHS / DHIP on July 1, 2023 and/or were participating in the PDC dental plan on June 30, 2023 are eligible to enroll in Duke's coverage effective July 1, 2023 and will not have a late entrant provision associated with their July 1, 2023 enrollment. Please see the "Important Summary for Employees Transitioning to the Duke Health Integrated Practice (DHIP) on July 1, 2023" in the "General Information About Your Benefits" section of this Summary Plan Description for additional details.

Cost of the Plan

Eligible employees covered under the Plan pay the entire premium for their benefits under the Plan in such amounts as determined solely by the insurance company, Ameritas. Premium payments are required to be paid on a before-tax basis through the Duke University Cafeteria and Premium Conversion Program.

When Coverage Ends

Member Terminations

Your membership in the Plan, and coverage under the Plan, may be terminated and written notice will be provided for any of the following reasons:

- Fraud or misrepresentation. This includes but is not limited to fraudulent statements or material misrepresentations of fact made on your enrollment application, including enrollment of ineligible dependents;
- Fraudulent use of services or facilities;
- Misuse of your identification card. This includes but is not limited to allowing someone else to use your Plan identification card;
- Nonpayment of your contribution toward coverage under the Plan; or
- Marriage of a surviving spouse.

The Plan is entitled to recover all expenses it incurs (including the reasonable value of services received, reasonable attorney's fees and any incidental expenses) because of fraud, misuse, or misrepresentation from the member who committed such fraud, misuse, or misrepresentation.

PLEASE NOTE: Your benefits and eligibility for coverage in other Duke sponsored benefit plans may be terminated for providing fraudulent or misrepresented information including, but not limited to, Health Care Plans, Retiree Health Care Plans, Vision Plan, Life Insurance Plans (including Gratuity to Spouse / Estate Plan), Children's Tuition Benefit Plan, Employee Tuition Assistance Plan, and Disability Plans. Employment with Duke may also be terminated.

Termination of Coverage

Members may not terminate coverage under the Plan except during the annual open enrollment period or within 30 days of a valid change in family status.

Subject to your continuation rights under COBRA, your Plan coverage will terminate if you lose your eligibility to be a member, or if the employee through whom you are enrolled in the Plan loses their Plan coverage. If you cease to be eligible to participate in the Plan because of an amendment to the Plan by Duke University, your coverage will terminate the date the amendment to the Plan takes effect. Coverage for all the members enrolled through an employee who loses their eligibility because of a Plan amendment will terminate the date the amendment takes effect. Coverage for all Plan members will terminate as of the date Duke terminates the Plan.

How the Dental Program Works

Coverage

Coverage and deductibles vary according to the Plan you choose, the procedures you receive and, if you select either the PPO or Plan A, the benefit level payable (Level 1, Level 2, or Level 3). Please refer to the comparison charts in the “Sample Comparison of Plan Options” section for a broad overview of the available benefits. Also, please read the following information about deductibles and benefits for a more detailed explanation.

Deductibles

A deductible is the amount of covered expenses for which no benefits are paid. Benefits will be paid only for covered expenses which exceed the deductible.

For all Plans, no deductible applies for Type 1 (preventive) procedures.

The PPO Plan Type 3 (Major) Procedures Deductible Applies Per Person.

The Plan A Type 2 (basic) procedures deductible applies per person, but only once during their lifetime. The Plan A combined Type 3 (major) and Type 4 procedures deductible amount applies per person each calendar year.

Plan B has a different deductible structure. In Plan B, Type 2, Type 3, and Type 4 deductibles are combined and apply to each person each calendar year.

Maximum Benefit

All three plans have an annual maximum benefit. If you reach this annual maximum benefit, Ameritas will not reimburse any additional services for the remainder of the calendar year unless you are eligible for Ameritas Rewards®. If you terminate participation in the Plan and subsequently enroll in the Plan during the same calendar year, all covered expenses paid by the Plan during that calendar year count toward the calendar year maximum benefit. The annual maximum benefit for the PPO Plan is \$2,000 per person; for Plan A is \$1,250 per person; and for Plan B is \$1,000 per person.

Ameritas Dental Rewards®

Dental Plan members who have at least one covered dental claim filed in the prior year and have less than \$500 in claims reimbursement in the prior year, will be eligible to carry over funds for possible future use. Each member meeting the criteria can carry over \$250 of their unused Annual Maximum for future use.

Additionally, if the member visits a network provider at any time during the year, they may receive an additional \$100 carryover.

The above carryover accumulation total is capped at \$1000. Members can continue to earn carryover dollars up to this \$1000 limit and it can be used to help offset out-of-pocket expenses if/when the member reaches their Annual Maximum. The carryover amount is in addition to the Annual Maximum.

PLEASE NOTE: Plan frequency and contract details apply. The carryover cannot be applied towards Orthodontia.

Covered Expenses

Covered expenses under the PPO Plan will be reimbursed based on the Maximum Allowable Charge (MAC) for all procedures — even if a member visits a non-participating provider.

For Plan A covered expenses are reimbursed using the usual and customary (U&C) allowance for each procedure as determined by Ameritas, the dental plan underwriter. The U&C is determined using the ZIP code of the provider. These expenses will be covered only for procedures done by a dentist or dental hygienist. These expenses are subject to the “Ineligible Expenses” list. If two or more procedures can be used as an appropriate treatment to correct a certain condition, the amount of the covered expense will be the charge for the least expensive procedure.

For Plan B, all covered dental services, not including Orthodontia, are reimbursed based on the schedule amount shown for procedures listed in your Plan certificate.

Expenses Incurred

An expense is incurred at the time the service is rendered or a supply is furnished, the impression is made for an appliance or change to an appliance, the tooth or teeth are prepared for a crown, bridge or gold restoration, or the pulp chamber is opened for root canal therapy.

The PPO Plan and Plan A Incentive Program

The Duke Dental Program offers a special “incentive program” to encourage participants to establish and continue an ongoing program of preventive care. During the first calendar year of enrollment in the PPO Plan or Plan A, all Type 2 procedures, subject to the application of the deductible, will be covered at 80% coinsurance of Plan allowance (Level 1). If you have at least one procedure performed within the first calendar year, the reimbursement level will be INCREASED to 90% coinsurance of Plan allowance in the second calendar year (Level 2). As long as you continue to visit the dentist each calendar year and have at least one procedure performed within the given calendar year, the reimbursement level will continue to increase to where in the third year of coverage, all Type 1 and Type 2 eligible covered expenses are reimbursed at 100% coinsurance of Plan allowance (Level 3). Should you fail to visit the dentist in any calendar year, fail to have at least one covered procedure performed within the given calendar year or fail to re-enroll, the reimbursement percentage for Type 2 procedures will return to 80% and the incentive program will begin again the following year.

Covered Procedures

Major categories are shown for each Plan option. See late entrant information under “Ineligible Expenses.”

Type 1 (Preventive) Procedures

No deductibles

- Oral Exams: Two treatments per calendar year.
- Prophylaxis (cleaning): Two treatments per calendar year.

- Fluoride Treatment: One treatment per year for children under age 19.
- X-rays: Entire denture series, panoramic survey (one in any three-year period), bitewing films (two treatments per calendar year).
- Pathology: Biopsy of oral tissue and histopathologic examination.
- Space Maintainers: Fixed and removable.

Type 2 (Basic) Procedures PPO Plan — No Deductible

Deductibles: Plan A — \$100 lifetime; Plan B — \$50 calendar year (Types 2 and 3, combined)

- Emergency Exams: Necessitated as the result of an accidental injury.
- Sealants: Limited to treatment of permanent molars only once in any 36-month period for children under 17.
- Oral Surgery: Extractions, impacted teeth, alveolar or gingival reconstruction, cysts, and neoplasms.
- General Anesthesia: Not available without a cutting procedure.
- Restorative Dentistry: Amalgam restorations, silicate restorations, resin restorations, recementations, full and partial denture repair.

Type 3 (Major) Procedures

Deductibles: PPO — \$50 calendar year (Types 3 and 4 combined); Plan A — \$75 calendar year (Types 3 and 4 combined); Plan B — \$50 calendar year (Types 2 and 3 combined)

Deductibles do not apply when Plan A and Plan B participants use a network provider.

- Restorative: In-lays, on-lays, and crowns.
- Prosthodontics — Fixed: Bridge abutments, pontics, and repair of crowns and bridges.
- Prosthodontics — Removable: Partial and complete upper and lower dentures, stress breaker, upper and lower stay-plate, addition of teeth to partial denture.

Type 4 Procedures

Deductibles: PPO — \$50 calendar year (Types 3 and 4 combined); Plan A — \$75 calendar year (Types 3 and 4 combined); Plan B — \$50 calendar year (Types 2 and 3 combined)

Deductibles do not apply when Plan A and Plan B participants use a network provider.

- Periodontics: Root planning, gingivectomy, sub-gingival curettage.
- Endodontics: Root canals.

Orthodontic Expense Benefits

Coverage will be paid for the length of the treatment indicated, not to exceed 24 months. See “Ineligible Expenses” #19, #20, and #21.

Orthodontic Treatment

Orthodontic treatment means the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

Treatment Program

Treatment program means an interdependent series of orthodontic services prescribed by a physician to correct a specific dental condition. A program will start when the active appliances are inserted. A program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

Expenses Incurred

An orthodontic expense is incurred:

- At the end of every quarter (three-month period) of treatment for a person who pursues an orthodontic program, but not beyond the date the treatment ends, or
- At the time the service is rendered for a person who incurs covered expenses but does not pursue a treatment program.

Benefit Calculation

Benefits will be payable when a covered expense is incurred. The covered expenses are based on the estimated cost of the patient's treatment program. Payments are prorated by quarter (three-month periods) over the estimated length of the program, but not for more than eight quarters, and multiplied by the orthodontic benefit percentage (50%). The last quarterly payment for a treatment may be changed if the estimated and actual cost of the treatment differs.

Coordination With Duke Reimbursement Accounts

It is recommended that you contact HealthEquity if you want to use both the Health Care Reimbursement Account and the Dental Program to cover the orthodontia expenses for a dependent child.

HealthEquity administers the Reimbursement Account Programs and can be reached at **877-924-3967**.

Ineligible Orthodontia Expenses

Covered expenses exclude and no benefits will be paid for expenses incurred:

- For a treatment program which began before the insured became covered for orthodontic expense benefits, or
- After the individual's insurance for orthodontic benefits terminates.

Sample Comparison of Plan Options

The hypothetical examples on the next page summarize the benefits you can expect to receive, depending on the Plan you choose.

The PPO Plan and Plan A provide a comprehensive benefit. The rates and benefits for Plan B have been designed to provide a quality, basic benefit. These options were chosen by Duke to give employees and dependents the choice of a benefit and/or price range that best suits their need.

In the following hypothetical examples, it is assumed that the deductible, if applicable, has been satisfied. The examples are for illustrative purposes only. Plan members should refer to the Plan Certificate for the current complete list of covered procedures.

Example 1

Joe visited the dentist to have a crown placed on his front tooth (ADA procedure code D2752). The dentist recommended a porcelain fused to noble metal crown. This procedure is considered a Type 3 (major) procedure. The dentist participates in the Ameritas network.

If Joe selected the PPO Option, his reimbursement from Ameritas would be calculated like this:

Dentist Normal Charge	\$1,150.00
Amount Allowed Under Plan (Contracted amount)	\$824.00
Coinsurance Level	50%
Amount Paid by Plan	\$412.00
Due Dentist	\$412.00

If Joe selected Plan A, his reimbursement from Ameritas would be calculated like this:

Dentist Normal Charge	\$1,150.00
Amount Allowed Under Plan (Based on U&C)	\$936.00
Coinsurance Level	50%
Amount Paid by Plan	\$468.50
Amount Due Dentist	\$682.50

If Joe selected Plan B, his reimbursement from Ameritas would be calculated like this:

Dentist Normal Charge	\$1,150.00
Amount Allowed Under Plan B	\$160.00 (Set Dollar Reimbursement)
Coinsurance Level	Set Dollar Reimbursement
Amount Paid by Plan	\$160.00
Amount Due Dentist	\$990.00

Example 2

Sue visited the dentist to have periodontal surgery (D4260). This procedure is considered a Type 4 (major) procedure. The dentist participates in the Ameritas network.

If Sue selected PPO Option, her reimbursement from Ameritas would be calculated like this:

Dentist Normal Charge	\$1,500.00
Amount Allowed Under Plan (Contracted amount)	\$781.00
Coinsurance Level	65%
Amount Paid by Plan	\$507.65
Amount Due Dentist	\$273.35

If Sue selected Plan A, her reimbursement from Ameritas would be calculated like this:

Dentist Normal Charge	\$1,700.00
Amount Allowed Under Plan (Based on U&C)	\$1,638.00
Coinsurance Level	65%
Amount Paid by Plan	\$1,064.70
Amount Due Dentist	\$635

If Sue selected Plan B, her reimbursement from Ameritas would be calculated like this:

Dentist Normal Charge	\$1,500.00
Amount Allowed Under Plan (Based on U&C)	\$263.25 (Set Dollar Reimbursement)
Coinsurance Level	Set Dollar Reimbursement
Amount Paid by Plan	\$263.25
Amount Due Dentist	\$1,236.75

Sample Procedures List for Plan A

The following is a sample list of dental procedures for which benefits are payable under Plan A. The amount that Ameritas pays per procedure is based on the usual and customary fees in the ZIP code area where the procedure is performed. (This sample applies to dentists located in areas where the ZIP code begins with 277 and may not reflect the fees charged in other areas.) All services are subject to the following coinsurance, deductible, and Plan provisions. These examples are for illustrative purposes only. Plan members should refer to the Plan Certificate for the current, complete list of covered procedures. Current Dental Terminology © American Dental Association.

Procedure Number	Procedure	Maximum Payment
D0120	Periodic oral evaluation	\$70.00
D1120	Prophylaxis — child (cleaning)	\$88.00
D1110	Prophylaxis — adult (cleaning)	\$116.00
D0330	Panoramic film	\$156.00
D0272	Bitewings — two films	\$64.00
D4910	Periodontal maintenance	\$161.00
D2140	Amalgam — one surface, primary or permanent	\$175.00
D2330	Resin-based composite — one surface, anterior	\$195.00
D3320	Root canal, bicuspid (excluding final restoration)	\$1,151.00
D7140	Extraction, erupted tooth or exposed root	\$186.00
D7210	Surgical removal of erupted tooth	\$370.00
D2751	Crown — porcelain fused to predominantly base metal	\$936.00
D5214	Mandibular partial denture	\$1,903.00
D0120	Periodic oral evaluation	\$70.00

Sample Procedures List for PPO Plan

ADA	Procedure	MAB
D120	Periodic oral evaluation — established patient	\$39.00
D272	Bitewings — two radiographic images	\$39.00
D1110	Prophylaxis — adult	\$79.00
D2140	Amalgam — one surface — primary or permanent	\$105.00
D2330	Resin-based composite — one surface, anterior	\$119.00
D2750	Crown — porcelain with gold	\$824.00
D2752	Crown — porcelain with semiprecious metal	\$824.00
D2792	Crown — semiprecious metal — full cast	\$864.00
D3330	Endodontic therapy, molar	\$941.00
D4341	Periodontal scaling and root planning — 4 or more teeth	\$176.00
D6240	Pontic — porcelain fused to high noble metal	\$829.00
D6242	Pontic — porcelain fused to noble metal	\$741.00
D6750	Crown — porcelain fused to high noble metal	\$857.00
D6752	Crown — porcelain fused to noble metal	\$766.00
D7140	Extraction, erupted tooth or exposed root	\$116.00

PLEASE NOTE: The scheduled amounts represent the Maximum Allowable Benefit (MAB) for providers within the Ameritas Managed Network.

*Allowances and out-of-pocket expenses may vary for provider panels leased by Ameritas. Fees are effective January 1, 2023 and may be subject to change.

Sample Procedure Lists for Plan B

The following is a sample list of dental procedures for which benefits are payable under Plan B. Any dollar amount is a maximum covered expense. Please read the section “Ineligible Expenses” for additional coverage information. Please refer to your Certificate for the current, complete list of covered procedures.

Current Dental Terminology © American Dental Association.

Type 1 (Preventive) Procedures

Procedure Number	Procedure	Maximum Payment
D0120	Periodic oral evaluation	\$18.18
D1120	Prophylaxis — child	\$30.30
D1110	Prophylaxis — adult (age 14 and over)	\$42.42
D0330	Panoramic film	\$54.54
D0272	Bitewings — two films	\$18.18

Type 2 (Basic) Procedures

Procedure Number	Procedure	Maximum Payment
D4910	Periodontal maintenance	\$62.40
D2140	Amalgam — one surface, primary or permanent	\$23.40
D2330	Resin-based composite — one surface, anterior	\$25.35
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$23.40
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$35.10
D3320	Root canal. Bicuspid (excluding final restoration)	\$195.00

Type 3 (Major) Procedures

Procedure Number	Procedure	Maximum Payment
D2751	Crown — porcelain fused to predominantly base metal	\$160.00
D5214	Mandibular partial denture — cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$224.00

Ineligible Expenses

Covered expenses exclude and no benefits will be paid for expenses incurred:

- 1) By late entrants, during the first twelve months the insured is covered, except for exams (excluding x-rays), cleanings, and fluoride applications. A late entrant is every person:
 - a) who did not enroll within 30 days from the date of employment or within 30 days from the date the person qualified for insurance; or
 - b) who has elected to become insured again after terminating coverage.
- 2) For any treatment which is for cosmetic purposes. Facings on crowns or pontics are considered cosmetic.
- 3) To replace any crown, bridge, onlay, partial denture, or full denture which was originally placed fewer than five years ago, regardless of whatever the original prosthetic was covered under the Plan. However, if the replacement is due to an accidental injury sustained while covered under this Plan, it will be a covered expense.
- 4) For any bridge, partial denture, or complete denture needed because of an extraction of a natural tooth that occurred while the person was not insured under this Plan. For the appliance or bridge to be eligible for coverage, the tooth must be extracted while the person is insured under this coverage and must include the replacement of the extracted tooth or teeth. The extraction of wisdom teeth (third molars) does not qualify for replacement.
- 5) For any procedure begun before a person becomes insured.

- 6) For any procedure begun after a person's insurance terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after a person's insurance terminates.
- 7) To replace lost or stolen appliances.
- 8) For appliances, restorations, or procedures to alter vertical dimension, restore or maintain occlusion, splint or replace tooth structure lost as a result of abrasion or attrition.
- 9) For any procedure which is not shown on the Table of Dental Procedures in your Certificate of Insurance.
- 10) For education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene, or dental plaque control.
- 11) For the completion of claim forms.
- 12) For sealants which are:
 - a) not applied to a permanent molar,
 - b) applied after attaining age 17, or
 - c) reapplied to a molar within three years from the date of a previous sealant application.
- 13) Subgingival curettage or root planing unless the presence of periodontal disease is confirmed by both x rays and pocket depth summaries of each tooth involved.
- 14) Because of an injury or sickness arising out of, or in the course or, work for wage or profit or that is eligible for benefits under any Workers' Compensation act or similar law.
- 15) For charges for which a person is not liable or which would have not been made had no insurance been in force.
- 16) For services which are not recommended by a dentist or which are not required for necessary care and treatment.
- 17) Because of war or any act of war, declared or not.
- 18) By a person if payment is not legal where the person is living when expenses are incurred.
- 19) For a treatment program which began before the insured became covered for orthodontic expense benefits.
- 20) After the individual's insurance for orthodontic benefits terminates.
- 21) For operating rooms and other facility charges.
- 22) For general anesthesia, unless administered in a dental office and in conjunction with a cutting procedure.

Coordination of Benefits

If you or any of your dependents incur charges which are covered by any other group plan, the benefits of this Plan will be coordinated with the benefits of the other plan so that the total benefits received are not greater than the charges incurred.

If you are covered by the Group Dental Insurance Program at the time you leave Duke, you may continue coverage under the following circumstances:

- Upon retirement from Duke after satisfying the retiree dental eligibility criteria, which is described in the Duke Retirement Planning Guide,
- If you become totally disabled and are receiving benefits from Duke under the Duke Disability Program,
- Upon termination or change in eligibility, you may continue coverage under COBRA for you and your covered dependents.

Estimate of Payment

If your dentist thinks charges for the proposed work will be \$200 or more, you and your dentist can complete a claim form for pre-statement of benefits. Your dentist shows the work to be done and what the charges will be. The claim form is then sent to Ameritas. Ameritas will estimate your benefits and send a report to your dentist.

How To File a Claim

Claims Procedure

Ameritas provides each employee with a Certificate of Insurance explaining the Plan benefits and limitations in complete detail. For claim forms or answers to your questions, call toll-free, **800-487-5553**.

Follow the steps below to file a claim:

- 1) Upon enrollment, a claim form is included with your Certificate of Insurance. Additional claim forms can be obtained from the Human Resources Information Center (HRIC), Ameritas, or the Duke website: hr.duke.edu/forms
- 2) Take the claim form with you to the dentist performing your service.
- 3) You complete Part 1 of the claim form. Part 1 is information about you and your employer and allows you to have benefits paid directly to your dentist.
- 4) Your dentist completes Part 2. Part 2 identifies the services that were performed and certifies that the dentist performed the services.
- 5) You or your dentist can send the claim form to:

Ameritas Life Insurance Corp.
Group Dental Claims
P.O. Box 82520
Lincoln, NE 68501-2520

All claims must be submitted within 180 days of the date of service. Ameritas will evaluate your claim promptly after they receive it. Within 30 days after they receive your claim, they will send you: (a) a written decision on your claim; or (b) a notice that they are extending the period to decide your claim for an additional 15 days. If the extension is due to your failure to provide information necessary to decide the claim, the extended time period for deciding your claim will not begin until you provide the information or otherwise respond.

If Ameritas extends the period to decide your claim, they will notify you of the following: (a) the reasons for the extension; (b) when they expect to decide your claim; and (c) any additional information needed to decide the claim.

If they request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, they may decide your claim based on the information received.

If they deny any part of your claim, you will receive a written notice of the denial containing:

- The reasons for the decision;
- Reference to any part of the Duke Group Dental Insurance policy on which their decision is based;
- Reference to any internal rule or guideline relied upon in making the decision, along with your right to receive a copy of these guidelines, free of charge, upon request;
- A statement that you may request an explanation of the scientific or clinical judgment relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of dental practice;
- A description of any additional information needed to support your claim;
- Information concerning your right to a review of the decision; and
- Information concerning your right to bring a civil action for benefits under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) if your claim is denied on review.

Claims Review Procedure

Ameritas Life Insurance Corp. reviews all claims and appeals filed under the Plan. This means that Ameritas has the discretionary authority to make all initial determinations with respect to claims filed under the Plan and to decide all appeals of any denied claims. Duke has no discretionary authority with respect to reviewing dental claims and appeals.

If all or part of a claim is denied, you may request a review. You may send Ameritas written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your request for review. There will be no charge for such copies. You may request the names of the experts they have consulted who provided advice to us about your claim.

The person conducting the grievance review will be someone other than the person who denied the claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. The Ameritas review will include any written comments or other items you submit to support your claim.

Ameritas will review your claim promptly after they receive your request. Within at least 60 days after they receive your request for review, they will send you a written decision on review.

If they deny any part of your claim on review, you will receive a written notice of denial containing:

- The reasons for the decision;
- Reference to the parts of the Duke Dental Group Insurance policy on which the decision is based;
- Reference to any internal rule or guideline relied upon in making the decision along with your right to receive a copy of these guidelines, free of charge, upon request;

- Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim;
- A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of dental practice; and
- Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

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

With respect to all claims or issues not subject to the claims procedures described for the Plan, such as your right as an eligible employee or dependent to apply for coverage under the Plan, you may make a claim by filing a written claim and proof of claim with the Plan Administrator in accordance with procedures and guidelines established from time to time by the Staff Fringe Benefits Committee (the Committee). The Plan Administrator will decide whether the claim will be allowed. Send your claim to:

**Dental Plan Administrator
Duke Benefits
705 Broad St.
Box 90502
Durham, NC 27708**

Within 90 days after receipt of a proof of claim by the Plan Administrator, as appropriate, or within 180 days if special circumstances require an extension of time, you will be notified of the decision with regard to your claim. In the event of special circumstances requiring an extension of time, written notice of the extension will be furnished to you prior to expiration of the 90-day period, setting forth the special circumstances and the date the decision will be furnished. If the claim is wholly or partially denied, notice thereof will be in writing and worded in a manner for you to understand. Such notice will set forth:

The specific reason(s) for the denial,

- Specific reference to pertinent Plan provisions on which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
- An explanation of the procedure for review of the denied claim.

If you are not notified of the decision concerning your claim in a timely manner, the claim will be deemed denied as of the close of the initial 90-day period (or the close of the extension period, if applicable). If you wish to appeal the denial, follow the instructions below.

Claims Review Procedure

Within 60 days following your receipt of notice from the Plan Administrator denying the claim in whole or in part or, if such notice is not given, within 60 days following the latest date on which such notice could have been timely given, you may appeal the denial of the claim by filing a written application for review with the Committee.

Send your appeals to:

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

Following such request for review, your appeal of the decision denying your claim will be fully and fairly reviewed. Prior to reaching a decision concerning your appeal, you will be given an opportunity to review pertinent documents and submit issues and comments in writing.

The decision on review of a claim denied in whole or in part will be made within 60 days following receipt of the request for review, or within 120 days if special circumstances require an extension of time, and you will be notified in writing of the decision. If special circumstances require an extension of time, written notice of the extension will be furnished to you prior to commencement of the extension. If the decision on review is not furnished in a timely manner, your claim will be deemed denied as of the close of the initial 60-day period, or the close of the extension period, if applicable.

If a claim is denied in whole or in part, the decision on review will set forth specific reasons for the decision written in a manner for you to understand, and will cite pertinent Plan provisions on which the decision is based. The decision on review of your claim by the Committee will be final and conclusive.

Any action required to be taken by you during the claims procedure or claims review procedure may be taken by a representative acting on your behalf. You may be required to provide evidence to verify the authority of any such representative to act on your behalf. Neither you nor your representative has the right to be present during the consideration of any appeal from the initial denial of your claim.

Authority of the Committee and the Plan Administrator

Both the Committee and the Plan Administrator have the duty and discretionary authority to interpret and construe the eligibility provisions of the Plan, subject to the objective terms of the Plan. Interpretations and determinations made by the Committee and the Plan Administrator will be applied uniformly to all persons similarly situated and will be binding and conclusive upon each eligible employee and dependent who is covered under the Plan and any other interested person. Such interpretations and determinations made by the Committee and the Plan Administrator will only be overruled by a court of law if the Committee and the Plan Administrator are found to have acted arbitrarily and capriciously in interpreting and construing the provisions of the Plan.

Other Information

See the "General Information" section of this booklet for:

- A summary of your rights under the Employee Retirement Income Security Act of 1974 (ERISA);
- Information about COBRA continuation coverage; and
- Administrative and other general information about this Plan.

It is intended that the Duke Dental Program qualify as "accident and health plans" and as "self-insured medical expense reimbursement plans" under the federal tax laws. This Benefit Program Description, which is a part of the Duke University Welfare and Fringe Benefit Plan along with the applicable Member Guides, shall constitute

the written Plan document for the Duke Dental Program. It is further intended that benefits payable under the Duke Dental Program be eligible for exclusion from gross income.

Duke reserves the right to amend or terminate these benefits or your eligibility for benefits (including an amendment to reduce benefits or eliminate benefits or any changes to the premium or contribution rates) for all participants or for a specific class of participants, including current or former employees, under the Duke Dental Program. The written Plan documents for the Duke Dental Program are not employment contracts or any type of employment guarantee.

DUKE VISION INSURANCE PROGRAM

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DUKE VISION INSURANCE PROGRAM

Introduction

The coverage for the Duke Vision Insurance Program is provided and underwritten by UnitedHealthcare Vision. While Duke's health plans provide coverage for annual eye exams, Duke offers a nationwide vision care plan to manage the cost of eyeglasses and contact lenses, as well as eye examinations. The vision care plan provides coverage for prescription lenses and frames, contact lenses (in lieu of eyeglasses), and a complete annual exam.

Under the plan, you can visit an optometrist or ophthalmologist within the UnitedHealthcare Vision network or you may choose to visit an out-of-network provider, which may result in higher out-of-pocket costs. If you have questions about the vision care plan or would like to find a network provider, you may visit myuhcvision.com or call **800-638-3120**.

The term "Duke" is used throughout this booklet. "Duke" refers to the University, Duke University Health System, Inc. and any other corporation or entity that adopts the Plan with the duly authorized approval of the Board of Trustees. When used in this Plan document, "Employer" shall refer to all of the foregoing collectively except where the context requires that such term refer to the corporation or entity that actually employs an individual.

The benefit program provided is based on an employee's company code and job code as reflected in the HR benefits administration system (SAP). Duke employees holding more than one position classification receive the benefits associated with their primary position classification as reflected in SAP. For example, a housestaff member who also works within DHIP, receives benefits associated with their housestaff position classification.

The word "spouse" is used in this benefit program's summary plan description. This means legal spouse. In addition, it refers to an employee's registered Same Sex Spousal Equivalent providing the employee was hired prior to January 1, 2016 and registered his/her partner with Duke HR prior to January 1, 2016. This employee's registered partner remains eligible under Duke's Same Sex Spousal Equivalent Policy and is included in the meaning of "spouse" for the purpose of this benefit program wherever permissible under federal and state law. The eligible status continues for the course of this relationship only.

Eligibility and Enrollment

You are eligible for vision coverage if you are a:

- Faculty employee holding a regular rank appointment who is receiving wages for Social Security purposes.
- Faculty employee holding other than a regular rank appointment and classified as a full-time or part-time member of the faculty scheduled to work at least 20 hours per week, who is receiving wages for Social Security purposes.
- Regular employee or Housestaff scheduled to work at least 20 hours per week.
- Postdoctoral scholar previously eligible for coverage.
- Employees at a \$0 rate of pay or scheduled too few weeks per year (Example: where weeks scheduled per year multiplied by hours scheduled is below 1,000) are generally not in a payroll / benefits eligible classification.

Employees on an approved Workers' Compensation leave and receiving wage replacement are eligible to continue their vision coverage while on leave. It is the employee's responsibility to contact the HRIC at **919-684-5600** to arrange for premium payment when on an approved leave of absence.

Eligible Dependents

The following dependents are eligible for enrollment in the Duke Vision Program:

- Your spouse;
- Your dependent child up to age 26 ("child" includes biological children, foster and legally adopted children, children placed for adoption with the employee, stepchildren, children for whom the employee has been ordered by a court or administrative agency to provide health benefits under the Plan, and, if the employee has a Registered Same Sex Spousal Equivalent who is enrolled in the Plan as an eligible dependent of the employee, the children of the employee's registered Same Sex Spousal Equivalent), who are under 26 years of age, and;
- Your children who are mentally or physically disabled and incapable of self-support after age 26, as long as:
 - Their disability began before they turned age 26;
 - They had continuous coverage under the Duke Vision Plan prior to age 26; and
 - A disabled dependent form is submitted to and approved by the Vision Plan prior to their 26th birthday.

Collective Bargaining Agreements

Group vision insurance benefits are a subject of good faith bargaining between Duke and certain employee representatives. The plan is maintained pursuant to certain collective bargaining agreements. The agreements are available for your inspection in the Staff and Labor Relations Department of Duke's Human Resources, **705 Broad Street, Durham, NC 27705**.

Enrolling

You have 30 days after the date of employment to enroll in the Group Vision Insurance Program.

If you do not enroll when you are first eligible (within 30 days after your date of employment or eligibility), you can enroll during the annual open enrollment period.

There are several types of coverage in which you may enroll:

- Employee Only Coverage (Individual)
- Employee and Spouse
- Employee and Child
- Employee and Children
- Family

A person who is enrolled in the Plan as an employee cannot also enroll as the dependent of another employee. A person who is enrolled in the Plan as the dependent of one employee cannot also enroll as the dependent of another employee.

PLEASE NOTE: Once you enroll in a particular type of coverage, you cannot stop or change your election until the next annual open enrollment period, unless you experience a qualifying event. Qualifying events include, but are not limited to, birth, marriage, divorce, death of a spouse or child, or termination of employment.

Effective Date of Coverage

New employees of Duke University and Duke University Health System are eligible for coverage effective on the first of the month following your employment / eligibility date.

When Coverage Ends

Member Terminations

Your membership in the Plan, and coverage under the Plan, may be terminated and written notice will be provided for any of the following reasons:

- Fraud or misrepresentation. This includes but is not limited to fraudulent statements or material misrepresentations of fact made on your enrollment application, including enrollment of ineligible dependents;
- Fraudulent use of services or facilities;
- Misuse of your coverage. This includes but is not limited to allowing someone else to use your Plan coverage eligibility; or
- Nonpayment of your contribution toward coverage under the Plan.

The Plan is entitled to recover all expenses it incurs (including the reasonable value of services received, reasonable attorney's fees and any incidental expenses) because of fraud, misuse or misrepresentation from the member who committed such fraud, misuse, or misrepresentation.

Termination of Coverage

Members may not terminate coverage under the Plan except during the annual open enrollment period or within 30 days of a valid change in family status.

Subject to your continuation rights under COBRA, your Plan coverage will terminate if you lose your eligibility to be a member, or if the employee through whom you are enrolled in the Plan loses their Plan coverage. If you cease to be eligible to participate in the Plan because of an amendment to the Plan by Duke University, your coverage will terminate the date the amendment to the Plan takes effect.

Coverage for all the members enrolled through an employee who loses their eligibility because of a Plan amendment will terminate the date the amendment takes effect. Coverage for all Plan members will terminate as of the date Duke terminates the Plan.

Cost of the Plan

Eligible employees covered under the Plan pay the entire premium for their benefits under the plan in such amounts as determined solely by the insurance company, UnitedHealthcare Vision. Premium payments are required to be paid on a before-tax basis through the Duke University Premium Conversion and Flexible Reimbursement Accounts Plan.

How the Vision Program Works

In-network, covered-in-full benefits (after applicable copay) include a comprehensive exam, eye glasses with standard single vision, lined bifocal, or lined trifocal lenses, standard scratch-resistant coating and the frame, or contact lenses in lieu of eyeglasses.

Vision Care Plan Chart (Eyeglass Frames and Lenses)

Benefits	Network Benefits	Out-of-Network Reimbursements
Vision Exam (once per calendar year) ¹	\$20 copay	Up to \$40
Materials Copay ²	\$20 copay	Not applicable
Frames (once every two calendar years) ¹	Up to \$150 allowance towards the purchase of frames	Up to \$45
Eyeglass Lenses per pair (once per calendar year) ¹	Single Vision, covered in full Lined Bifocal, covered in full Lined Trifocal, covered in full Lenticular, covered in full	Single Vision, up to \$40 Lined Bifocal, up to \$60 Lined Trifocal, up to \$80 Lenticular, up to \$80
Lens Options	Photochromic Lenses, covered in full Tints, Covered in full Standard Anti-Reflective Coating, covered in full Standard Scratch-resistant Coating, covered in full Ultraviolet Coating, covered in full Standard Progressive Lenses, covered in full Deluxe Progressive Lenses, covered in full Premium Progressive Lenses, covered in full Platinum Progressive Lenses, covered in full Polycarbonate Lenses for Adults, covered in full Polycarbonate Lenses for Dependent Children (up to age 19), covered in full	Not covered

¹ Usage during prior periods of employment during the same calendar year count towards the 12-month / 24-month period.

² Materials copay is a single payment that applies to the purchase of eyeglass lenses and frames or contact lenses (in lieu of eyeglasses). All contact lenses must be purchased at one time.

Vision Care Plan Chart (Contact Lenses)

Benefits	Network Benefits	Out-of-Network Reimbursements
Elective Contact Lenses ¹ in lieu of eyeglasses (once every calendar year) ²	Covered in full after copay (up to 6 boxes) including evaluation, fitting, and up to two follow-up visits	Up to \$150
Additional Elective Contacts Options	Up to \$150 towards the purchase of contacts (materials copay does not apply); does not include fitting fee	Up to \$150
Medically Necessary ³	Covered in full after applicable copay	Up to \$210

¹ Benefit covers up to 6 boxes (which must be purchased at the same time in order to receive the full \$150 in-network allowance. There is only one annual service authorization for this benefit.)

² Usage during prior periods of employment during the same calendar year count towards the 12-month / 24-month benefit period.

³ Determined at the provider's discretion for one or more of the following conditions: following post cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming how much of a reimbursement you can expect to receive before you purchase such contacts.

Accessing and Using Your Benefits

UnitedHealthcare Vision does not send out identification cards to enrolled members. However, you may print a personalized ID card by completing the Member Login information at myuhcvision.com and selecting 'Print ID card' from the member benefits page. The steps listed below will help you access your vision benefits.

Step 1: Review Your Customized Benefits

A summary of the benefits offered under the vision care plan are available in the Vision Care Plan Chart located above.

Step 2: Find a Conveniently Located Provider

You may locate a UnitedHealthcare Vision network provider by logging on to myuhcvision.com or by calling their 24-hour, toll-free provider locator service at **800-839-3242**. You may also choose to use an out-of-network provider and still receive benefits under the plan. Details about submitting an out-of-network claim are located under "How To File a Claim."

Additionally, you may contact UnitedHealthcare Vision customer service at **800-638-3120**.

Step 3: Schedule Your Appointment

Always identify yourself as a UnitedHealthcare Vision participant when making an appointment with a UnitedHealthcare Vision provider. This will assist your provider in obtaining a claim authorization number before your visit. Provide the primary insured's Duke Unique ID (plus leading zeroes for a total of a nine digit number located on the back of your Duke ID card) and patient's name and date of birth.

Step 4: Receive Your Eye Exam

The network provider, a state-licensed optometrist or ophthalmologist, will perform a complete eye examination which includes a case history of the patient and an examination for eye disease and vision impairment. Should vision correction be required, your provider will determine your specific prescription for glasses or contacts. Should a disease or eye disorder be found, you may be referred to your health plan for medical eye coverage.

PLEASE NOTE: If you wish to use an out-of-network provider for your eye exam, you may take your prescription to a UnitedHealthcare Vision network provider for your glasses or contact lenses.

If you are enrolled in one of Duke's health plans, you can continue to receive coverage for an annual eye exam with the health plan's copay. UnitedHealthcare Vision will reimburse you for your health plan's vision examination copay if you visit a provider outside of UnitedHealthcare Vision's network.

Details about submitting an out-of-network claim are located under "How To File a Claim."

The Duke Eye Center does not participate in the UnitedHealthcare Vision network. An exam is covered under all of the Duke Health Plans, and the copay cost filed with UnitedHealthcare Vision.

Step 5: Your Eyewear

If prescription eyewear is necessary, your UnitedHealthcare Vision provider will assist with your selection and order your prescription. Your UnitedHealthcare Vision provider will telephone you when your eyewear arrives. Eyewear is dispensed at the provider's office to ensure optical accuracy and proper fit.

Ineligible Expenses

The following services and materials are excluded from coverage under the vision care plan:

- Post cataract lenses
- Non-prescription items
- Medical or surgical treatment for eye disease that requires the services of a physician
- Workers' Compensation services or materials
- Services or materials that the patient, without cost, obtains from any governmental organization or program
- Services or materials that are not specifically covered by the policy
- Replacement or repair of lenses and/or frames that have been lost or broken
- Cosmetic extras, except as stated in the policy

Continuation of Benefits

If you are covered by the Group Vision Insurance Program at the time you leave Duke, you may continue coverage under the following circumstance:

- Upon termination or change in eligibility, you may continue coverage under COBRA for you and your covered dependents.

Your benefit and eligibility for coverage in this plan will be immediately terminated if you provide fraudulent or misrepresented information. This includes, but is not limited to, fraudulent statements or material misrepresentation of facts. Your benefit and eligibility for the Vision Plan will be terminated and also your

benefits and eligibility for coverage in other Duke-sponsored benefit plans including, but not limited to, Health Care Plans, Retiree Health Care Plans, Dental Plans, Reimbursement Account Programs, Life Insurance Plans (including Gratuity to Spouse / Estate Plan), Children's Tuition Grant Plan, Employee Tuition Assistance Plan and Disability Plans. Employment with Duke may also be terminated for providing fraudulent or misrepresented information.

How To File a Claim

Out-of-Network Claims Procedure

If you choose an out-of-network provider, you must submit the following information:

- The original itemized paid receipt
- Primary insured's name and Duke Unique ID number (plus leading zeroes for a total of a nine-digit number located on the back of your Duke ID card)
- Patient's name and date of birth
- Complete home address

Out-of-network claims should be sent to:

UnitedHealthcare Vision Claims Department
P.O. Box 30978
Salt Lake City, Utah 84130

PLEASE NOTE: Receipts for services and materials purchased on different dates must be submitted together to receive reimbursement. Claims must be submitted within 12 months of the date of service to be eligible for reimbursement.

Claims Review Procedure

Since network providers must receive preauthorization to perform services prior to the scheduled appointment, denied claims rarely occur. However, if a submitted claim is denied, and if the member wishes to appeal, the appeal must be submitted in writing, within 60 days of the date of the Explanation of Benefits, to:

UnitedHealthcare Vision Claims Department
P.O. Box 30978
Salt Lake City, Utah 84130
Attention: Claims Appeals

If the member decides to appeal, they have the right to review any pertinent information, and then submit issues and comments in writing. The claim will then be reconsidered, and the member will receive written notice of the determination within 60 days. If the claim is again denied, in whole or in part, the member will receive a written explanation of the denial and the program, or contract provision, on which the denial is based. All levels of UnitedHealthcare Vision's appeals process are ERISA compliant and follow the Department of Labor laws regarding ERISA appeal and grievance information. UnitedHealthcare Vision 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 claims or issues not subject to the claims procedures described for the plan, such as your right as an eligible employee or dependent to apply for coverage under the plan, you may make a claim by filing a written claim and proof of claim with the Plan Administrator in accordance with procedures and guidelines established from time to time by the Staff Fringe Benefits Committee (the Committee). The Plan Administrator will decide whether the claim will be allowed. Send your claim to:

**Vision Plan Administrator
Duke Benefits
705 Broad St.
Box 90502
Durham, NC 27708**

Within 90 days after receipt of proof of claim by the Plan Administrator, as appropriate, or within 180 days if special circumstances require an extension of time, you will be notified of the decision with regard to your claim. In the event of special circumstances requiring an extension of time, written notice of the extension will be furnished to you prior to expiration of the 90-day period, setting forth the special circumstances and the date the decision will be furnished. If the claim is wholly or partially denied, notice thereof will be in writing and worded in a manner for you to understand. Such notice will set forth:

- The specific reason(s) for the denial,
- Specific reference to pertinent plan provisions on which the denial is based,
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, and

An explanation of the procedure for review of the denied claim.

If you are not notified of the decision concerning your claim in a timely manner, the claim will be deemed denied as of the close of the initial 90-day period (or the close of the extension period, if applicable). If you wish to appeal the denial, follow the instructions below.

Claims Review Procedure

Within 60 days following your receipt of notice from the Plan Administrator denying the claim in whole or in part or, if such notice is not given, within 60 days following the latest date on which such notice could have been timely given, you may appeal the denial of the claim by filing a written application for review with the Committee.

Send your appeals to:

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

Following such request for review, your appeal of the decision denying your claim will be fully and fairly reviewed. Prior to reaching a decision concerning your appeal, you will be given an opportunity to review pertinent documents and submit issues and comments in writing.

The decision on review of a claim denied in whole or in part will be made within 60 days following receipt of the request for review, or within 120 days if special circumstances require an extension of time, and you will be notified in writing of the decision. If special circumstances require an extension of time, written notice of the extension will be furnished to you prior to commencement of the extension. If the decision on review is not furnished in a timely manner, your claim will be deemed denied as of the close of the initial 60-day period, or the close of the extension period, if applicable.

If a claim is denied in whole or in part, the decision on review will set forth specific reasons for the decision written in a manner for you to understand and will cite pertinent plan provisions on which the decision is based. The decision on review of your claim by the Committee will be final and conclusive.

Any action required to be taken by you during the claims procedure or claims review procedure may be taken by a representative acting on your behalf. You may be required to provide evidence to verify the authority of any such representative to act on your behalf. Neither you nor your representative has the right to be present during the consideration of any appeal from the initial denial of your claim.

Authority of the Committee and the Plan Administrator

Both the Committee and the Plan Administrator have the duty and discretionary authority to interpret and construe the eligibility provisions of the plan, subject to the objective terms of the plan. Interpretations and determinations made by the Committee and the Plan Administrator will be applied uniformly to all persons similarly situated and will be binding and conclusive upon each eligible employee and dependent who is covered under the plan and any other interested person. Such interpretations and determinations made by the Committee and the Plan Administrator will only be overruled by a court of law if the Committee and the Plan Administrator are found to have acted arbitrarily and capriciously in interpreting and construing the provisions of the plan.

Other Information

See the “General Information” section of this booklet for:

- A summary of your rights under the Employee Retirement Income Security Act of 1974 (ERISA);
- Information about COBRA continuation coverage; and
- Administrative and other general information about this plan.

It is intended that the Duke Vision Program qualify as an “accident and health plan” under federal tax laws. This Benefit Program Description, which is a part of the Duke University Welfare and Fringe Benefit Plan along with the underlying insurance contracts, shall constitute the written plan document for the Duke Vision Program. It is further intended that benefits payable under the Duke Vision Program be eligible for exclusion from gross income. Duke reserves the right to change or terminate these benefits or your eligibility for benefits under the Duke Vision Program. The written plan documents for the Duke Vision Program are not employment contracts or any type of employment guarantee.

DUKE REIMBURSEMENT ACCOUNT PROGRAMS

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DUKE REIMBURSEMENT ACCOUNT PROGRAMS

Introduction

To help you pay for your health care and dependent care expenses, Duke offers Health Care and Dependent Care Reimbursement Accounts. You can participate in either or both accounts. The accounts allow you to set aside some of your pay on a pre-tax basis to pay for eligible medical, dental, vision, and dependent care bills. You make contributions to your reimbursement accounts through convenient payroll deductions each pay period. And, because you do not pay taxes on the amount you contribute, your federal and state income taxes may be reduced.

Your contributions are taken out of your paycheck automatically. As you have eligible health care expenses, you use your reimbursement debit card and you fill out a claim for your dependent care, attach the appropriate documentation (receipt, taxpayer identification number, etc.) and send the claim to HealthEquity, the benefits claims processor. The money will be deducted from your accounts and paid to you each time you submit a request for reimbursement.

The term "Duke" is used throughout this booklet. "Duke" refers to the University, Duke University Health System, Inc. and any other corporation or entity that adopts the Plan with the duly authorized approval of the Board of Trustees. When used in this Plan document, "Employer" shall refer to all of the foregoing collectively except where the context requires that such term refer to the corporation or entity that actually employs an individual.

The benefit program provided is based on an employee's company code and job code as reflected in the HR benefits administration system (SAP). Duke employees holding more than one position classification receive the benefits associated with their primary position classification as reflected in SAP. For example, a housestaff member who also works within DHIP, receives benefits associated with their housestaff position classification.

Eligibility and Enrollment

Eligibility

You are eligible to participate in the reimbursement accounts if:

- You are a faculty employee holding a regular rank appointment who is receiving wages for Social Security purposes;
- You are a faculty employee holding other than a regular rank appointment and classified as a full-time or part-time member of the faculty scheduled to work at least 20 hours per week, who is receiving wages for Social Security purposes;
- You are a regular employee or housestaff scheduled to work at least 20 hours per week;
- You are in a bargaining unit that has agreed to allow its members to participate; and
- Neither you nor your spouse are contributing to, or receiving contributions to, a Health Savings Account (HSA).
- Employees at a \$0 rate of pay or scheduled too few weeks per year (Example: where weeks scheduled per year multiplied by hours scheduled is below 1,000) are generally not in a payroll / benefits eligible classification.

Employees on an approved Workers' Compensation leave and wage replacements are not eligible to enroll in or continue enrollment in the reimbursement accounts.

Your benefit and eligibility for coverage in this plan will be immediately terminated if you provide fraudulent or misrepresented information. This includes, but is not limited to, fraudulent statements or material misrepresentation of facts. Your benefit and eligibility for the Reimbursement Account Program will be terminated and your benefits and eligibility for coverage in other Duke-sponsored benefit plans including, but not limited to, Health Care Plans, Retiree Health Care Plans, Dental Plans, Vision Plan, Life Insurance Plans (including Gratuity to Spouse / Estate Plan), Children's Tuition Grant Plan, Employee Tuition Assistance Plan, and Disability Plans. Employment with Duke may also be terminated for providing fraudulent or misrepresented information.

When Participation Begins

You are eligible effective the first of the month following your date of hire/eligibility with Duke or date of qualifying life event. Otherwise, your effective date is January 1 if you enroll during open enrollment.

Enrolling

You can elect to participate in one or both reimbursement accounts. You will be offered the opportunity to enroll each year during open enrollment. Contribution elections will not carry over from one year to the next.

What Happens After you Enroll?

After you enroll, recordkeeping account(s) will be established in your name. The account will be credited each pay period with the contribution you elect, beginning with the first paycheck of your participation.

PLEASE NOTE: If your monthly or biweekly paycheck is not sufficient for your full reimbursement account deduction to be taken, no amount will be deducted for your reimbursement account. Partial deductions are not taken for reimbursement accounts.

New Hires

You may enroll in one or both reimbursement accounts. No election is required if you choose not to participate. Your participation in the accounts is not retroactive.

If you do not enroll within 30 days after your date of hire, you will not be able to contribute to the reimbursement accounts for the rest of that plan year unless you have a qualified change in status, as described in “Changing Your Benefit Election.” However, at the next open enrollment, you will be able to elect to contribute to one or both accounts effective the next plan year.

Open Enrollment

You can enroll in one or both reimbursement accounts each year during open enrollment.

Participation becomes effective January 1 of the next plan year. To continue your participation, you must re-enroll every year.

Changing Your Benefit Election

Your benefit elections become effective January 1 and continue through December 31. Federal law strictly limits the circumstances under which you may make election changes outside the open enrollment period.

You may make certain election changes for the current year if you have a qualifying event (see below) and the requested change is consistent with the event. You must notify the Human Resources Information Center (HRIC) at **919-684-5600** of an event within 30 days.

Qualifying events include:

- Your marriage, divorce, or annulment;
- A change in the number of your dependents, due to birth or adoption (or placement for adoption) of a child, or death of a spouse or child;
- A change in your, your spouse’s, or your dependent’s employment status that affects eligibility for coverage (including termination or commencement of employment, reduction or increase in hours of employment, or start of or return from an unpaid leave of absence);
- Your dependent’s commencement or cessation of eligibility for coverage under the plan, for example, because he or she turns age 26;
- Your (or your spouse’s or dependent’s) change in health coverage eligibility due to a relocation of residence or workplace;
- Death of a spouse or dependent; and
- Change in rates charged by your day care provider (allows you to change your Dependent Care Reimbursement Account election only).

If you have a qualifying status change, you may increase or decrease your reimbursement account contributions, but only if the change is consistent with the status change. For example, if you adopt a child, you may increase (not decrease) your contributions to the Health Care Reimbursement Account and/or the Dependent Care Reimbursement Account. Additionally, if you adopt a second child and your spouse decides to stay home, you could decrease (not increase) your contributions to the Dependent Care Reimbursement Account, and increase (not decrease) your contributions to the Health Care Reimbursement Account.

As a reminder, beginning a leave of absence (whether paid or unpaid) is considered a family status change. Since the IRS does not allow reimbursement for day care expenses while you are not working, you should consider stopping your Dependent Care Reimbursement Account deductions if you are not working during your leave.

Employees on approved leave of absence are eligible to continue contributions to the Health Care Reimbursement Account while on leave. If this applies to you, contact the HRIC for details. If you do not make contributions to the Health Care Reimbursement Account while on leave, expenses you incur during your leave are not eligible for reimbursement.

You must report a change in status by calling the HRIC at **919-684-5600** and providing documentation within 30 days of the event. Otherwise, you'll have to wait until the next open enrollment to make changes effective for the beginning of the next plan year. You will need to provide documentation such as a birth, marriage, or death certificate, or a divorce decree.

When Participation Ends

Your participation in the reimbursement accounts ends on December 31 of each plan year. To continue your participation in the accounts, you must re-enroll each year during the annual open enrollment period.

Your participation also will end on the date any of the following events occurs:

- You are no longer an active employee on the payroll (see "Effect of Termination on Your Reimbursement Accounts");
- The plan terminates;
- You are no longer regularly scheduled to work at least 20 hours per week;
- You become eligible for Long Term Disability or Workers' Compensation Insurance; or
- You are no longer a member of the class of employees eligible to participate.

If you are on Long Term Disability, you may continue to submit claims for eligible expenses incurred during the plan year up until the date your disability benefits / payment begins.

If you are enrolled in the Duke Basic medical care plan, you will receive a contribution from the University to your Health Care Reimbursement Account. Eligible health care expenses are reimbursable until the last day of the following month after your last day worked, to coincide with the end date of your Duke Basic medical coverage.

Effect of Termination on Your Reimbursement Accounts

If you terminate employment, retire, or die during the year, you or your estate may continue to submit claims for eligible health care expenses incurred during the plan year and up until the last day of the pay period of your date of termination, retirement, or death. Eligible health care expenses are reimbursable up to the amount of your annual health care reimbursement account election, provided they were incurred on or prior to the last day of the pay period of your date of termination, retirement, or death.

You are eligible to continue to incur and submit expenses for dependent care until the end of the plan year (December 31) in which you become ineligible for benefits or terminate employment. However, you are only able to file claims / request reimbursement for any remaining funds in your Dependent Care Reimbursement Account that were payroll deducted prior to your ineligibility or termination.

The deadline for submitting these expenses to HealthEquity is April 15 of the following plan year.

If you are laid off for less than 30 days, then you have the option of making up the missed deposit, reducing the election amount by the missed amount or making a new election. If, however, the layoff period is greater than 30 days you must make a new election amount.

Continuing Coverage — COBRA Option

Under federal COBRA law, you have the right to pay your Health Care Reimbursement Account contributions (plus 2%) on an after-tax basis after your employment ends. Continuing payment allows you to access your annual election amount for the rest of the year.

This option may be particularly important to you if you have a high balance in your Health Care Reimbursement Account and have not yet incurred an anticipated eligible expense, as it keeps your access to the account open after your termination.

Generally, you may not change your annual election when you experience an event that qualifies you for COBRA. However, if your COBRA event is also a qualified change in family status, you may be eligible to change your election for the remainder of the plan year.

How Reimbursement Accounts Work

Tax Savings

Because your deposits to Duke reimbursement accounts are deducted from your paycheck before federal, state, Social Security, and Medicare taxes are withheld, each dollar you deposit reduces the taxable income reported on your W-2 form, so you may save on income taxes.

Your Pre-Tax Contributions and Social Security

Contributing to the reimbursement accounts on a pre-tax basis gives you the advantage of lowering your federal income and FICA taxes.

However, lowering your income could cause a reduction in your monthly Social Security benefits down the road due to your before-tax contributions. While the reduction is small, you should consider it as you make your reimbursement account contribution decisions.

Separate Accounting

According to federal law, contributions to the Health Care Reimbursement Account and the Dependent Care Reimbursement Account cannot be used interchangeably. Any contributions you make to the Health Care Reimbursement Account must be used for eligible health care expenses; any contributions made to the Dependent Care Reimbursement Account must be used for eligible dependent care expenses. Federal law mandates that reimbursement accounts be reviewed by Duke to ensure they meet specific guidelines. The amounts you contribute to the accounts may be reduced to comply with federal guidelines.

The “Use It or Lose It” Rule

The U.S. Department of the Treasury and Internal Revenue Service modified the “use it or lose it” rule that required any remaining balance at the end of the plan year to be forfeited. See hr.duke.edu/benefits/reimbursement/health-care for information about how much of your unused HealthEquity Health Care Reimbursement Account balance can be carried over into the next plan year. Periodically, this amount will increase based on Internal Revenue Service / Department of Treasury guidance. However, any amount remaining in your account after December 31, will be forfeited unless claims for eligible expenses

incurred January 1 – December 31 are submitted by April 15 of the new plan year. You must be an active employee in a benefits-eligible work status on December 31 to be eligible for the carryover provision.

Claims for expenses incurred during the new plan year and processed before the carryover transfer date (approximately May 1) will be paid first from the new plan year available balance and will be paid second from the previous plan year carryover funds.

Claims for expenses incurred during the new plan year and processed after the carryover transfer date (approximately May 1) will be paid from the new plan year available balance, which will include any carryover funds from the previous plan year.

PLEASE NOTE: According to federal law, any money left in your Dependent Care Reimbursement Account at the close of the plan year will be forfeited.

You may submit your claims for expense reimbursement for services received during the plan year in which the money was contributed until April 15 of the following year. You will forfeit any money left unclaimed in your Dependent Care Reimbursement Account after April 15.

Impact on Other Benefits

Reimbursement account contributions will not affect other Duke Benefit plans that are based upon pay. Those benefit plans will continue to be based on your pay before the reduction for your reimbursement account contributions. However, because your contributions are not subject to Social Security taxes, your eventual Social Security benefits may be slightly less when you retire or if you should become disabled.

Unverified Expenses

When using your HealthEquity Health Care Card, eligible health care expenses may require verification. If unverified expenses are not resolved, the unverified amounts become taxable income to you and an issue that may need to be resolved between you and the Internal Revenue Service, independent of the plan.

The Advantage of Pre-Tax Deductions

Your premiums are deducted from your paycheck before taxes are calculated, thereby reducing your taxable income. This, in turn, reduces what you will owe in federal and state income taxes.

How Do I Decide How Much To Contribute?

The “use-it-or-lose-it” aspect of Dependent Care Reimbursement Accounts may seem risky, but most participants think the benefit of tax savings outweighs the possibility of forfeiting unused contributions, especially since you decide how much you want to set aside each year.

The IRC permits employers to allow plan participants to carry over a portion of their year end balance. Duke has included this in our plan design. For 2024, up to \$640 of your unused Health Care Reimbursement Account remaining balance can be carried over into the next plan year. This makes contributing to this account much less risky.

The minimum annual contribution for Health Care and Dependent Care Reimbursement Accounts is \$130; the maximum annual contribution for Health Care Reimbursement Accounts is established by the IRC. In 2024, that maximum amount is \$3,200. The maximum annual contribution for Dependent Care Reimbursement Accounts is \$5,000. Periodically, the maximum amount allowed for the HCRA is increased by the Internal Revenue Service / Department of Treasury.

PLEASE NOTE: If your monthly or biweekly paycheck is not sufficient for your full reimbursement account deduction to be taken, no amount will be deducted for your reimbursement account. Partial deductions are not taken for reimbursement accounts.

Generally, it's better to be conservative in your cost estimates, especially when you are just starting out with an account.

If you have questions, want account updates, need to check on the status of claims, or need forms, call HealthEquity, the claims administrator for the reimbursement accounts, at **877-924-3967**.

HealthEquity customer service representatives are available Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern Time. You may also call HealthEquity's 24-hour automated voice response system at **877-924-3967**. Access to your personal online account is available at any time by logging on through your Duke@Work account.

Health Care Reimbursement Account

With the Health Care Reimbursement Account, you can make contributions to an account and be reimbursed for eligible health care expenses.

Generally, the Internal Revenue Code (IRC) does not include expenses for Same Sex Spousal Equivalents as eligible for reimbursement as spouses, unless the partner meets the IRC definition of a qualifying relative (i.e., claimed as a dependent on the employee's taxes). See the "Qualifying Relative" definition or refer to Internal Revenue Code Section 152. Eligible health care expenses include medically necessary medical, dental, vision, prescription drug expenses, and over-the-counter medications.

Eligible Dependents

You can use your Health Care Reimbursement Account to pay for health-related expenses incurred by any of the following people — even if they are not covered by your employer's health plans.

- Yourself
- Your spouse
- Your qualifying child*
- Your qualifying relative*

* Special rules allow a dependent to be eligible for this plan even when that dependent does not qualify to be claimed as your tax dependent on your tax return form. See the definitions below.

A Qualifying Child

- Is any of the following: your child, grandchild, stepchild, foster child or adopted child; brother, half-brother or stepbrother; sister, half-sister or stepsister; nephew or niece; or the child or grandchild of any of the relatives listed above;
- Will reside with you for more than half the calendar year;
- Disregard temporary absences due to illness, education, business, vacation, or military service. You must maintain a home for the child during the temporary absence and the child must be expected to return after the absence;

- Is eligible until the last day of the month in which the child turns age 26, unless the child is permanently and totally disabled;
- Will provide no more than 50% of their own support for the calendar year;
- Is a citizen, national or resident of the US; or a resident of Canada or Mexico (unless the child is adopted).

A Qualifying Relative

- In general, is any of the following: your child, grandchild, stepchild, foster child or adopted child; brother, half-brother or stepbrother; sister, half-sister or stepsister; nephew or niece; the child or grandchild of any of the relatives listed above; your father, grandfather or stepfather; mother, grandmother or stepmother; uncle or aunt; or son-, daughter-, father-, mother-, brother- or sister-in-law. Or, any other person who will reside with you for the entire year (while not in violation of local law);
- Will not be claimed by any other person as a qualifying child for the calendar year;
- Is a citizen, national or resident of the US; or a resident of Canada or Mexico (unless the person is an adopted child);
- And, you will provide more than 50% of this person's support for the calendar year.

Please refer to Internal Revenue Code Section 152 for more details.

Special Circumstances

Divorced or separated parents: Check with your legal or tax advisor to see if special rules apply to you that would enable your child to be claimed by the noncustodial parent or by both parents.

Tie-breaker: If two or more people want to claim the same child as their qualifying child, the person who has the right to is: (1) the child's parent — if one person is the child's parent and the other is not, (2) the parent with whom the child lives longest in the year — if both people are the child's parents, (3) the parent with the higher adjusted gross income — if both people are the child's parents and the child lives equally with both during the year, or (4) the person with the higher adjusted gross income — if both people are not the child's parents.

Eligible Expenses

A person is a qualifying child or a qualifying relative for an entire calendar year. You can use your Health Care Reimbursement Account to pay for eligible health care products and services used by your qualifying child or relative during your coverage period — provided the expenses are used during the calendar year in which the dependent is considered your qualifying child or relative.

Health Care Reimbursement Account: Eligible Expenses

Medical expenses are defined by the Internal Revenue Code (IRC) as costs of diagnosis, cure, mitigation, treatment or prevention of disease, and costs for treatments affecting any part or function of the body. The expenses must be primarily to alleviate or prevent a physical or mental defect or illness. They do not include expenses that are merely beneficial to general health, such as vitamins or vacation.

With that in mind, below are some of the medical expenses eligible for payment under the Health Care Reimbursement Account, to the extent such expenses are not covered by your medical or dental insurance. This list is not meant to be all-inclusive. Other expenses not specifically mentioned may also qualify. For additional information, please refer to IRS Publication 502 "Medical and Dental Expenses." However, the two exceptions to be aware of are:

- 1) Insurance premiums are not reimbursable under a Health Care Reimbursement Account (HCRA), and;
- 2) The reimbursement under a HCRA is based only upon when the expense was incurred; i.e., date of service, not the date paid. To be eligible, the service has to be provided in your plan year.

List of Eligible Expenses

In general, expenses must be medically necessary and prescribed by your physician. The following are examples of eligible expenses:

- Acupuncture
- Alcoholism treatment
- Ambulance fee
- Animal trained to aid deaf person
- Artificial limbs
- Braille books and magazines (difference in cost only)
- Car controls for the disabled
- Chiropractor's fees
- Christian Science practitioner fees
- Contact lenses and cleaning solutions
- Copays, deductibles, and coinsurance not covered by insurance
- Dancing lessons (for treatment of a medical condition)
- Dental fees (for non-cosmetic purposes)
- Doctor's fees
- Drug addiction treatment
- Eyeglasses (prescribed)
- Eye surgery (e.g., LASIK and radical keratotomy)
- Face masks
- Feminine hygiene products
- Fitness programs (as treatment for a medical condition diagnosed by a licensed healthcare professional)
- Guide Dogs (dog, training, care)
- Hand sanitizer
- Hand sanitizing wipes

Hearing aids / exams
Hospital services
Infertility treatments
Lab fees
Lamaze classes for expectant mothers
Menstrual care products
Mileage (requires receipt from physician and distance traveled)
Nursing services (wages and taxes)
Optometrist's fees
Orthodontia expenses
Over-the-counter medications
Prescription drugs and medications*
Psychotherapy for approved medical care (by approved provider)
Smoking cessation program fees and prescription drugs
Surgery
Telephone for the hearing impaired
Therapy (medical)
Transplants
Tuition at special schools for the disabled (select circumstances only)
Varicose vein removal surgery
Vitamins (prescribed)
Weight-loss programs at physician's discretion to treat existing disease
Wheelchairs
X-rays

PLEASE NOTE: Insurance premiums are not eligible expenses under a reimbursement account plan.

Over-the-Counter Drugs and Medicines

In addition to the health care expenses noted above, over-the-counter drugs and medicines are reimbursable under your Health Care Reimbursement Account. The expenses that may be reimbursed depend on whether the drug or medicine treats a specific medical condition or is used mostly for a person's general good health. Drugs and medicines that are primarily used for a person's general good health or hygiene (e.g., mouthwash) may only be reimbursed if they are used to treat a specific medical condition and a prescription or letter of

medical necessity* from the doctor or dentist is required. Most over-the-counter drugs or medicines are eligible; cosmetic, toiletry, or sundry items are “not” eligible.

*The letter of medical necessity order date must be on or before the date of service.

Health Care Reimbursement Account: Ineligible Expenses

In the list below are some examples of expenses that are not eligible for reimbursement under a Health Care Reimbursement Account. If you want to determine whether or not a particular expense is eligible for reimbursement, refer to HealthEquity’s website healthequity.com/fsa-qme. This is not meant to be an all-inclusive list.

Expenses to promote general health are not reimbursable under the Health Care Reimbursement Account. The following are examples of ineligible expenses:

- Babysitting and childcare
- Calcium supplements
- Cancelled appointment fees
- COBRA premiums
- Contact lens insurance
- Cosmetic surgery / procedures
- Custom fitovers (clip-ons)
- Diaper service
- Discounted fees / write-offs
- Electrolysis
- Exercise equipment*
- Eyeglass insurance
- Hair loss medication
- Hair transplant
- Health club dues
- Herbs and herbal medicines
- Illegal operations or substances
- Insurance premiums
- Insurance premium interest charge
- Lamaze class***
- Marriage therapy**
- Massage therapy**

Maternity clothes
Personal trainer
Prescription drug discount
Program premiums
Retin-A*
Rogaine
Special foods* (cost difference of common product)
Student health premiums (for dental and medical services)
Swimming lessons*
Tattoo removal
Teeth whitening / bleaching
Toiletries, toothpaste, etc.
Treatment program (at a health club)*
Veneers*
Vision discount program premiums
Vitamins*
Weight loss programs and/or drugs*

*Eligible only with doctor's certification identifying the medical condition and length of treatment program.

**Eligible only with doctor's certification identifying the physical nature of the medical condition and length of treatment program. Massage therapy for the sole purpose of tension / stress relief or depression (even with a doctor's statement) does not qualify as an eligible expense.

***Eligible expenses are limited to the mother's instruction related to birth.

How Much Can I Contribute to the Health Care Reimbursement Account?

Periodically, the IRS and Social Security Administration release cost-of-living (COLA) adjustments that apply to Health Care Reimbursement Accounts. The new annual limit for Health Care Reimbursement Accounts is \$3,050 for plan years starting on or after January 1, 2023. The maximum you can contribute to your Health Care Reimbursement Account during the plan year January 1 – December 31 is \$3,050. If you and your spouse are enrolled in a Health Care Reimbursement Account, each of you is eligible to deposit \$3,050 in a Health Care Reimbursement Account in the same plan year.

(Note: If you enroll in the Duke Basic health plan, the contribution(s) made by Duke is not included in this limit.)

Important Tax Considerations

When you pay expenses through the Health Care Reimbursement Account, you lose the opportunity to take a federal income tax deduction for those expenses. Normally, you would be able to deduct any health care expense above 7.5% of your adjusted gross income. So, when you enroll each year, you will need to decide

whether you want to take the deduction or pay for those expenses through the account. To determine which method works best for you, contact a tax advisor.

Enrollment and Changes during the Year

If you have a status change, as defined earlier, that affects your Health Care Reimbursement Account, you can make changes that are consistent with your status change during the year. You must notify the HRIC by calling **919-684-5600** within 30 days of the status change if you want to change your reimbursement account contribution.

Notes about Health Care Reimbursement Account for Duke Basic Members

All Duke Basic members will receive an annual contribution to a health care reimbursement account based on the level of coverage selected:

- \$200 for Individual
- \$300 for Employee / Child
- \$400 for Employee / Children
- \$400 for Employee / Spouse or Employee / Same Sex Spousal Equivalent
- \$500 for Family

It can take up to 60 days for the Duke Basic contribution to be posted to your Health Care Reimbursement Account.

PLEASE NOTE: Duke will not make additional contributions to the Health Care Reimbursement Account for Duke Basic participants if dependents are added during the year due to a qualifying event such as birth or marriage.

If you terminate coverage in Duke Basic during the current plan year then re-enroll in coverage later in the same plan year, you will not receive a second contribution to a Health Care Reimbursement Account.

Also, if you or your spouse are enrolled in a Health Savings Account (HSA), please contact the HRIC at 919-684-5600 before enrolling in Duke Basic. Duke does not offer a high deductible health plan. If you have an HSA from a previous employer, you cannot contribute to your HSA while you are covered under a Duke medical plan.

Dependent Care Reimbursement Account

Eligible Dependents

Per the IRS rules effective January 1, 2005.

You can use your Dependent Care Account to pay for work-related* care for your eligible dependents:

- Your qualifying child* — up to 13.
- Your spouse, or a qualifying child or relative* — who is physically or mentally incapable of self-care.

* See the tests below to determine if you have a qualifying child or relative, or visit wageworks.com/media/838920/3846-dcfsa-pmb-frm.pdf to take the tests.

A Qualifying Child

Is any of the following: your child, grandchild, stepchild, foster child or adopted child; brother, half-brother or stepbrother; sister, half-sister or stepsister; nephew or niece; or the child or grandchild of any of the relatives listed above, and

- Will reside with you for more than half the calendar year;
- Disregard temporary absences due to illness, education, business, vacation, or military service. You must maintain a home for the child during the temporary absence and the child must be expected to return after the absence;
- Will be under the age of 13, or physically or mentally incapable of self-care, when the dependent care is provided;
- If the child is 13 or older and physically or mentally incapable of self-care, they must regularly spend at least 8 hours a day in your home and not file a joint tax return with their spouse for the calendar year;
- Will provide no more than 50% of their own support for the calendar year;
- Is a citizen, national or resident of the US; or a resident of Canada or Mexico (unless the child is adopted);
- And, you are not the qualifying child or relative of any other person.

A Qualifying Relative

Is any of the following: your child, grandchild, stepchild, foster child or adopted child; brother, half-brother or stepbrother; sister, half-sister or stepsister; nephew or niece; the child or grandchild of any of the relatives listed above; your father, grandfather or stepfather; mother, grandmother or stepmother; uncle or aunt; or son-, daughter-, father-, mother-, brother- or sister-in-law. Or, any other person who will reside with you for the entire year (while not in violation of local law), and

- Will reside with you for more than half the year;
- Disregard temporary absences due to illness, education, business, vacation, or military service. You must maintain a home for the person during the temporary absence and the person must be expected to return after the absence;
- Will regularly spend at least eight hours a day in your home;
- Will not file a joint tax return with their spouse for the calendar year (unless the qualifying relative is your spouse);
- Will not be claimed by any other person as a qualifying child for the calendar year;
- Is a citizen, national or resident of the US; or a resident of Canada or Mexico (unless the person is an adopted child).
- And, you...
 - Will provide more than 50% of this person's support for the calendar year;
 - Are not the qualifying child or relative of any other person.

And, all of the following must be true about the care:

- Care is provided while you work or to enable you to work. If you are married, the care is provided while your spouse also works or to enable your spouse to work or go to school full-time (at least 5 months a year) or while your spouse is incapable of self-care.
- Care is provided when the dependent meets the definition of a qualifying child or relative (per the IRS, based on a tax year.)
- Care may be provided by a relative or non-relative but is not provided by your child under the age of 19 (tax dependent or not) or another tax dependent.
- Your care provider conforms to state and local laws (including being licensed, if required) and can provide you with their Social Security or Tax ID number. You will need this to request payment or file a claim.

Special Circumstances

Divorced or separated parents: Check with your legal or tax advisor to see if special rules apply to you that would enable your child to be claimed by the noncustodial parent or by both parents.

Tie-breaker: If two or more people want to claim the same child as their qualifying child, the person who has the right to is: (1) the child's parent — if one person is the child's parent and the other is not, (2) the parent with whom the child lives longest in the year — if both people are the child's parents, (3) the parent with the higher adjusted gross income — if both people are the child's parents and the child lives equally with both during the year, or (4) the person with the higher adjusted gross income - if both people are not the child's parents.

Eligible Expenses

A person is determined to be a qualifying child or a qualifying relative on a daily basis. You can use your Dependent Care Account to pay for eligible dependent care services provided for a qualifying child or relative during your coverage period — as long as the services are provided on days the dependent is a qualifying child or relative.

Please note, you can only submit expenses for reimbursement incurred after your date of participation in the plan. For example, if you incurred daycare expenses in February but did not enroll in the plan until March, your February expenses would not be reimbursable under this plan. Deposits made for dependent care are not eligible for reimbursement since care must occur prior to reimbursement of expenses.

Examples of Dependent Care Expenses Allowed Under Federal Law

Examples of eligible expenses for dependent care services during the hours you (and your spouse, if you are married) work include:

- A qualified day care center or summer day camp;
- Before-school and after-school day care programs;
- A babysitter in or out of your home (during your working hours);
- Certain expenses for a housekeeper whose duties include day care;
- A relative who cares for your eligible dependent(s), as long as that relative is not one of your eligible dependents or one of your children under age 19;

- Someone who cares for an elderly or incapacitated dependent who lives with you; and
- An adult day care facility for an elderly or incapacitated dependent who lives with you (excluding overnight or nursing home facility expenses).

PLEASE NOTE: A complete description of eligible expenses is found in IRS Publication 503, “Child and Dependent Care Expenses.” It is available on the Internet at irs.gov, from your local public library, or by calling **800-TAX-FORM**.

Examples of dependent care expenses not allowed under federal law:

- Child support payments
- Food, clothing, and entertainment
- Cleaning and cooking services not provided by the caregiver
- Educational supplies
- Overnight camp
- Activity fees
- Late payment fees
- Medical expenses
- Expenses incurred when you (or your spouse) are not working or your spouse is not a full-time student or mentally or physically incapable of self-care
- Expenses for 24-hour custodial care, such as nursing home care
- Expenses applied toward a federal income tax credit
- Day care expenses for children aged 13 and over
- Nursery school and kindergarten tuition

What Does Incapable of Self-care Mean?

Individuals who are considered incapable of self-care are those who are not able to dress, clean, or feed themselves because of physical or mental disability, and who require constant attention to prevent them from injuring themselves or others.

How Much Can I Contribute to the Dependent Care Reimbursement Account?

The maximum you can deposit to your Dependent Care Reimbursement Account during the plan year January 1 – December 31 is \$5,000 and depends on the following:

- If you are a single parent or if you and your spouse file a joint income tax return, you can deposit up to \$416.66 per month (or \$192.30 every two weeks) for a 12-month plan year. The maximum monthly contribution may be higher than \$416.66 (or \$192.30 every 2 weeks) for participants enrolled in the Plan less than 12 months as long as no more than \$5,000 is deposited on an annual basis.
- If you are married and file separate income tax returns, each spouse has a plan year limit of \$208.33 per month (or \$96.15 every two weeks). The maximum monthly contribution may be higher than

\$208.33 (or \$96.15 every two weeks) for participants enrolled in the Plan less than 12 months as long as no more than \$2,500 is deposited on an annual basis.

These limits apply to the total amount deposited in your Dependent Care Reimbursement Account and in all similar plans (including a plan at your spouse's employer, for example).

Other federal regulations also affect the amount you may deposit:

- If you are married, your annual deposit may not exceed the lesser of your annual income or that of your spouse. In addition, your deposit to the Duke reimbursement accounts may not exceed half of your gross pay each pay period;
- If your spouse has no earned income and is not a full-time student or disabled, you are not eligible for a Dependent Care Reimbursement Account;
- If your spouse is a full-time student or is disabled (meaning your spouse is unable to take care of himself or herself), your spouse is treated as having an income of \$200 per month (\$400 per month if two or more dependents receive day care). If you are in this situation, you may not deposit more than \$200 (or \$400) into your account per month regardless of your own income; and
- If you are considered under federal law to be highly compensated (for example, earning over \$135,000 in 2022), your dependent care election may need to be adjusted based on the results of federally required non-discrimination tests. If you are affected, you will be notified.
- If you divorce, become legally separated, or live apart from your spouse at least six months of the tax year, you may want to seek immediate income tax advice. You will have 30 days from the event to stop or change your reimbursement account contribution.

PLEASE NOTE: If your monthly or biweekly paycheck is not sufficient for your full reimbursement account deduction to be taken, no amount will be deducted for your reimbursement account. Partial deductions are not taken for reimbursement accounts.

You are responsible for ensuring that you do not exceed any specific lower limitations that may apply to your family situation. In addition, you are also responsible for ensuring that your participation in all similar programs (such as a program through your spouse's employer) meets all the requirements.

Duke-Contracted Facilities

If you use a Duke-contracted facility for dependent care, such as the Duke Children's Campus, and receive a subsidy, the amount you can contribute to a Dependent Care Reimbursement Account is reduced dollar-for-dollar. Contact the HRIC at **919-684-5600** for more information.

Example of Eligible vs. Ineligible Dependent Care Expenses

Jim sends his two children to a day care program during the workweek while he and his wife work. This expense is allowed under the Dependent Care Reimbursement Account, so Jim can file for reimbursement. However, the cost of a babysitter when Jim and his wife go out on a Saturday night cannot be reimbursed, since the expense was incurred when the couple was not working. Expenses incurred outside of the workweek cannot be claimed as eligible dependent care expenses.

Enrollment and Changes During the Year

If you have a status change as defined earlier that affects your Dependent Care Reimbursement Account, you can make changes that are consistent with your status change during the year. You must notify the HRIC

within 30 days of the status change if you need to change your Dependent Care Reimbursement Account contribution as a result.

Dependent Care Reimbursement Account vs. Income Tax Credit

Federal and North Carolina law both provide a dependent care tax credit. Based on recent changes in federal tax laws, most employees may save more money by participating in the Dependent Care Reimbursement Account than by filing for the tax credit.

The amount of your day care expense that is eligible for the “tax credit” is reduced dollar-for-dollar by the amount that is reimbursed under the Dependent Care Reimbursement Account. This means you cannot take the “tax credit” on any expense that has been paid through the Dependent Care Reimbursement Account. Accordingly, you need to determine whether the reimbursement account or “tax credit” is more beneficial to you. Before deciding, you may want to consult your tax advisor.

These guidelines are based on information available about current tax laws and rates. You will need to review both options carefully to determine which will be more beneficial to you.

Keep in mind that you have immediate tax savings through the reimbursement account through pre-tax payroll deductions, while the tax credit is a once-a-year feature when you file your tax returns.

To obtain a tax credit you must complete IRS Form 2441, “Child and Dependent Care Expenses,” along with your IRS Form 1040, “U.S. Income Tax Return.”

It’s important to understand that you cannot take the tax credit on any expense that has been paid through a dependent care reimbursement account.

In fact, the tax credit is reduced dollar-for-dollar by any expense that has been reimbursed through a dependent care reimbursement account. Before making a decision, you may want to talk to your tax advisor.

For more information about the Dependent Care Tax Credit, please refer to IRS Publication 503 or consult a tax advisor.

All participants can view information pertaining to the reimbursement accounts at hr.duke.edu/benefits/reimbursement-accounts. Forms and instructions for filing claims are included on this website. Additional forms are available at hr.duke.edu/forms or by contacting the HRIC.

For the Health Care Reimbursement Account, you must submit an itemized bill or receipt with your claim, and in some cases, an Explanation of Benefits (EOB) if the service was covered under an insurance plan and you are claiming the unreimbursed portion of the health / dental / vision expenses through your Health Care Reimbursement Account. A cancelled check is not allowable under federal law as proof of the expense. When using the HealthEquity healthcare card, you may also be required to submit an itemized bill / statement or EOB to substantiate eligible expenses that do not match an existing copy.

When you submit a Dependent Care Reimbursement Account claim, you must report the name, address, and taxpayer identification number of each dependent care provider. If your daycare is a religious or nonprofit provider, you must state such in a letter and attach with each claim your file. If you pay for medical, dental, or dependent care expenses in advance, you will be reimbursed once the service is performed or received.

To receive reimbursement for expenses with this plan, you must provide appropriate documentation to substantiate your expenses. The IRS requires that reimbursement account participants maintain complete

documentation including but not limited to keeping copies of receipts for reimbursed expenses. Contact your tax advisor for further details regarding IRS requirements for documentation.

How To File for Benefits

Overpayment

In the event of overpayment, you agree to return the amount of the overpayment to the plan administrator or have the amount of the overpayment deducted from your paycheck.

Where To Send Your Request for Benefit Payments

Send claims to:

HealthEquity Claims Administrator
P.O. Box 14053
Lexington, KY 40512
Or fax to: 877-353-9236

Eligible expenses are processed daily and reimbursement will be mailed directly to your home or payment can be deposited into your checking account. Complete a direct deposit authorization form by logging into your personal online account at hr.duke.edu/benefits/reimbursement to receive reimbursements directly into your checking account.

Run-out Period

You have a run-out period — beginning January 1 and ending on April 15 — to submit paperwork for expenses incurred during the previous calendar year. For example, if you incurred eligible expenses one year, you would have until April 15 of the following year to submit your claim. **After April 15, you forfeit any money that was contributed the previous year and was left in your Dependent Care Reimbursement Account.**

Although you have until April 15 to submit your claims, only expenses from the previous calendar year — January 1 through December 31 — are eligible for reimbursement. As an additional reminder, you must be a participant in the plan during the time period when the expenses are incurred in order to claim them for reimbursement.

Duke has not implemented the provision that extends the plan year beyond a calendar year.

See hr.duke.edu/benefits/reimbursement for information about how much of your unused funds you can carry over into the next plan year for the Health Care Reimbursement Account. **There is no carryover provision for the Dependent Care Reimbursement Account.**

Appealing a Denied Health Care Reimbursement Account Claim

If your claim for a benefit is denied, in whole or in part, you will be provided with the following information in writing within 30 days after receiving your initial claim, or 45 days in special situations:

- The reason for denial;
- The plan provisions that are the basis for denial;
- An explanation of what other material or information is needed and why it is needed; and
- An explanation of the claims review process and time limits for appealing the determination, your right to obtain information about those procedures, and the right to sue in federal court.

You have the right to request certain documentation, as required by the Employee Retirement Income Security Act of 1974 (ERISA), which was used in making the adverse determination. This will be provided to you free of charge upon request.

If an extension is necessary due to the need for additional information, you will be notified of the specific information needed. The claim determination will be made within 15 days from the receipt of your response.

If you disagree with the decision, you may request a review of the decision by notifying HealthEquity in writing within 180 days of the date you receive notice of the denial. First level appeals should be mailed to HealthEquity at the following address:

HealthEquity Claims Appeal Board
PO Box 14034
Lexington, KY 40512
Or fax to 877-220-3248

You will be able to examine all the materials related to your claim, such as the plan's official documents. HealthEquity will decide on your appeal within 30 days of when it is received.

If you do not agree with this decision, you have the right to a second level appeal to the Plan Administrator. Requests for second level appeals should be sent to:

Reimbursement Account Plan Administrator
Duke Benefits
705 Broad St.
Box 90502
Durham, NC 27708

The Plan Administrator will decide on your appeal within 30 days of your second level appeal request.

If any of these claim deadlines falls on a Saturday, Sunday, or holiday, the deadline is postponed until the next business day. The Plan Administrator's decision on your appeal is final and conclusive.

If you are dissatisfied with the Plan Administrator's decision after you have pursued these steps, you have the right to file a lawsuit in a 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 event for which the claim was made occurred.

Appealing a Denied Dependent Care Reimbursement Account Claim

If you have questions about your Dependent Care Reimbursement Account claim, please contact:

Reimbursement Account Plan Administrator
Duke Benefits
705 Broad St.
Box 90502
Durham, NC 27708

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:

**Reimbursement Account 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 the 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 a 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 event for which the claim was made occurred.

Your Rights Under ERISA

For a summary of your rights under the Employee Retirement Income Security Act of 1974 (ERISA), please refer to the "General Information" section in this booklet.

It is intended that the Health Care Reimbursement Account Program qualify as an "accident and health plan" and as a "self-insured medical expense reimbursement plan" and that the Dependent Care Reimbursement Account Program qualify as a "dependent care assistance program" under federal tax laws. The provisions contained in this Benefit Program Description, which is a part of the Duke University Welfare and Fringe Benefit Plan, shall constitute the separate written plans for such Programs to the extent required under federal tax laws or other applicable laws. It is further intended that benefits payable under the Reimbursement Account Programs be eligible for exclusion from gross income under federal tax laws. Duke reserves the right to change or terminate these benefits or your eligibility for benefits under the Programs. The written plan documents for the Duke Reimbursement Account Programs are not an employment contract or any type of employment guarantee.

DUKE LIFE INSURANCE PROGRAM

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DUKE LIFE INSURANCE PROGRAM

Introduction

The term “Duke” is used throughout this booklet. “Duke” refers to the University, Duke University Health System, Inc. and any other corporation or entity that adopts the Plan with the duly authorized approval of the Board of Trustees. When used in this Plan document, “Employer” shall refer to all of the foregoing collectively except where the context requires that such term refer to the corporation or entity that actually employs an individual.

The benefit program provided is based on an employee’s company code and job code as reflected in the HR benefits administration system (SAP). Duke employees holding more than one position classification receive the benefits associated with their primary position classification as reflected in SAP. For example, a housestaff member who also works within DHIP, receives benefits associated with their housestaff position classification.

The word “spouse” is used in this benefit program’s Summary Plan Description. This means legal spouse. In addition, it refers to an employee’s registered Same Sex Spousal Equivalent providing the employee was hired prior to January 1, 2016 and registered his/her partner with Duke HR prior to January 1, 2016. This employee’s registered partner remains eligible under Duke’s Same Sex Spousal Equivalent Policy and is included in the meaning of “spouse” for the purpose of this benefit program wherever permissible under federal and state law. The eligible status continues for the course of this relationship only.

Eligibility and Enrollment

Eligibility for Coverage

Eligible employees are automatically enrolled in the following plans, after meeting the service requirements:

- Basic Life Insurance;
- Survivor Benefit;
- Business Travel and Accident Insurance; and
- Insurance Certificate Plan.

In addition, you may be eligible to enroll in the following voluntary life insurance plans:

- Supplemental Life Insurance; and
- Personal Accident Insurance.

Each plan has different eligibility requirements. Please see each section for specific details.

PLEASE NOTE: Your benefit and eligibility for coverage in this plan will be immediately terminated if you provide fraudulent or misrepresented information. This includes, but is not limited to, fraudulent statements or material misrepresentation of facts. Your benefit and eligibility for any of the Life Insurance Plans (including Gratuity to Spouse / Estate Plan) will be terminated and your benefits and eligibility for coverage in other Duke-sponsored benefit plans including, but not limited to, Health Care Plans, Retiree Health Care Plans, Dental Plans, Vision Plan, Reimbursement Account Programs, Children's Tuition Grant Plan, Employee Tuition Assistance Plan, and Disability Plans.

Employment with Duke may also be terminated for providing fraudulent or misrepresented information.

Eligible Dependents

Your dependents may be enrolled in Supplemental Life Insurance and Personal Accident Insurance. Your eligible dependents may include your children and your spouse (please see appropriate plan sections for dependent eligibility guidelines). You may not cover your spouse as a dependent if your spouse is enrolled for coverage as an employee of Duke.

The Basic Life Insurance Plan

The Duke Life Insurance Program offers the Basic Life Insurance Plan, which also provides accidental death and dismemberment (AD&D) insurance. Life insurance coverage provides a benefit to your survivors in the event of your death, while AD&D insurance provides benefits in the event of your death as the result of an accident or if you suffer a covered loss.

Eligibility for Coverage

You are automatically insured under this plan if you are:

- An active, regular employee regularly scheduled to work at least 20 hours per week;
- A faculty employee holding a regular rank appointment who is receiving wages for Social Security purposes;
- A faculty employee holding other than a regular rank appointment scheduled to work at least 20 hours per week, and who is receiving wages for Social Security purposes;
- An employee or faculty member determined to be eligible to receive benefits under Duke's Long Term Disability plan (while still satisfying the waiting period) or Duke's Workers' Compensation program; or
- On an approved FMLA leave (paid or unpaid) or an approved short term disability claim and eligible for the Plan at the time their leave began.

In addition, you must continue to be eligible under the Plan until the time of your death, by working the required hours, as noted above. If you take an unpaid leave of absence (except for FMLA), you will lose your eligibility for this plan during the period of the leave, unless you contact the HRIC at **919-684-5600** to arrange for premium payment.

Housestaff and 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

Your coverage becomes effective on the date you are both actively at work at Duke and meet the eligibility requirements. If you are not actively employed at Duke, benefits become effective when you return to active employment.

When Coverage Ends

Coverage ends if your scheduled work hours are reduced below 20 hours per week for employees, you change from a regular rank faculty employee to a part-time non-regular rank faculty employee scheduled for fewer than 20 hours per week, you retire, you terminate employment with Duke, you reach age 70 and are receiving benefits under Duke's Long Term Disability Plan, or the Plan ends. You can, however, keep the insurance by paying the premium while you are on an approved leave of absence, sabbatical, or for up to six months if you are laid off. See Conversion of Coverage for information about converting to an individual policy when your coverage ends. It is the employee's responsibility to contact the HRIC at **919-684-5600** to arrange for premium payment when on an approved leave of absence.

Paying for Coverage

Duke pays the entire cost of this coverage for active, eligible employees.

Beneficiary Designation for the Basic Life Insurance Plan

Your Basic Life Insurance beneficiary designation is kept on file. You can review, add or change your beneficiary for the Basic Life Insurance Plan at any time and complete a beneficiary designation form online at forms.hr.duke.edu/benefits/basic which is a secure website that requires your NetID and password. You also have the option to complete and return a paper beneficiary form. The beneficiary designation with the most recent date, in good form and properly signed, constitutes the only effective designation. The change is effective the date that it is received by Duke Benefits.

PLEASE NOTE: Separate beneficiary designations are required for each life insurance plan. It is the employee's responsibility to ensure beneficiary designations are accurate, up-to-date, and reviewed on a regular basis. Please visit hr.duke.edu/forms/basic-life-insurance-beneficiary-designation-form to view the beneficiary designation form.

Benefit Coverage

Coverage is automatically provided at \$10,000, with an additional Accidental Death and Dismemberment (AD&D) benefit of up to \$10,000. The AD&D benefit you receive is based on the loss, as described in the following chart. To receive benefits, the injury must be the sole cause of the loss, and the loss must occur not more than 365 days after the date of the accident.

What Is Considered a Loss under the AD&D Policy?

- Loss of life, hands or feet completely severed through or above the wrist or ankle joint or loss of sight in one or both eyes.
- Loss of sight must be total and irrecoverable.
- Loss of thumb and index finger means that all the thumb and index finger are cut off at or above the joint closest to the wrist. This benefit is not payable if a benefit is payable for the loss of the same entire hand.
- Loss of speech must be total and irrecoverable.
- Loss of hearing must be total and irrecoverable.
- Paralysis means loss of use of a limb, without severance. A physician must determine the paralysis to be permanent, complete and irreversible.
- Brain damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least 5 days and persists for 12 consecutive months after the date of the accidental injury.
- Coma or Comatose, for the purpose of this provision, means complete and continuous:
 - Unconsciousness and
 - Inability to respond to external or internal stimuli.

Loss Coverage and Benefit Amounts

Loss	Benefit Paid
Loss of life	100%
Loss of both hands or feet	100%
Loss of sight in both eyes	100%
Loss of one hand and foot	100%
Loss of one hand and sight in one eye	100%
Loss of one foot and sight in one eye	100%
Loss of speech <u>and</u> hearing in both ears	100%
Loss of thumb and index finger of the same hand	25%
Paralysis of both upper and lower limbs	100%
Paralysis of both of both limbs	50%
Paralysis of the upper and lower limbs on one side of the body	50%
Paralysis of both arms	50%
Brain damage	100%
Coma	*1%

*1% of the full AD&D benefit amount payable monthly beginning on the 7th day of the Coma for the duration of the Coma, up to a maximum of 60 months or \$10,000.

Air Bag Benefit

If an Air Bag is deployed for the covered person during the accident and the covered person dies because of the accident while driving or riding in a passenger car and wearing a properly fastened seat belt, Lincoln Life Assurance Company of Boston will pay an additional benefit of 5% of the AD&D Full Amount to a maximum of \$10,000. Passenger Car means any validly registered four-wheel private passenger car licensed for use on public highways. It does not include any commercially licensed car, or any private car being used for commercial purposes, or any vehicle used for recreational or professional racing. No benefit will be paid if the covered person was the driver of the automobile and did not hold a current valid driver's license.

Brain Damage Benefit

Brain Damage is a covered loss that pays a benefit equal to 100% of the AD&D Full Amount as long as the brain damage manifests itself within 30 days of the accidental injury, the covered person requires hospitalization for at least 5 days and brain damage persists for 12 consecutive months after the injury. Brain Damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life.

Common Carrier Benefit

The Common Carrier Benefit pays an additional benefit equal to the 100% of the AD&D Full Amount if the covered person dies as a result of an accidental injury while traveling in a Common Carrier.

Common Carrier means a government regulated entity that is in the business of transporting fare-paying passengers. This does not include chartered or other privately arranged transportation, taxis, or limousines.

Coma Benefit

The Coma Benefit pays an additional benefit equal to 1% of the AD&D Full Amount provided the insured becomes comatose within a 30-day period from the date of the accident and remains comatose for at least 7 days.

Human Immunodeficiency Virus (HIV) Benefit

The HIV Benefit provides an additional benefit if the employee sustains an accidental injury in the performance of their occupational duties. The HIV benefit is equal to 20% of the AD&D Full Amount provided the employee completes a Workers' Compensation Injury report and submits to a blood test for HIV and AIDS Related Complex (ARC) within 48 hours of the injury; and the employee tests positive for HIV or ARC within 1 year(s) after the accidental injury.

Repatriation of Remains Benefit

Repatriation of Remains Benefit pays an additional benefit if the covered person dies as a result of an accidental injury while at least 100 miles from their principal place of residence. The benefit amount is equal to the charge of transporting the deceased's body to the city of the principal residence, not to exceed \$5,000.

Seat Belt Benefit

If a covered person dies as a result of the accident while driving or riding in a passenger car and wearing a properly fastened seat belt, Lincoln Life Assurance Company of Boston will pay an additional benefit of 10% of the AD&D Full Amount to a maximum of \$1,000. "Passenger Car" means any validly registered four-wheel private passenger car. It does not include any commercially licensed car, or any private car being used for commercial purposes, or any vehicle used for recreational or professional racing. The minimum benefit amount is \$1,000.

Workplace Felonious Assault Benefit

The Workplace Felonious Assault Benefit pays an additional benefit equal to 20% of the AD&D Full Amount to a maximum \$20,000 if the employee suffers a covered loss resulting from an accidental injury caused by a Felonious Assault committed at the employer's place of business or while the employee is engaged in the employer's business (not including working from home or regular commuting) by someone other than You or a member of your Immediate Family.

"Felonious Assault" means an assault committed during the commission of a felony as defined by the laws of the jurisdiction in which the act was committed.

"Immediate Family Member" means your spouse; and your and your spouse's children; parents; siblings; grandparents; and grandchildren.

Accidental Death & Dismemberment Exclusions and Limitations

No benefits are payable by Lincoln Life Assurance Company of Boston for any loss that is contributed to or caused by:

- War, declared or undeclared, or any act of war;
- Intentionally self-inflicted injuries;
- Suicide or suicide attempt;
- Active participation in a riot;

- Committing or attempting to commit a felony;
- Disease, bodily or mental illness (or medical or surgical treatment thereof excluding accidental ptomaine poisoning);
- Infections, except bacterial infection resulting from an accidental injury;
- Controlled substances (as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments) that are voluntarily taken, ingested or injected, unless prescribed or administered by a Physician;
- Serving full-time active duty in the Armed Forces of any country or international authority;
- Boarding, leaving, or being in or on any kind of aircraft. However, this exclusion will not apply if the Covered Person is a fare-paying passenger on a commercial aircraft or traveling as a passenger or working as a pilot or a crew member in any aircraft that is owned or leased by or on behalf of the Sponsor;
- The presence of alcohol in the Covered Person's blood which raises a presumption that the Covered Person was under the influence of alcohol and contributed to the cause of the accident. The blood alcohol level is governed by the jurisdiction of the state in which the accident occurred; or
- Hazardous sports, including but not limited to, motor sports (land or water), mountain climbing, skydiving, parachuting, bungee jumping, hang gliding and scuba diving.

No benefit will be payable for any loss suffered as a result of Accidental Injury during any period of incarceration.

With respect to this provision, "Participation" shall include promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in defense of the Covered Person, if such actions or defense are not taken against persons seeking to maintain or restore law and order including, but not limited to police officers and fire fighters.

With respect to this provision, "Riot" shall include all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether or not acting with a common intent and whether or not damage to persons or property or unlawful act or acts is the intent or consequence of such disorder.

Conversion of Coverage

When your coverage ends, you may convert your life insurance coverage to an individual policy and pay the cost of the coverage to the insurer. You may not convert your AD&D coverage. To apply for an individual life insurance conversion policy, contact Lincoln Life Assurance Company of Boston by phone within 31 days after coverage ends, at **800-423-2765**, Option #1, to receive a quote.

Claims Due to Loss

In the event of your disability, dismemberment, or death, you or your beneficiary must make a written claim for the benefits with the plan's underwriter, Lincoln Life Assurance Company of Boston, and provide proof of the loss. Claims for accidental death or dismemberment benefits must be made to the underwriter within 30 days after the date of the accident which caused the loss.

Follow the steps below to file claims for benefits:

- 1) Request a claim form by filing a written request with the underwriter. For your convenience, claim forms are also available from the HRIC at **919-684-5600**.
- 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 the underwriter at the following address:

**Lincoln Life Assurance Company of Boston Group Life Claims
P.O. Box 2578
Omaha, NE 68172-9688**

Or

**Lincoln Financial Group Life
Group Claims — SystemOne
8801 Indian Hills Drive
Omaha, NE 68114 (overnight)
Phone: 888-787-2129
Fax: 603-427-1888**

For AD&D claims, your proof must include a description of the event, and the nature and extent of the accident that caused the loss. Proof may also include a medical examination conducted by a physician of the insurance company's choosing and an autopsy. Proof must be furnished within 30 days of the date of the loss. Late notice or proof will not cause a claim to be denied or reduced as long as the notice or proof is given as soon as possible. No lawsuit may be started against the underwriter to obtain benefits until 60 days after proof is given or more than three years after the time proof must be given.

Once your claim is received, if approved, it will be processed for payment. If sufficient information is not received to process your claim, you or 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 sole responsibility for the review and final decision on any denied claim and is the named fiduciary for purposes of the review and final decision.

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

With respect to all other 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:

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

The Plan Administrator will review your claims 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 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, disability, or dismemberment occurred.

The Survivor Benefit

(Also known as the “gratuity to spouse” or “estate plan”) provides a lump sum benefit to your spouse or your estate in the event of your death while you are employed by Duke.

Eligibility for Coverage

You are automatically covered under this plan if you are:

- An active, regular employee regularly scheduled to work at least 30 hours per week;
- A faculty employee holding a regular rank appointment who is receiving wages for Social Security purposes;
- A faculty employee holding other than a regular rank appointment and classified as a full-time member of the faculty, who is receiving wages for Social Security purposes; or
- An employee or faculty member on an approved short term disability claim, or approved for benefits under Duke’s Long Term Disability plan (while still satisfying the waiting period) or Duke’s Workers’ Compensation program that met the above criteria prior to beginning leave.

You must have at least one year of service with Duke to be enrolled in this plan. In addition, you must continue to be eligible under the plan until the time of your death, by working the required hours, as noted above.

If you take an unpaid leave of absence (except for FMLA), you will lose your eligibility for this plan during the period of the leave. However, coverage will continue for full-time faculty members on an approved sabbatical leave and employees and faculty receiving benefits under Duke’s Long Term Disability Plan.

Housestaff and employees covered by a collective bargaining agreement (unless coverage was mutually agreed to in the bargaining agreement) are not eligible for this plan. However, once a Housestaff member moves into a regular faculty position, prior to any break in service, the continuous service date as Housestaff is used for calculating eligibility for this program.

When Coverage Begins

Your coverage becomes effective on the date you are actively at work at Duke and meet the eligibility requirements. If you are not actively employed at Duke, benefits become effective when you return to active employment.

When Coverage Ends

Coverage ends if your scheduled work hours are reduced below 30 hours per week for employees, you change from a regular rank faculty member to a part-time non-regular rank faculty member or are no longer receiving wages for Social Security purposes, you retire, you terminate employment with Duke, or the plan ends.

Paying for Coverage

Duke pays the entire cost of this coverage.

Benefit Coverage

The plan provides one month’s pay* for each complete year of full-time benefits-eligible service, up to a maximum of six months of pay. Benefits are calculated based on the salary at the time of death. The benefit amount is reduced by any amount you may owe Duke at the time of your death, such as loans, travel advances, or overpayments made to you under Duke’s Long Term Disability plan.

*For clinical faculty / physicians, your Current Monthly Earnings includes monthly base salary, plus where applicable, the regular, recurring monthly amount reflected in Duke's payroll system as "supplemental pay."

PLEASE NOTE: The Private Diagnostic Clinic (PDC) continuous service date for employees that transitioned from the PDC to DUHS / DHIP on July 1, 2023 is excluded for purposes of determining the amount of the benefit for this program. Only Duke University, Duke University Health System, and DHIP service while in a benefits-eligible status prior to July 1, 2023 is counted for determining service under this program. For example, a \$0 rate of pay is not a benefit-eligible status. Please see the "Important Summary for Employees Transitioning to the Duke Health Integrated Practice (DHIP) on July 1, 2023" in the "General Information About Your Benefits" section of this Summary Plan Description for additional details.

Taxation of Benefit Payments

Duke University generally will not withhold income taxes from the amount of the benefit disbursement; however, based on current IRC regulation, this benefit is likely to be taxable income because it is provided by Duke and not through an insurer. Please consult with your tax advisor to help you determine the actual income tax liability for this payment for which you may be responsible for payment. If the benefit is taxable to you or your estate, the taxation will be based on the year the gratuity payment is received. Duke will issue a 1099 to your estate for the amount of the benefit provided.

The HRIC at **919-684-5600** will initiate the request for the gratuity payment upon notification of the employee's death. The death must be reported within 12 months of the date of death in order for the benefit to be paid.

How To File for Benefits

Your beneficiary or the executor or administrator of your estate may file a claim for a benefit by giving the Plan Administrator sufficient proof of your death. The Plan Administrator may also request submission of sufficient evidence of the right of your beneficiary or the executor or administrator of your estate to receive the benefit payable under the plan. The death must be reported within 12 months of the date of death for the benefit to be paid. Submit the claim to:

**HRIC
Duke University
705 Broad St.
Box 90502
Durham, NC 27708**

Appeals of Eligibility, Right To Participate, and Claims 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. The Plan Administrator will decide whether the claim will be allowed. Send your claim to:

**Survivor Benefit 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 or dismemberment occurred.

Business Travel Assistance

Duke provides Travel and Accident Insurance to eligible employees traveling on Duke business.

- International Travel — coverage for business travel outside of the U.S. provided by International SOS.
- Stateside Travel — coverage for business travel within the U.S. provided through ACE USA Travel Assistance Services by Europ Assistance USA.
- Business Travel and Accident Insurance — insurance benefits in the event of your accidental death or injury while you are working or as a result of an accident that occurs while you are traveling outside your city of employment. These benefits are provided by ACE American Insurance Company.

International SOS Program

International Business Travel

Duke University continues to put your health and safety as our top priority while traveling on behalf of the University. Duke recognizes that in this rapidly changing world, you may have apprehension about travel, security, and health. It may be challenging for you to contact one of our staff members while traveling should something unexpected occur. It is for these reasons that the University has contracted for travel assistance and evacuation services from a company called International SOS.

International SOS Assistance gives peace of mind to travelers and expatriates all over the world. Services range from telephone advice and referrals to full-scale evacuation by private air ambulance. The SOS network of multilingual critical care and aeromedical specialists operates 24 hours a day, 365 days a year from SOS Alarm Centers around the world.

Your SOS membership, provided by Duke, is additional protection against unexpected difficulties that can arise when you are away from home on a Duke program. It is designed to supplement the policies, procedures, and support staff which the University already has in place as well as your personal international health insurance.

Whenever you travel away from your country or residence, make sure you have your International SOS card with you. Also make sure you review important medical and safety information about the country to which you are traveling. We encourage you to learn more about the Program Benefits and to review answers in Frequently Asked Questions.

While you are abroad, you should always attempt to notify University staff as instructed during your orientation. If you are traveling, and/or in a situation where you are not able to reach University staff, you should contact SOS, who will begin to meet your needs immediately as well as notify our on-call staff in the United States. Please be aware that some of the services outlined below which SOS provides have additional charges. These services have been marked so that you are aware of them. Should you activate a service which has an additional charge, you authorize Duke University to bill you for this charge once we have been informed of the actual amount by International SOS. Please know that such charges may not be billed until after you have returned from your time abroad.

While the services listed below are comprehensive, International SOS is an assistance program, not international health insurance. Duke University has contracted with International SOS to offer our travelers the highest possible level of travel, medical and security advice and services, as well as online access to information which many insurance companies do not offer. However, Duke requires all travelers on the University's behalf to maintain health insurance which covers them while abroad. You should determine how your health insurance applies to international care prior to departure.

Duke University is pleased to offer our community the myriad and comprehensive services of International SOS. With the wellbeing of our travelers as a top priority, International SOS will provide a seamless integration of meeting emergency needs for you while abroad in conjunction with our onsite personnel, policies, and procedures. Should you have any questions about International SOS, please contact the Corporate Risk Management department at **919-684-6226**.

Eligibility for Coverage

Travelers covered under this program include Duke students, volunteers, alumna and employees and immediate family (spouse, dependent children, or life partner) while abroad on Duke University-related programs or business.

Program Benefits Medical Services

(Fees may apply for evacuation and travel services.)

- Emergency evacuation
- Medically supervised repatriation
- Companion ticket
- Additional travel and accommodation arrangements after medical evacuation
- Repatriation of mortal remains
- Return home of minor children
- Medical monitoring
- Inpatient admission and identification of receiving physician
- Emergency and routine medical advice
- Pre-trip information on travel health issues
- Medical and dental referrals
- Outpatient referrals
- Outpatient case management
- Claims assistance
- Outpatient medical expense guarantee and payment (fees will apply)
- Inpatient medical expense guarantee, cost review and payment (fees will apply)
- Dispatch of medication and medical supplies (fees will apply)
- Travel services
- Legal referrals
- Emergency message transmission
- Translations and interpreters (fees may apply)

- Lost document advice
- Ground transportation and accommodations for accompanying family

Members

(Fees may apply)

- Emergency personal cash advances (fees will apply)
- International SOS Clinics

Security Services

- Security evacuation assistance
- Online travel security information
- Access to security crisis center

Q. What is the role of International SOS?

A. International SOS provides you with worldwide quality health care and emergency assistance services 24 hours a day designed to supplement and integrate with Duke University services, procedures, and policies. You should always attempt to activate Duke University onsite emergency contacts where applicable, who will assist you. If they are not available, then proceed to contact International SOS directly.

Q. How can International SOS help?

A. International SOS provides you and your family with assurance that you will be assisted during emergency situations that may arise during travel or international relocation. One phone call connects you to the International SOS network of multilingual specialists for immediate help. International SOS services are designed to help you with medical, personal, travel, security, and legal problems when away from home. Call International SOS at any time to speak with a physician or security specialist about simple or critical matters.

Q. How does it work?

A. Carry the International SOS membership card with you at all times. It includes the telephone numbers of the three major worldwide International SOS Alarm Centers. In the event of an emergency, call one of the emergency phone numbers listed on the card. If you do not have a card, you can print one by visiting the International SOS website.

Q. What do I need to do to use the program?

A. In order to utilize any of the medical or travel services listed under Program Benefits, contact any Alarm Center from anywhere in the world by calling directly, calling collect or calling the toll-free number. To ensure a prompt response when calling, you should be prepared to provide the following:

- Your name, location, age, gender and nationality;
- Your International SOS membership number: 11BSGC000072 (use this code to access the Duke University International SOS website);
- The telephone number from which you are calling (in case you are disconnected);
- Your relationship to Duke University (faculty, staff, student, alumni, etc.);
- Your relationship to the Duke University member (if the person calling is not the member);

- What Duke program or department your travel is associated with;
- Name, location and telephone number of the hospital, clinic or treating doctor (when applicable).

Q. What if I have pre-trip questions about my travel destination?

A. In addition to calling the Alarm Center for any pre-trip questions you may have, you can access Country Guides from the International SOS website by using your **International SOS membership number: 11BSGC000072**. These comprehensive guides provide both medical and general travel advice, such as information on the standard of health care, how to pay for medical care, the availability of medications, safety of the blood supply, embassy / visa information, dialing code information, cultural etiquette, financial information, and voltage / plug information.

Q. Do I need to activate my membership?

A. No, your membership is already active. Simply carry the card at all times while traveling. Whenever you need service, contact one of the emergency phone numbers listed on the back of the card. You do not need to report specific trip dates to International SOS each time you travel. However, you can create a personal online account with SOS into which you can save medical, family and emergency information.

Unless you input your information into your account it will not be available for staff in the event of an emergency. Medical and personal information can only be accessed by an International SOS physician.

Q. Who is covered?

A. Travelers covered under this program include Duke students, volunteers, alumna and employees and immediate family (spouse, dependent children, or life partner) while abroad on Duke University related programs or business.

Q. What are email alerts?

A. You have the option to sign up for email alerts. You can choose to sign up for medical and/or security alerts. Medical alerts are issued when there is an unusual health risk that, in the opinion of the International SOS medical staff, may negatively impact travelers or expatriates visiting a country. Security alerts are issued when International SOS Security professionals have identified a security risk in a specific country.

Q. What do I do if my card is lost or stolen?

A. You can print another card from the International SOS website.

Q. What if I need a doctor?

A. The International SOS Worldwide Alarm Centers are listed on the back of your card. Call the International SOS Alarm Center that is nearest to you for a referral to a doctor who speaks your language.

Q. What if I need a lawyer while overseas?

A. Call the nearest International SOS Worldwide Alarm Center for legal referrals. If you are in a situation where you require legal assistance, onsite staff or University contacts should be informed of this immediately.

Q. What if I need prescription medication?

A. We can help if you require a prescription that a local physician cannot obtain, or you need to replace lost, stolen, or depleted medication. International SOS will, when permissible by local law, send the medication you need (fees may apply).

Q. What if I am hospitalized?

A. Call the nearest International SOS Worldwide Alarm Center. International SOS will immediately take steps to evaluate the care you are receiving and determine what actions must be taken to ensure your safe and speedy recovery. International SOS will notify Duke University staff immediately if you have not already done so.

Q. What if local medical facilities are not adequate?

A. If you are hospitalized in an area where adequate medical facilities are not available, International SOS will obtain approval from Duke University's Health and Medical Services to evacuate you to a medical facility capable of providing the required care. A physician supervises evacuations, and when necessary, a medical specialist or nurse will accompany you during the evacuation. An air ambulance will be used when required.

Q. What happens when I am released from the hospital and still need help?

A. When your condition is stabilized and International SOS has determined that it is medically advisable to bring you home or to a facility near your permanent residence, International SOS will again obtain approval from Duke University and arrange the repatriation under medical supervision.

Q. Will International SOS pay my medical bills?

A. After a line of credit is opened in your name, International SOS will guarantee and pay all costs associated with your medical care. You are ultimately responsible for the costs of medical care. International SOS is NOT health insurance. International SOS will also medically monitor and evaluate your condition and ongoing medical expenses during your hospitalization. In situations where medical care is critical, by activating SOS you authorize medical care as necessary, and acknowledge that you will be billed for such care.

Q. What should I do in the event of a security emergency?

A. Contact International SOS, a security specialist will assist you.

Q. What is security evacuation assistance and coordination?

A. The International SOS Security Division will assist Duke University in the event of threatening situations such as civil and/or political unrest, insurrections, revolution or similar situations by providing information, guidance and resources in the event personal safety and security can no longer be assured.

Q. How do I access up-to-the-minute information about security alerts, warnings, and the latest situations?

A. You can visit the International SOS security online website.

In the Event of Death . . .

International SOS will render all assistance possible to the University, obtain clearances, and arrange transportation for the return of mortal remains. In such an event, Duke University will be the point of contact for the family in this situation.

ACE Travel Assistance Services

Business Travel Within the U.S.

ACE American Insurance Company offers worldwide travel assistance services to employees, students and their eligible dependents or other individuals covered under its accident and sickness insurance plans.

These services are provided by Europ Assistance USA and are not insured benefits. Europ Assistance USA is under contract with ACE American Insurance Company to provide certain services in conjunction with insurance benefits.

This ACE insurance plan may provide for reimbursement of some or all service expenses based on the terms and conditions of the policy of insurance purchased by Duke.

Policy Number: ADD N00944234

Policy Term: October 25, 2022 to October 25, 2023, and as subsequently renewed for additional terms by agreement of the Company and the Insurer.

Eligibility for Services

Employees, students, and their eligible dependents, if covered under the ACE policy issued to Duke, are eligible for services during the Policy Term subject to the limitations listed below. Emergency Medical Services and Emergency Travel Services are available only if a covered person is traveling at least 100 miles away from their legal residence. Pre-trip information services are available at any time.

24-Hour Access

Insured employees, students and their eligible dependents will be able to reach the Europ Assistance Coordination Center by calling toll-free 24 hours a day, 365 days a year, to confirm coverage and obtain access to available services.

Toll-free from within the USA and Canada: **800-243-6124**

The following is a summary of services available:

Emergency Medical Services

- **Medical Monitoring** — When notified of a Medical Emergency resulting from a covered accident or emergency sickness, Europ Assistance's multilingual staff will, if in their judgment it is appropriate, attempt to contact local attending medical personnel to better understand the covered person's condition. If appropriate, Europ Assistance will monitor the covered person's condition and will remain in communication with their family, subject to applicable privacy laws, until the medical problem is resolved.
- **Medical Referrals** — Upon request, Europ Assistance will use its best efforts to provide the names, addresses and telephone numbers of doctors, hospitals, dentists, and dental clinics in the area where the covered person is traveling. Europ Assistance will also attempt to confirm the availability of the provider, ascertain required payments that a covered person will be required to pay and make an appointment for a covered person with the medical provider of their choice.

In a serious Medical Emergency, it is advisable that a covered person first try to arrange for immediate emergency help through local sources and then call Europ Assistance. Europ Assistance shall not be responsible for determining the appropriate medical specialty for handling the covered person's condition, nor for providing medical diagnosis or treatment.

Europ Assistance cannot guarantee the quality of the medical services provider or the medical facility. The final selection of a local doctor or medical facility is the right and responsibility of the covered person.

- **Emergency Medical Payments, Medical Expense Guarantee, Hospital Admission Guarantee** — When necessary to obtain Emergency Medical Services for a covered person, Europ Assistance will arrange a payment guarantee to cover onsite medical and hospital expenses should it be necessary to provide a guarantee of payment to a medical provider, or to make arrangements to pay in local currency, emergency payments to cover onsite medical and hospital expenses. This payment is limited

to the maximum benefit allowable under the Policy. Europ Assistance will work with you or the covered person's family to guarantee any amount required in excess of policy limits.

- **Emergency Medical Transport or Medical Evacuation** — If, in the event of a Medical Emergency and upon request of a Doctor designated by Europ Assistance in consultation with a local attending Doctor, Europ Assistance will arrange and pay for transportation under medical supervision to a different hospital or treatment facility or transportation to the covered person's place of residence for treatment if it is determined to be Medically Necessary. As part of a medical evacuation, Europ Assistance will also make all necessary arrangements for ground transportation to and from the hospital, as well as pre-admission arrangements, where possible, at the receiving hospital. Payment for these services is limited to the maximum benefit allowable under the Policy.

All medical decisions (such as the medical need for evacuation, medical equipment, and the medical personnel to be used) and the final destination will be made by Europ Assistance's designated doctors in consultation with a local attending doctor based on medical factors. Their decisions shall be conclusive in determining the need for such services. Should you decide to make these arrangements without the assistance of Europ Assistance, Europ Assistance cannot be held liable for the services rendered or the cost. Any bills received for services arranged without Europ Assistance will be reviewed and processed in accordance to the lesser of the actual cost or the cost for the services had Europ Assistance made all of the arrangements.

- **Dispatch of a Doctor or Specialist** — If, based on the information available, a covered person's condition cannot be adequately assessed to evaluate the need for transport or evacuation, Europ Assistance will dispatch a doctor or specialist to the covered person's location to make an assessment. Europ Assistance will pay the cost of the doctor's or specialist's travel and services provided on location up to the maximum benefit allowable under the Policy.
- **Return of Remains** — In the event of a covered person's death while on a covered trip, Europ Assistance will arrange for and pay all necessary expenses (including government authorization and a container appropriate for transportation) for the return of the remains to the covered person's place of residence for burial. Payment for these services is limited to the maximum benefit allowable under the Policy. Should you decide to make these arrangements without the assistance of Europ Assistance, we cannot be held liable for the services rendered or the cost. Any bills received for services arranged without Europ Assistance will be reviewed and processed in accordance to the lesser of the actual cost or the cost for the services had Europ Assistance made all of the arrangements.
- **Family Reunion Travel Arrangements** — Europ Assistance will coordinate emergency travel arrangements for family members to join a hospitalized covered person or to accompany the covered person's mortal remains to the covered person's place of residence. Payment for these services is the responsibility of the traveling family member unless paid for by you or covered under the Policy.
- **Escort Transportation** — If it is reasonably possible for a family member or traveling companion traveling with the covered person to accompany the covered person during a medical evacuation or transportation of remains, Europ Assistance will make the necessary arrangements for the trip. Payment for these services is the responsibility of the traveling family member or traveling companion unless paid for by you or covered under the Policy.
- **Return of Dependent Children** — If a covered person is traveling alone with dependent children under age 18 and is hospitalized, and therefore, the dependent children are left unattended, Europ Assistance will arrange for the children's return home with an appropriate escort, if necessary. Any return tickets for

the children must be exchanged for the new travel arrangements. Payment for these services is the responsibility of the covered person's family unless paid for by you or covered under the Policy.

- **Return of a Traveling Companion** — If a covered person's traveling companion's trip is delayed and previously made travel arrangements are lost because of the covered person's Medical Emergency, Europ Assistance will arrange for the traveling companion's new travel arrangements to their return destination or the next destination on the trip itinerary at the option of the traveling companion. Payment for these services is the responsibility of the traveling companion unless covered under the Policy.
- **Visit of a Family Member or Friend** — If a covered person is traveling alone and must be hospitalized for more than seven (7) consecutive days in a hospital, Europ Assistance will make travel arrangements for one family member or one friend designated by the covered person from their home to the place where the covered person is hospitalized. Payment for these services is the responsibility of the traveling family member or friend unless covered under the Policy.
- **Replacement of Medication or Eyeglasses** — If a covered person has an unexpected need for prescription medication while traveling; loses, forgets, or runs out of prescription medication; or breaks, loses, or has eyeglasses stolen while traveling, Europ Assistance will attempt to locate the medication, eyeglasses or their equivalent and attempt to arrange for the covered person to obtain it locally, where it is available or to have it shipped to him or her, subject to local laws, if it is not available locally. Payment for the prescription medication, eyeglasses or any shipping expense is the covered person's responsibility.

Emergency Travel Services

- **Emergency Message Relay** — A covered person may send and receive emergency messages toll-free 24 hours a day through the Europ Assistance Customer Service Center. This service is staffed by multilingual professionals and is available to a covered person for contact with relatives, friends, and business associates. This service offers unlimited usage as long as messages are related directly to an emergency situation.
- **Emergency Travel Arrangements** — Europ Assistance will make new reservations for airlines, hotels, and other travel-related services in the event of an emergency or the unexpected need for a covered person to return home prior to the scheduled return date.
- **Emergency Cash** — Europ Assistance will deliver emergency funds to a covered person provided there is satisfactory guarantee of reimbursement. The method of delivery of emergency funds will vary according to the need in a given situation. A satisfactory guarantee of reimbursement is the ability to debit a company credit card or a covered person's debit card and then arrange for the delivery of the advance.
- **Legal Assistance / Bail** — Europ Assistance will assist a covered person in the location of local attorneys and will advance bail funds, where permitted by law and with a satisfactory guarantee of reimbursement. A satisfactory guarantee of reimbursement is the ability to debit a company credit card or a covered person's debit card in the amount required and then arrange for the delivery of the advance.
- **Location of Lost Items** — Europ Assistance will assist a covered person in the location of lost luggage, documents and personal items. Airlines, government authorities and card issuers are among those who will be contacted, if necessary.

Interpretation / Translation

The multilingual staff at the Europ Assistance Customer Service Center in Washington, D.C. will assist a covered person with foreign language and interpretation problems over the telephone.

Limitations

Payment for services rendered or the costs incurred by Europ Assistance on behalf of a covered person will be reimbursed by ACE American Insurance Company to the extent covered under the Policy.

To the extent these services or any advanced payments are not covered under the Policy, you or the covered person will be responsible for payment. ACE American Insurance Company reserves the right to recover any amounts paid outside of the Policy limits from any third party who would otherwise be responsible for payment in the absence of the policy benefits.

All services must be arranged by, and approved by, Europ Assistance to be covered under the Policy.

All travel arrangements will be economy fare for the most direct route available based on the traveler's designation. No personal deviations are allowed.

Europ Assistance reserves the right to suspend, curtail or limit its services in any areas in the event of rebellion, riot, insurrection, military uprising, war, terrorism, labor disputes, strikes, nuclear accidents, acts of God or refusal of the authorities to fully provide services. Should a covered person travel in any area in which any of these events have occurred, Europ Assistance will endeavor to provide services to the best of its ability.

IMPORTANT NOTICE: In all cases, the medical provider, facility, legal counsel or other professional service provider suggested by Europ Assistance are not employees or agents of Europ Assistance and the choice of provider is the covered person's alone. Europ Assistance assumes no liability for the services provided to a covered person under this arrangement, nor is it liable for any negligence or other wrongful acts or omissions of any of the legal or health care professionals providing services to a covered person.

The Business Travel and Accident Insurance Plan

Duke provides Business Travel and Accident Insurance benefits in the event of your accidental death or injury while you are working or as a result of an accident that occurs while you are traveling outside your city of employment, providing that traveling is not part of your regular job duties.

Regular commuting to and from work is excluded. The plan requires that you be eligible for travel reimbursement and be on a business trip. The death or loss must occur within 365 days after the covered accident. Business Travel and Accident benefits are paid in addition to any other Duke life insurance and AD&D benefits to which you may be entitled.

Eligibility for Coverage

You are automatically enrolled in this plan if you are an active employee or faculty member defined as Class 1 or Class 2. A Class 1 employee is one who works a minimum of 30 hours a week and is under 70 years of age. A Class 2 employee is one who works a minimum of 30 hours a week and is over 70 years of age.

Housestaff, casual labor, students, or employees covered by a collective bargaining agreement (unless coverage was mutually agreed to in the bargaining agreement) are not eligible for this plan.

Your dependents are also eligible for coverage under this plan only while they are traveling on business or relocation with you. Eligible dependents are your lawful spouse under age 70; or your unmarried child, from the moment of birth to age 19, 25 if a full-time student, who is chiefly dependent on you for support. A child, for

eligibility purposes, includes your: 1) biological child; 2) adopted child, beginning with any waiting period pending finalization of the child's adoption; 3) a stepchild who resides with the insured or depends on the insured for financial support; 4) a foster child; or 5) newborn child. Your dependent cannot be eligible if you are not eligible for coverage under the plan.

According to the Business Travel Hazard, the insured and dependent is covered based on the following:

The Covered Accident must take place while the Covered Person is:

- On business for the policyholder; and
- In the course of the policyholder's business; or
- Traveling on a Relocation Trip at the expense and direction of the policyholder.

Only the Insureds in Class 1 and Class 2 are covered for the Business and Pleasure Hazard. The dependents are not included.

A 14-day sojourn is covered for both the insured and dependent as part of the policy, due to it being of a business nature.

When Coverage Begins

Your coverage becomes effective on the date you are both actively at work at Duke and meet the eligibility requirements. If you are not actively employed at Duke, benefits become effective when you return to active employment.

When Coverage Ends

Coverage ends if you move into an ineligible category, terminate employment with Duke, or the Plan ends.

Paying for Coverage

Duke pays the entire cost of this coverage.

Covered Activities

24 Hour Coverage (Business and Pleasure)

The Plan will pay the benefits described in the Policy when a Covered Person suffers a Covered Accident any time while insured by the Policy. Unless otherwise specified, the Plan will pay benefits only once for a Covered Accident. Only the insureds in Class 1 and Class 2 are covered for the Business and Pleasure Provision. Dependents are not included.

Business Travel Coverage (Business Only)

The Covered Accident must take place while:

- On business for the policyholder; and
- In the course of the policyholder's business.

This coverage does not include commuting between home and the place of work.

This coverage will start at the actual start of the trip. It does not matter whether the trip starts at the Covered Person's home, place of work, or other place. It will end on the first of the following dates to occur:

- The date a Covered Person returns to their home;

- The date a Covered Person returns to their place of work; or
- The date a Covered Person makes a Personal Deviation.

“Personal Deviation” means:

- An activity that is not reasonably related to the policyholder’s business; and
- Not incidental to the purpose of the trip.

Definitions

- “Covered Accident” means an accident that occurs while coverage is in force for a Covered Person and results directly and independently of all other causes in a loss or Injury covered by the Policy for which benefits are payable.
- “Deductible” means the dollar amount of Covered Expenses that must be incurred as an out-of-pocket expense by each Covered Person per Injury basis before Accident Medical Expense Benefits and/or other Additional Benefits paid on an expense incurred basis are payable under the Policy.
- “Injury” means accidental bodily harm sustained by a Covered Person that results directly and independently from all other causes from a Covered Accident. The Injury must be caused solely through external, violent, and accidental means. All injuries sustained by one person in any one Covered Accident, including all related conditions and recurrent symptoms of these injuries, and are considered a single Injury.
- “Medically Necessary” means a treatment, service or supply that is: 1) required to treat an Injury; 2) prescribed or ordered by a Doctor or furnished by a Hospital; 3) performed in the least costly setting required by the Covered Person’s condition; and 4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. Purchasing or renting 1) air conditioners; 2) air purifiers; 3) motorized transportation equipment; 4) escalators or elevators in private homes; 5) eyeglass frames or lenses; 6) hearing aids; 7) swimming pools or supplies for them; and 8) general exercise equipment are not Medically Necessary. A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. The Plan may, at its discretion, consider the cost of the alternative to be the Covered Expense.
- “Usual and Customary Charge” means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

Bomb Scare, Bomb Search or Bomb Explosion Coverage

The Covered Accident must take place while:

- The Covered Person is on the policyholder’s premises when the Covered Accident occurs;
- The Covered Accident is caused by or results from a Bomb Scare, Search or Explosion, as defined below:
 - “Bomb” means any real or dummy explosive device placed with intent to damage, scare, or cause injury.
 - “Scare” means any real or false report of a Bomb on the premises of the policyholder.
 - “Search” means any organized search for a reported Bomb.

- “Explosion” means any detonation of a Bomb on the policyholder’s premises that appears to have been intended to cause injury or unlawful property damage, whether or not the presence of the Bomb was reported before detonation. It does not include any act of declared or undeclared war in the United States of America or Canada, or acceptance of known explosives as cargo.

Owned, Leased, and Operated Aircraft

The Covered Accident must take place while:

- The Covered Person is riding in, or getting on or off of, a covered aircraft; or
- As a result of a Covered Person being struck by a covered aircraft.
- Away from the policyholder’s premises in the Covered Person’s city of permanent assignment;
- On business for the policyholder; and
- In the course of the policyholder’s business.

This coverage will start at the actual start of the trip. It does not matter whether the trip starts at the Covered Person’s home, place of work, or other place. It will end on the first of the following dates to occur:

- The date a Covered Person returns to their home;
- The date a Covered Person returns to their place of work; or
- The date a Covered Person makes a Personal Deviation.

“Personal Deviation” means:

- An activity that is not reasonably related to the policyholder’s business; and
- Not incidental to the purpose of the trip.

Business Travel Coverage: Relocation (Applicable Only to Dependents of Classes 1 and 2 Insureds)

The Covered Accident must take place while the Covered Person is:

- On business for the policyholder; and
- In the course of the policyholder’s business; or
- Traveling on a Relocation Trip at the expense and direction of the policyholder.

This coverage will start at the actual start of the trip. It does not matter whether the trip starts at the Covered Person’s home, place of work, or other place. It will end on the first of the following dates to occur:

- The date a Covered Person returns to their home;
- The date a Covered Person returns to their place of work; or
- The date a Covered Person makes a Personal Deviation.

“Personal Deviation” means:

- An activity that is not reasonably related to the policyholder’s business; and

- Not incidental to the purpose of the trip.

Exposure and Disappearance

Coverage under this hazard includes exposure to the elements after the forced landing, stranding, sinking, or wrecking of a vehicle in which the Covered Person was traveling.

A Covered Person is presumed dead if:

- He or she is in a vehicle that disappears, sinks, or is stranded or wrecked on a trip covered by this Policy; and
- The body is not found within one year of the Covered Accident.

Aircraft Restrictions

If the Covered Accident happens while a Covered Person is riding in, or getting on or off of an aircraft, the Plan will pay benefits, but only if:

- The Covered Person is riding as a passenger only, and not as a pilot or member of the crew; and
- The aircraft has a valid certificate of airworthiness; and
- The aircraft is flown by a pilot with a valid license; and
- The aircraft is not being used for:
 - Crop dusting, spraying, or seeding; fire fighting; sky writing; sky diving or hang gliding; pipeline or power line inspection; aerial photography or exploration; racing, endurance tests, stunt or acrobatic flying; or (ii) any operation which requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on.)
 - The aircraft is a military transport aircraft flown by the U.S. Military Airlift Command (MAC), or a similar air transport service of another country.

Exclusions

The Plan will not pay benefits for any loss or Injury that is caused by, or results from:

- Intentionally self-inflicted Injury.
- Suicide or attempted suicide.
- War or any act of war, whether declared or not.
- Service in the military, naval or air service of any country.
- Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food.
- Piloting or serving as a crewmember or riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline (except as provided by the Policy).
- Commission of, or attempt to commit, a felony, an assault or other criminal activity.

Aggregate Limit

Benefit Maximum: \$2,000,000

The Plan will not pay more than the Benefit Maximum for all losses per Covered Accident. If, in the absence of this provision, the Plan would pay more than Benefit Maximum for all losses from one Covered Accident, then the benefits payable to each person with a valid claim will be reduced proportionately, so the total amount the Plan will pay is the Benefit Maximum.

Benefit Coverage

Accidental Death & Dismemberment Benefits Classes 1 and 2:

<u>Covered Activity</u>	<u>Principal Sum</u>
24 Hour Coverage	\$5,000
Business Travel Coverage (Business Only)	\$200,000
Bomb Scare, Bomb Search or Bomb Explosion Coverage	\$200,000
Owned, Leased and Operated Aircraft for flights on Covered Aircraft	\$200,000

Dependents:

<u>Covered Activity</u>	<u>Principal Sum</u>
Business Travel Coverage: Relocation while traveling with an Insured	\$50,000

Time Period for Accident: 365 days from the date of a Covered Accident

If Injury to the Covered Person results, within the Time Period for Accident shown in the Schedule of Benefits, in any one of the losses shown below, ACE USA will pay the Benefit Amount shown below for that loss. The Principal Sum is shown in the Schedule of Benefits. If multiple losses occur, only one Benefit Amount, the largest, will be paid for all losses due to the same Covered Accident.

Schedule of Covered Losses

<u>Covered Loss</u>	<u>Benefit Amount</u>
Life	100% of the Principal Sum
Two or More Members	100% of the Principal Sum
Quadriplegia	100% of the Principal Sum
Loss of Use of Four Limbs	100% of the Principal Sum
Loss of Use of Three Limbs	75% of the Principal Sum
Paraplegia	75% of the Principal Sum
Loss of Use of Two Limbs	67% of the Principal Sum
One Member	50% of the Principal Sum
Hemiplegia	50% of the Principal Sum
Loss of Use of One Limb	50% of the Principal Sum

Thumb and Index Finger of the Same Hand

25% of the Principal Sum

“Quadriplegia” means total Paralysis of both upper and lower limbs. “Hemiplegia” means total Paralysis of the upper and lower limbs on one side of the body. “Paraplegia” means total Paralysis of both lower limbs and both upper limbs. “Paralysis” means total loss of use. A Doctor must determine the loss of use to be complete and not reversible at the time the claim is submitted. “Member” means Loss of Hand or Foot, Loss of Sight, Loss of Speech and Loss of Hearing. “Loss of Hand or Foot” means complete Severance through or above the wrist or ankle joint. “Loss of Sight” means the total, permanent Loss of Sight of one eye. “Loss of Speech” means total and permanent loss of audible communication that is irrecoverable by natural, surgical, or artificial means. “Loss of Hearing” means total and permanent Loss of Hearing in both ears that is irrecoverable and cannot be corrected by any means. “Loss of a Thumb and Index Finger of the Same Hand” means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand). “Severance” means the complete separation and dismemberment of the part from the body. “Loss of Use” means total paralysis of a limb or limbs which is determined by a competent medical authority to be permanent, complete and irreversible with respect to: 1) arm, at or above the elbow joint; 2) leg, at or above the knee joint; 3) hand, at or above the wrist joint; and, 4) foot, at or above the ankle joint.

Accident Medical Expense Benefits

Benefit Maximum: \$5,000

Maximum Benefit Period: 365 days from the date of the Covered Accident

Deductible: \$0

The Plan will pay Accident Medical Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident. These benefits are subject to the Deductible, Maximum Benefit Period, Benefit Maximum and other terms or limits shown in the Schedule of Benefits.

Accident Medical Expense Benefits Are Only Payable:

- For Usual and Customary Charges incurred after the Deductible has been met;
- For those Medically Necessary Covered Expenses that the Covered Person receives; and
- If the first incurred expenses are within 30 days from the date of the Covered Accident.

No benefits will be paid for any expenses incurred that, in judgment of ACE USA, are in excess of Usual and Customary Charges.

Covered Medical Expenses

- 1) Hospital Room and Board Expenses: the daily room rate when a Covered Person is Hospital Confined and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.
- 2) Ancillary Hospital Expenses: services and supplies including operating room, laboratory tests, anesthesia, and medicines (excluding take home drugs) when Hospital Confined.
- 3) Medical Emergency Care (room and supplies) Expenses: incurred within 72 hours of a Covered Accident and including the attending Doctor’s charges, X-rays, laboratory procedures, use of the emergency room and supplies.
- 4) Outpatient Surgical Room and Supply Expenses for use of the surgical facility.

- 5) Outpatient diagnostic X-rays, laboratory procedures, and tests.
- 6) Doctor Non-Surgical Treatment / Examination Expenses (excluding medicines) including the Doctor's initial visit, each necessary follow-up visit, and consultation visits when referred by the attending Doctor.
- 7) Doctor's Surgical Expenses (as shown in the Schedule of Benefits). If an Injury requires multiple surgical procedures through the same incision, ACE USA will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session but through different incisions, ACE USA will pay as shown in the Schedule of Benefits for the most expensive procedure and 50% of covered expenses for the additional surgeries.
- 8) Assistant Surgeon Expenses when Medically Necessary.
- 9) Anesthesiologist Expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
- 10) Outpatient Laboratory Test Expenses.
- 11) Physiotherapy Expenses on an inpatient or outpatient basis limited to one visit per day (as shown in the Schedule of Benefits); expenses include treatment and office visits connected with such treatment when prescribed by a Doctor, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, massage, or any form of physical therapy.
- 12) X-ray Expenses (including reading charges) but not for dental X-rays.
- 13) Diagnostic Imaging Expenses: including Magnetic Resonance Imaging (MRI) and CAT Scan.
- 14) Dental Expenses including dental x-rays for the repair or treatment of each injured tooth that is whole, sound and a natural tooth at the time of the Covered Accident.
- 15) Ambulance Expenses for transportation from the emergency site to the Hospital.
- 16) Rehabilitative braces or appliances prescribed by a Doctor. This must be durable medical equipment that 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of the purchase price.
- 17) Prescription Drug Expenses (for injuries only) prescribed by a Doctor and administered on an outpatient basis.
- 18) Medical Equipment Rental Expenses for a wheelchair or other medical equipment that has therapeutic value for a Covered Person. ACE USA will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs, eyeglasses, and hearing aids.
- 19) Medical Services and Supplies: expenses for blood and blood transfusions; oxygen and its administration.

Additional Benefits

Disability Benefit

(Applicable Only to Class 1 Insureds)

Permanent Total Disability Lump Sum Benefit Amount: \$200,000

Time Period for Loss: 30 days from the date of the Covered Accident

Benefit Waiting Period: 365 days

ACE USA will pay the Disability Benefit shown in the Schedule of Benefits if a Covered Person is Permanently Totally Disabled as a direct result of, and from no other cause but, a Covered Accident. Disability Benefits will begin when:

- The applicable Benefit Waiting Period shown in the Schedule of Benefits for this benefit is satisfied; and
- The Covered Person provides satisfactory proof of Permanent Total Disability to ACE USA.

“Total Disability” or “Totally Disabled” means, due to an Injury from a Covered Accident, a Covered Person:

- If employed, cannot do any work for which he or she is, or may become, qualified by reason of education, experience or training; and
- If not employed, cannot perform the normal and customary activities of a healthy person of like age and sex.

“Permanent Total Disability” or “Permanently Totally Disabled” means a Covered Person is Totally Disabled and is expected to remain so disabled, as certified by a Doctor, for the rest of their life.

Permanent Total Disability must be the result of the same Covered Accident that caused the Total Disability.

Felonious Assault Benefit

Benefit Maximum: \$10,000

ACE USA will pay the Felonious Assault Benefit shown in the Schedule of Benefits if a Covered Person dies as the result of an Injury that occurs as a direct result of a Felonious Assault. A person other than another person covered by the Policy, a Covered Person’s Immediate Family Member or household member must inflict the assault.

“Felonious Assault” means an act of physical violence against a person covered by this Policy. “Immediate Family Member” means a Covered Person’s parent, sister, brother, husband, wife, or children.

Seatbelt and Airbag Benefit

Full Seatbelt Benefit: 10% of the Principal Sum up to a Maximum Benefit of \$25,000

Airbag Benefit: 10% of the Principal Sum up to a Maximum Benefit of \$25,000

The Plan will pay benefits shown in the Schedule of Benefits, subject to the conditions described below, when a Covered Person dies or is dismembered directly and independently from injuries sustained while wearing a seatbelt and operating or riding as a passenger in an Automobile. An additional benefit is provided if the Covered Person was also positioned in a seat protected by a properly functioning and properly deployed Supplemental Restraint System (Airbag).

Verification of proper use of the seatbelt at the time of the Covered Accident and that the Supplemental Restraint System properly inflated upon impact must be a part of an official police report of the Covered Accident or be certified, in writing, by the investigating officer(s) and submitted with the Covered Person's claims to ACE USA.

In the case of a child, seatbelt means a child restraint, as required by state law and approved by the National Highway Traffic Safety Administration, properly secured and being used as recommended by its manufacturer for children of like age and weight at the time of the Covered Accident.

"Supplemental Restraint System" means an airbag that inflates upon impact for added protection to the head and chest areas.

"Automobile" means a self-propelled private passenger motor vehicle with four or more wheels that is a type both designed and required to be licensed for use on the highway of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, sport utility vehicle, or a motor vehicle of the pickup, van, camper, or motor-home type. Automobile does not include a mobile home or any motor vehicle that is used in mass or public transit.

Claims Information

To request a claim form, submit a written notice of any loss covered by the policy to ACE USA or any of their agents. This notice must identify the insured person and the policy. A claim form will be sent to you or your beneficiary within 15 days of receipt of the notice. If not included with your original notice, written proof of your loss must be provided to the insurer within 90 days of the loss, except in the case of a disability loss. Claims for disability benefits must be made to the insurer within 30 days after the date of the accident which caused the loss.

To file a claim, you or your beneficiaries must complete the steps below:

- 1) Request a claim form by filing written proof of the cause of your loss with ACE USA. For your convenience, claim forms are also available from the HRIC at **919-684-5600**.
- 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 the underwriter at the following address:

ACE USA
1 Beaver Valley Road
P.O. Box 15417
Wilmington, DE 19850
Policy # ADD N00944234
From Within the USA or Canada: 800-336-0627
Outside the USA or Canada: 302-476-6194
Fax: 302-476-6154

Once your claim is received, if approved, it will be processed for payment. If sufficient information is not received to process your claim, you or 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.

Duke University's 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:

**Business Travel and Accident
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 or dismemberment occurred.

Cigna Medical Benefits Abroad

Cigna Global Health Benefits' Medical Benefits Abroad (MBA) offers eligible employees and dependents supplemental benefit coverage for unexpected injuries and illnesses that may occur while traveling internationally on Duke business for six months or less.

Coverage under the plan is available without enrollment and at no additional cost for full-time benefits-eligible employees traveling on Duke business. The plan also covers a spouse and dependent children up to age 26 when traveling with the employee. The employee must also have primary health insurance coverage through Duke or another insurance provider.

Your MBA Plan Includes:

- Hospital admissions, surgeries, outpatient medical care, and ambulance service for emergency medical treatment.
- Prescription drugs and replacement medicine for lost prescriptions that are medically necessary.
- Medical evacuations in case you require immediate medical attention and adequate facilities are not locally available.
- Personal travel of up to seven days when taken in combination with your business trip.
- Medical care for you and your family members that are traveling with you.

Should something occur, call the number on the back of your Cigna MBA ID card to reach the customer service team.

For a full list of what your plan covers, please refer to the Certificate of Insurance at:

hr.duke.edu/benefits/medical/medical-insurance/medical-benefits-abroad

Finding a Doctor or Hospital Abroad

You can find doctors and hospitals from the Cigna global directory of pre-screened health care professionals whenever you need them — even before you need care. You can also identify doctors and hospitals that bill Cigna directly. Simply look below the doctor's contact information for a note that says "direct settlement may be available." If so, all you need to do is present your Cigna MBA ID Card.

If direct billing is not available, the doctor or hospital may accept a guarantee of payment from Cigna and will then file the claim directly with Cigna — reducing the need for you to submit any paperwork or pay in full for your care. Your doctor does not need to have a previous agreement with Cigna to request a Guarantee of Payment. All you must do is ask the doctor if they will accept it. Then, they simply call Cigna with the request at the number on the back of your Cigna MBA ID Card.

In situations where the doctor does not have a direct billing arrangement with Cigna and will not accept a guarantee of payment, you can still receive care. After your visit, complete a claim form along with the eligibility verification form, and clearly state how you would like to be reimbursed. Instructions to file a claim are provided on the form.

When you are traveling outside of your country of residence to the U.S. and need to receive emergency care during your visit, it is important that you show your Cigna MBA ID card to the doctor or hospital. This ensures that the doctor and hospital can reach Cigna at the dedicated MBA phone line to verify your benefits.

Other Resources Available

Your MBA plan gives you access to one central online resource that is tailored exclusively for your needs. It is Cigna Envoy for international business travelers located at **CignaEnvoy.com**. You can access information on over 200 countries before you leave for your trip. You can research:

- Currency and exchange rates
- Immunization requirements
- Security alerts
- Voltage requirements

- Country weather and time
- Disease prevention tips

To Access Cigna Envoy:

- 1) Go to **CignaEnvoy.com**.
- 2) Select Int'l Business traveler from the drop-down box in the "Choose your website" section
- 3) Click "Go"
- 4) Log in by inserting the username: **05449BMBA** and password: **Cigna1**

How to Reach Cigna Medical Abroad

Online: **CignaEnvoy.com**

By Phone: Toll-free: **800-243-1348**; Direct (collect calls accepted): **302-797-3535**; Toll-free facsimile number: **800-243-6998**; Direct facsimile number: **302-797-3150**

Mail Delivery: Cigna, P.O. Box 15111 Wilmington, DE 19850-5111 U.S.A.

Courier Delivery: Cigna, 300 Bellevue Parkway, Wilmington, DE

Frequently Asked Questions:

Q. How much do I have to pay for medical benefits abroad?

A. No cost applies and no enrollment process is necessary for coverage through Cigna's Medical Benefits Abroad. Eligible employees only need to download a group ID card for the Medical Benefits Abroad program with Duke's policy number.

Q. Do I or my dependents have to be covered by one of Duke's medical insurance plans to receive coverage through Cigna MBA?

A. Cigna MBA is designed to supplement your primary insurance, so you and your dependents must have health coverage through Duke or other insurance provider.

Q. If I am covered through Duke Options or one of Duke's other medical insurance plans, should I still use the Cigna MBA plan?

A. Yes. The Cigna MBA plan will limit your out-of-pocket costs or the need to pay up front for services and then file for reimbursement. If you use a provider in the Cigna global directory of pre-screened health care professionals, the cost is billed directly to Cigna. If direct billing is not available, the doctor or hospital may accept a Guarantee of Payment from Cigna and will then file the claim directly with Cigna. Otherwise, a claim form can be submitted to Cigna for reimbursement.

The Insurance Certificate Plan

The Insurance Certificate Plan provides a death benefit to the spouse or estate of employees covered under the Plan on or before December 1, 1974.

Eligibility for Coverage

You are covered under this Plan if you are:

- An active Duke University employee as of December 1, 1974, and were participating in the group life insurance program, and
- A participant in the group life insurance program during at least 10 years of consecutive service beginning on or before December 1, 1974.
- Employees on an approved Workers' Compensation leave and receiving wage replacement are eligible to continue their coverage under this plan while on leave.

In order to participate, you must not have terminated employment for any reason prior to age 65 or have died while employed by Duke. Housestaff and employees covered by a collective bargaining agreement are not eligible for this plan.

When Coverage Begins

If you are eligible for the benefit, you will automatically be issued a certificate after your retirement or termination of employment with Duke, provided you meet the above criteria.

Paying for Coverage

Duke pays for the entire cost of this coverage.

Benefit Coverage

The amount of the benefit for any certificate issued after December 1, 1974 is \$2,500.

How To File for Benefits

Your beneficiary or the executor or administrator of your estate may file a claim for a benefit by giving the Plan Administrator sufficient proof of your death. The Plan Administrator may also request submission of sufficient evidence of the right of your beneficiary or the executor or administrator of your estate to receive the benefit payable under the Plan. Submit your claim to:

**HRIC
Duke University
705 Broad St.
Box 90502
Durham, NC 27708**

Appeals of Eligibility, Right To Participate, and Claims 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. The Plan Administrator will decide whether the claim will be allowed. Send your claim to:

**Insurance Certificate 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.

Taxation of Benefit Payments

Duke University generally will not withhold income taxes from the amount of the benefit disbursement; however, based on current IRC regulation, this benefit is likely to be taxable income because it is provided by Duke and not through an insurer. Please consult with your tax advisor to help you determine the actual income tax liability for this payment for which you may be responsible for payment. If the benefit is taxable to you or the estate, the taxation will be based on the year the gratuity payment is received. Duke will issue a 1099 to your estate for the amount of the benefit provided.

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 legal spouse and your eligible dependent children (age 14 days to 26 years if the child is unmarried.)

Eligibility for Coverage

You are eligible to enroll in this Plan if you are an active regular employee, faculty member, or Housestaff member, and 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.

Employees on an approved Workers' Compensation leave and receiving wage replacement are eligible to continue coverage under this Plan, at the active employee rate, while on leave. During this time, you will need to arrange for direct billing with Mercer Voluntary Benefits for your premium payment.

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 30 days after your date of hire or initial 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 Mercer Voluntary Benefits (Mercer), if you have enrolled within 30 days after your date of hire or initial period of 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 program administrator if you have enrolled your dependent within 30 days after your date of hire or 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 Mercer Voluntary Benefits. 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 26, marry; or
- The Plan terminates.

Evidence of Insurability

Evidence of insurability is required if you:

- Apply for coverage more than 30 days after the date of hire or the date when you are first eligible;
- Apply for coverage for your newly eligible spouse 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.

An evidence of insurability form can be obtained from the program administrator, Mercer Voluntary Benefits, by calling **800-552-9670** or logging on to personal-plans.com/duke.

What is evidence of insurability?

A statement of your, your dependent's, or your spouse's medical history used to determine if you, your dependent, or your spouse 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'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, Mercer Voluntary Benefits 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.

Beneficiary Designation

Your Supplemental Life Insurance beneficiary designation is kept on file with the claims administrator, Mercer. Contact Mercer at **800-552-9670** review or update your beneficiaries under this program.

Benefit Coverage

You can select coverage amounts of one to eight times your annual pay* to a maximum \$2,500,000, and up to \$100,000 for your spouse and \$10,000 for each dependent child. Employee coverage is required for a dependent to participate. Employees must have active coverage in effect at the time of issuance of spouse coverage. If the employee cancels their policy after the spouse has been issued coverage, the spouse may maintain spouse only coverage. 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 will equal \$60,000 [$\$17,100 \times 3 = \$51,300$, rounded up to \$60,000].

*For clinical faculty/physicians, your annual pay includes monthly base pay salary, plus where applicable, the regular, recurring monthly amount reflected in Duke's payroll system as "supplemental pay" multiplied by twelve.

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 30 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 of up to \$10,000, the plan requires that he or she not be confined on the effective date of coverage. If confined, the coverage will take effect when the confinement ends. Coverage is guaranteed within 30 days after your date of hire or eligibility or within 31 days of your marriage if these requirements are met. Coverage of up to \$100,000 is available for your spouse but requires additional medical screening.

Coverage also may be purchased for your unmarried child (including your legally adopted child or stepchild) who is under age 26, but not less than 14 days old, and who is dependent on you for support. Underwriting requirements require that he or she is not confined on the effective date of coverage. If confined, the coverage will take effect when the confinement ends. You may enroll your newborn child within 31 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 accordingly.

If your annual pay in effect as of October 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. Automatic increases apply to supplemental life policies based on multiples of salary. Former PDC Members who elected the same flat dollar amount in place of the PDC coverage amount will not receive an annual automatic increase. For example, a million dollar policy at the PDC will not increase. However, as noted, any coverage that is based on a multiple of salary is eligible for automatic increase.

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. Accelerated benefits are payable only once.

How To Designate a Beneficiary

Separate beneficiary designations are required for each life insurance plan. It is the employee's responsibility to ensure beneficiary designations are accurate, up-to-date, reviewed on a regular basis, and sent to the correct carrier/administrator. Please complete the "Supplemental Life Insurance Beneficiary Form"

(hr.duke.edu/forms/supplemental-life-insurance-beneficiary-designation-form) to designate your beneficiary for the Supplemental Life Insurance coverage, AND send that form to:

**Mercer Voluntary Benefits
P.O. Box 9122
Des Moines, IA 50306-9122
Phone: 1-800-552-9670**

Continuation of Coverage

When you retire, terminate or go on a leave of absence, you may continue your coverage by paying premiums directly to the program administrator if the group Plan is still in effect. Retirees must meet the Rule of 75 to be eligible for retiree rates. Employees and faculty members on a leave of absence or \$0.00 rate of pay for greater than 12 months are not eligible for active rates and will be moved to the terminated rate structure. You may keep this coverage until you reach age 95.

Retirees may continue their current level of coverage (1-8 times annual pay, up to \$2,500,000) as of their retirement date at the retiree group rate, or reduce coverage with the following options:

- Reduce coverage to a flat \$25,000;
- Decrease coverage to any of the levels from 1-8 times annual pay, which is less than the amount in effect on the date of retirement; or,
- Decrease coverage in increments of \$50,000 to an amount not less than \$25,000.
- Once a retiree decreases their coverage amount, they will not have the option to increase coverage at a later date.

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.

The child may request conversion to an individual certificate by notifying Mercer and completing an enrollment form in accordance with the terms of your certificate. The request must be made within 31 days of the date the child becomes ineligible. Mercer does not send out notification of ineligibility. Please call Mercer 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 Mercer Voluntary Benefits.
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:

**Mercer Voluntary Benefits
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, The Lincoln National life Insurance Company (Lincoln), determines whether the claim is allowed. If a claim is denied in whole or in part, Lincoln will notify you/your beneficiary and explain its procedure for reviewing a denied claim.

Lincoln 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.

Lincoln reviews all claims and appeals filed under the Plan. This means that Lincoln has the discretionary authority to make all initial determinations with respect to claims filed under the Plan and to decide all appeals of any denied claims. Duke has no discretionary authority with respect to reviewing life insurance claims and appeals. When an initial coverage review has been denied, a request for appeal may be submitted by the employee. You will be required to send a written request for review that must include the following:

- The reasons you feel the application should not have been denied;
- Your application ID;
- Additional supporting medical documentation, such as treatment notes and test results that were not previously submitted for review from treating providers; and
- Any additional information you feel will support the appeal.

Please mail your request to:

**The Lincoln National Life Insurance Company
P.O. Box 2870
Omaha, NE 68103-2870,
or fax it to 603-333-8774**

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

With respect to all claims or issues not subject to the claims procedures described for the Plan, such as your right as an eligible employee or dependent to apply for coverage under the Plan and/or the administrative processes pertaining to the Plan, you may make a claim by filing a written claim and proof of claim with the Plan Administrator in accordance with procedures and guidelines established from time to time by the Staff Fringe Benefits Committee (the Committee). The Plan Administrator will decide whether the claim will be allowed.

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.

The Personal Accident Insurance Plan

The Duke Life Insurance Plan offers you the opportunity to purchase Personal Accident Insurance to protect you and your loved ones in the event of your accidental death or dismemberment or in the event of permanent, total disability as a result of an accident.

Eligibility for Coverage

You are eligible to participate in this plan if you are an active regular employee, faculty member, or Housestaff member and are regularly scheduled to work at least 20 hours per week. You must enroll in this plan to participate. To enroll, complete the form available from the HRIC at **919-684-5600** or on the HR Benefits website at hr.duke.edu/benefits/finance/life-insurance/personal-accident-insurance. You may enroll at any time and coverage is guaranteed.

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

Employees on an approved Workers' Compensation leave and receiving wage replacement are eligible to continue their coverage under this plan while on leave. It is the employee's responsibility to contact the Benefits Office to arrange for premium payment when on an approved leave of absence.

When Coverage Begins

Your coverage becomes effective on the first of the month following your enrollment if you are both actively at work at Duke and meet the eligibility requirements. If you are not actively employed at Duke, benefits become effective when you return to active employment.

When Coverage Ends

Your coverage will end if any of the following events occurs:

- You are no longer classified as an eligible employee;
- You stop making the required contributions;
- Your dependent child reaches age 19 (23rd birthday if enrolled as a full-time student at an accredited college or university) or marries.
- The coverage will terminate on the renewal date following the above dates, whichever is first. You must notify Mutual of Omaha in writing if your child is no longer eligible for coverage; or
- The Plan terminates.

Paying for Coverage

You pay the full cost of Personal Accident Insurance coverage using after-tax dollars withheld from your paycheck through regular payroll deductions. Employees receiving a Duke Long Term Disability benefit pay for their Personal Accident Insurance coverage via personal check or money order on an annual basis, with payment due by the 25th of January. It is the employee's responsibility to contact the HRIC at **919-684-5600** to arrange for premium payment when on an approved leave of absence.

You can choose between "individual" and "family" coverage. If you choose individual coverage, your premium will be \$0.15 per month for each \$10,000 of coverage you elect. The premium for family coverage is \$0.27 per month for each \$10,000 of coverage you elect. Your premium is based on your principal amount, regardless of your age.

Premium Waiver

If you suffer loss of life due to a covered injury, the insurance of any dependent insured hereunder will continue without premium payment until whichever of the following occurs first:

- The date the spouse remarries;
- The date the insurance terminates;
- The date an unmarried dependent child ceases to be eligible due to age or marriage; or
- The date the Benefit Period ends.

The Benefit Period is 12 months beginning on the date of your death.

Benefit Coverage

You can select coverage of a principal amount between \$50,000 and \$750,000, in multiples of \$10,000. Your coverage amount cannot exceed 10 times your annual pay.*

*For clinical faculty/physicians, your annual pay includes monthly base pay salary, plus where applicable, the regular, recurring monthly amount reflected in Duke's payroll system as "supplemental pay" multiplied by

twelve.3If you select coverage for yourself, you also may select accidental death (but not disability) coverage for your spouse and your eligible dependent children. (Your spouse must be under age 70. Your unmarried children are considered eligible dependents under age 19 or age 23 when enrolled as a full-time student in an accredited college or university. Disabled dependent children must be insured prior to their 19th birthday in order to continue coverage after their 19th birthday.) Coverage for your spouse is equal to 60% of your principal sum. Coverage for your eligible dependent children is equal to 20% of your principal amount.

Age Reduction

The benefit is paid in the event of an accidental death based on the principal amount selected, your age on the date of loss (if it is your death or injury), and the applicable percentage based upon the family member’s status as a spouse (60%) or child (20%). Your benefit amount is reduced if you are over age 69. The amount of the benefit you or your beneficiary will be eligible to receive is based on the following table:

Benefit Amounts and Age Ranges

Age	Percentage of Principal Amount
Up to Age 69	100%
70 to 74	82.5%
75 to 79	57.5%
80 to 84	37.5%
85 and Over	20%

Dismemberment

The plan provides dismemberment benefits based on the table below if the injury or loss of life occurs within 365 days after the covered accident.

Disability Benefit

The Personal Accident Insurance Plan provides a benefit of up to \$750,000 if you become totally and permanently disabled as a result of a covered accident within 365 days of its occurrence. You must be under the age of 70 at the time of the accident to receive a benefit. The disability benefit applies only to Duke Employees. Benefits paid under this provision will be reduced by any benefits payable under the Accidental Death and Specific Loss section of the insurance certificate.

Losses and Benefit Payment Percentages

Loss	Benefit Paid
Life	100%
Both hands or both feet	100%
Sight in both eyes	100%
Sight of one eye	50%
Speech	50%
Hearing in both ears	50%
One hand or one foot	50%

Common Disaster Benefit

If you and your spouse die as a result of a covered injury caused by the same accident, then the benefit amount pays 100% of the principal sum amount for both the employee and spouse.

Exposure and Disappearance Due to Air Travel Accidents

If you are exposed to the elements because of an accident resulting in the disappearance, sinking, or damaging of an air conveyance on which you are covered by this policy and in which you were riding, and if as a result of such exposure you suffer a loss for which benefits are otherwise payable hereunder, such loss will be covered under this policy.

If you disappear because of an accident which results in the disappearance or sinking of an air conveyance on which you were covered by this policy and in which you were riding, and if your body has not been found within 52 weeks after the date of such accident, it will be presumed, subject to no evidence to the contrary, that you suffered loss of life as a result of injuries covered by this policy.

What Is a Loss?

With regard to hands and feet, loss means the actual severance through or above wrist or ankle joints. With regard to thumb and index finger, loss means the actual severance through or above the third joints. With regard to sight, speech, or hearing, loss means entire and irrecoverable loss.

Seat Belt Usage Benefit

Personal Accident Insurance coverage also includes a seat belt usage benefit if you or an insured family member suffers a covered loss as a result of an accident.

Should you or a covered dependent receive injuries covered by the policy which result in loss of life, the Personal Accident Insurance coverage will pay \$25,000; if at the time of the accident you or the covered dependent were:

- The operator of or a passenger in a private passenger automobile; and
- Utilizing a seat belt.

Seat belt usage must be verified by a doctor, a coroner or a traffic officer, or other person of competent authority. This benefit will be payable in addition to any benefits otherwise payable under this policy.

Education Benefits

If a dependent child is enrolled in and attending either the 12th grade or an accredited college or university on the date of a covered accident which results in your death, the Personal Accident Insurance coverage will pay benefits in the amount of 5% of the Principal Sum or \$2,500 per child per year, whichever is less, for each year of full-time uninterrupted college or university attendance subsequently completed by the child, subject to the following:

- Benefits may not exceed \$2,500 annually nor a maximum of four annual payments.
- Benefits are payable only for each of the four consecutive years following the date the dependent child graduated from the 12th grade.

Surviving Spouse / Registered Same Sex Spousal Equivalent Training Benefits

If you have family coverage and suffer loss of life in a covered accident, the Personal Accident Insurance coverage will pay the surviving spouse within 54 months following the date of the accident, the expense

incurred by the spouse not to exceed 5% of your principal sum amount. This benefit is payable for any licensed professional or trade school training program provided the spouse has:

- Enrolled for the purpose of obtaining an independent source of support and maintenance;
- Successfully completed the program; and
- Received a certificate or degree upon completion.

Continuation of Medical Coverage Benefit

If your surviving dependent spouse and/or child elect to continue medical coverage under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) or any applicable state continuation law, the Personal Accident Insurance coverage will pay 3% of your principal sum up to \$3,000 for a three-year period.

HIV Occupational Accident Benefit

If you suffer injuries due to a covered accident while performing duties causing you to acquire and test positive for Human Immunodeficiency Virus (HIV) and/or AIDS Related Complex (ARC), within one year of the covered accident, the Personal Accident Insurance coverage will pay 1% of your principal sum up to \$5,000. The benefit amount will be payable in equal monthly installments for 24 months. Benefits will terminate at the end of the month in which you die or the date on which the Personal Accident Insurer has paid the benefit amount, whichever occurs first. Benefits paid under this provision will be reduced by any benefits payable under the Accidental Death and Specific Loss section of the insurance certificate.

Air Travel Coverage

You or a dependent is covered for injuries received while traveling as a passenger (not as a pilot or member of a crew) and getting on or off:

1. Any licensed U.S. civil aircraft or its foreign equivalent:
 - a. Operated by a person holding a valid and in-force pilot certificate (other than a student certificate) of a rating authorizing him or her to operate it.
 - b. Where the primary purpose of the flight is transporting passengers or passengers and cargo.
2. Any transport-type, multi-engined fixed-wing aircraft operated by:
 - a. The Military Airlift Command (MAC) of the United States;
 - b. The Department of National Defense (Canada);
 - c. The Royal Air Force Air Transport Command of Great Britain; or
3. Any aircraft of the United States Department of Defense, other than a single-engine jet:
 - a. Operated by a pilot with proper authorization;
 - b. Where the primary purpose of the flight is transporting passengers or passengers and cargo.

Additional Benefits

Hemiplegia, Paraplegia, and Quadriplegia — Included for all Insured Persons (including dependents). Hemi / Para / Quadriplegia (beginning within 60 days of covered accident, continuing for one year) pays 50%, 75%, and 100% of Principal Sum, respectively. (Only one of the amounts, the largest applicable, listed here or in the

Benefits for Specific Loss provision of the certificate or if insured under the Permanent Total Disability Benefits Rider, will be paid for injuries resulting from one accident.)

Air Bag Benefit Rider — Included for all Insured Persons (including dependents.) Pays \$10,000 for loss of life in covered auto accident, if, at the time of the accident, an Air Bag restraint system was in place and operable.

Accident-Only Coma Benefit Rider — When covered injuries result in treatment by a legally qualified physician beginning within 7 days of injury, this benefit will pay 5% of the applicable Principal Sum monthly after 31 days for up to 20 months if insured person lapses into an irreversible coma from a covered injury. Remainder of any Principal Sum paid upon death.

Children's Dismemberment Benefit — Included on Family Plans only. Non-loss-of life plegia and dismemberment benefits increased to 100% of Child's applicable Principal Sum.

Day Care Benefit Rider — Included only if Children also covered. Pays 5% of Insured's principal sum to \$5,000 maximum for each dependent Child enrolled in day care facility at time of loss (or within 90 days of loss) if Insured dies from a covered accident. \$1,000 alternate benefit to Employee's beneficiary if no eligible Children.

Rehabilitative Services Benefit — Included for all Insured Persons. Pays 5% to \$5,000 maximum after a \$250 deductible, for losses incurred for rehabilitative services (when the Insured is totally disabled) within 52 weeks of the date of the covered accident.

Exclusions

Personal Accident Insurance does not cover:

- Suicide or any attempt thereat;
- Loss caused by an act of declared or undeclared war;
- Injuries received while participating in training exercises or maneuvers of an armed service while a member of an armed service;
- Injuries received while traveling by air (except as provided under the Coverage section);
- Injuries received because the covered person was under the influence of any controlled substance unless administered on the advice of a physician; or
- Injuries received because the insured person was intoxicated.

Conversion of Coverage

When your coverage ends, you may convert to an individual AD&D policy by contacting the insurance carrier within 31 days of the date you lose eligibility. For further information and assistance with this process, call Mutual of Omaha at **844-579-5586**.

Claims Information

To request a claim form, submit a written notice of any loss covered by the policy to the underwriter, Mutual of Omaha Insurance Company, within 20 days of the loss or as soon as reasonably possible. This notice must identify the insured person and the policy. A claim form will be sent to you or your beneficiary within 15 days of receipt of the notice. If not included with your original notice, written proof of your loss must be provided to the insurer within 90 days of the loss or as soon as possible within one year.

To file a claim, you or your beneficiaries must complete the steps below:

1. Request a claim form by filing a written proof of the cause of your loss with Mutual of Omaha Insurance Company at the address noted below. For your convenience, claim forms are also available from the HRIC at **919-684-5600**.
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 the underwriter at the following address:

**Mutual of Omaha
Special Risk Claims
P.O. Box 31156
Omaha, NE 68131-0156
844-579-5586
mutualofomaha.com**

Once your claim is received, if approved, it will be processed for payment. If sufficient information is not received to process your claim, you or 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 the 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:

**Personal Accident 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 or dismemberment occurred.

This insurance plan is underwritten by Mutual of Omaha. This is for illustrative purposes only and is not a contract. Please remember that only the insurance policy can give actual terms, coverage, amounts, conditions, and exclusions. To obtain a copy of your policy, please contact the Human Resources Information Center at **919-684-5600**.

The Post-Retirement Group Term Life Insurance Plan

This information pertains only to Duke Employees currently holding Provident Life and Accident Post-Retirement Group Term Life contracts. It is not available for new enrollments.

This plan provides life insurance benefits after your retirement and is entirely employee-paid. You may select this plan prior to retirement and begin paying for coverage with regular pre-tax deductions from your paycheck.

Your premiums are added to a "retired lives reserve fund" where the interest rate is guaranteed never to drop below 5%. This reserve fund pays death benefits only; no cash or loan values are available through this plan.

Eligibility for Coverage

You are eligible to participate in this plan if you currently hold a Provident Life and Accident Post-Retirement Group Term Life contract and are an active, regular employee regularly scheduled to work at least 30 hours per week or a faculty member regularly scheduled to work at least 40 hours per week. Housestaff and employees covered by a collective bargaining agreement (unless coverage was mutually agreed to in the bargaining agreement) are not eligible for this plan.

Coverage is guaranteed if you select a target retirement date at least five years in the future. For example, if you are 50, you may decide to retire at age 55 and receive a benefit. If you plan to retire with fewer than five years notice, you must satisfy the required medical questions.

Employees on an approved Workers' Compensation leave and receiving wage replacement are eligible to continue their coverage under this plan, while on leave. During this time, you will need to arrange for direct billing with the Holroyd Agency for your premium payment.

When Coverage Begins

Your coverage becomes effective on the date you are both actively at work at Duke and meet the eligibility requirements (see above.) If you are not actively employed at Duke, benefits become effective when you return to active employment.

When Coverage Ends

Your coverage will end if any of the following events occurs:

- You are no longer classified as an eligible employee;
- You stop making the required contributions; or
- The plan terminates.

Paying for Coverage

You pay the full cost of this coverage using pre-tax dollars withheld from your paycheck through regular payroll deductions. Your premium will depend on how far you are from your target retirement date and how much life insurance coverage you select. Your insurance will be “paid up” to your elected coverage amount when you retire, if you retire at your projected retirement date and have not missed any premium deductions.

Benefit Coverage

You may purchase up to \$50,000 of coverage that is “paid-up” at the time of your retirement. “Paid-up” means that you don’t need to make any additional premium payments after you retire. If you die before your retirement, your beneficiary will receive a death benefit equal to the greater of the following:

- All of the premiums you paid; or
- The value of the “retired lives reserve fund.”

If you leave Duke or retire prior to your target retirement date, you will receive a certificate of paid-up insurance for a lesser amount than you had originally elected to purchase. This reduced death benefit would be payable after your target retirement date.

Claims Information

In the event of your death, you or your beneficiary must make written claim for the benefits and provide proof of the cause of your loss. You or 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 the HRIC.
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:

Holroyd Agency
2508 Hinton St.
Raleigh, NC 27612
919-819-0456

Once your claim is received, if approved, it will be processed for payment. If sufficient information is not received to process your claim, you or 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 the 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:

Post-Retirement Group Term 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 or later than three years have passed after you file your claim.

Your Rights Under ERISA

For a summary of your rights under the Employee Retirement Income Security Act of 1974 (ERISA), please refer to the "General Information" section in this booklet.

This Summary Plan Description, which is a part of the Duke University Welfare and Fringe Benefits Plan along with the underlying insurance contracts, shall constitute the written plan document for the Duke Life Insurance Program. Duke reserves the right to change or terminate these benefits or your eligibility for benefits under the Duke Life Insurance Program. The written plan documents for the Duke Life Insurance Program are not employment contracts or any type of employment guarantee.

Personal Casualty Insurance

Personal Casualty Insurance, also known as Property Insurance and offered through the Auto and Home Insurance Program, provides you with additional options to select from as you consider your auto and home insurance needs.

The information provided here is for your convenience. Duke University does not sponsor or endorse this coverage, but you can choose to have premiums for this coverage deducted from your Duke paycheck.

Home, Auto, Renters, and Excess Liability Insurance

Personal Casualty Insurance protects you in the event of an accident or natural disaster that damages personal property that you own, or against personal liability in the case of property damage or personal injury to another person as a result of your actions. Policies available include homeowners, renters, automobile, and excess liability insurance. Duke employees may receive policy quotes from Travelers and Farmers at a special rate through Mercer Voluntary Benefits' Auto and Home Insurance Benefit Program.

The insurance is provided through Mercer Voluntary Benefits and provides:

- Rates that may be lower than individual rates.*
- Convenient payroll deduction of your premiums.
- Discounts including a payroll deduction, multi-policy and tenure discount.**

Since homeowners and renters insurance is based on several factors including the state in which you live, the type of construction of your home, and many other factors, this insurance may not give you the lowest premium.

*Discounts are not available from all carriers and only available to those who qualify. Coverages, discounts, and billing options are subject to state availability, individual qualification, and/or the insuring company's underwriting guidelines.

**Savings are not guaranteed.

Eligibility for Coverage

You are eligible to participate in this program if you are an active employee scheduled to work at least 20 hours per week. Issuance of coverage is not guaranteed coverage. You may not qualify for auto insurance based on state regulations, driving record, types of coverage you need, the people who need to be insured, and applicable underwriting guidelines. You may not qualify for homeowner's or renter's insurance based on whether you live in an area prone to severe weather, the age of your home, types of coverage you need, the possessions that need to be insured, prior losses, and other underwriting guidelines.

Employees on an approved Workers' Compensation leave and receiving wage replacement are eligible to continue their coverage under this program, while on leave. During this time, you will need to arrange for direct billing with Mercer Voluntary Benefits for your premium payment.

When Coverage Begins

If you are accepted for coverage, your auto insurance can start the day after you apply for the coverage over the phone. If you want to receive proof of your new coverage sooner rather than later, you can receive temporary insurance cards by fax. Your permanent cards will be mailed to you. If you are accepted for coverage, your homeowner's / renter's insurance can start the day after you apply for coverage over the phone. It can also begin at a later date you specify. You will receive your insurance policy in the mail.

Paying for Coverage

You pay the full cost of Personal Casualty Insurance coverage using after-tax dollars withheld from your paycheck through regular payroll deductions. Auto insurance premiums may also be paid directly to the insurance carrier or via bank deductions. Either option allows you to spread your payments over the policy term, giving you more manageable payment installments with no interest charges or service fees.

Alternatively, you can elect to pay by check, or add the cost to your mortgage or escrow payment.

How the Plans Work

You do not have to wait until your current policy expires to switch. Call toll-free **800-552-9670** at any time of the year to speak to a professional representative and receive comparative quotes on auto, home, boat, or other insurance from two insurance carriers: Travelers and Farmers.

Obtaining a Quote

Obtaining a free, no-obligation quote is easy. You can:

- Call the Mercer Service Center at **800-552-9670** to work with an insurance counselor over the phone.
- Complete the online quote process (dukevoluntarybenefits.com). You will need to answer a series of questions regarding your insurance requirements and driving history. The site will guide you through the process with helpful tips and easy to understand explanations. Based on the information you provide, you can receive an immediate quote. In some more complicated cases, you may be instructed to contact the service center to speak with an insurance counselor. Having the following information in hand will help expedite the quote process:
 - Your current auto and home policy information
 - Your social security number
 - Year, make and model of your vehicle(s)
 - Vehicle identification number(s)
 - For each driver on your policy:
 - Date of birth
 - Driver's license number
 - History of accidents and violations
 - Year your house was built
 - Square footage and special features of your house

Quotes are based on the information you provide and may change due to consumer reports the carrier obtains.

Continuation of Coverage

Travelers

When you retire, terminate, or go on a leave of absence from Duke, you can continue your Travelers auto coverage without interruption, subject to applicable law and the policies' terms and conditions, by paying your premiums directly to Travelers via direct checking or bank account deduction, credit card billing or home billing. Payments should be sent to:

**Travelers Remittance Center
One Tower Square
Hartford, CT 06183-1001**

Retirees and terminating employees remain eligible for group rates.

Farmers

When you retire, terminate, or go on a leave of absence from Duke, you can continue your Farmers coverage without interruption, subject to applicable law and underwriting guidelines. Retirees are still eligible for group rates, but other terminating employees are not. Although payroll deduction will no longer be available, you can opt for bank account deduction or home billing. Payments should be sent to:

**Farmers
P.O. Box 41753
Philadelphia, PA 19101**

Portability is available in all states to those who leave Duke, except for Michigan.

Claims Information

For Auto Insurance, call Mercer Voluntary Benefits Service Center at **800-552-9670** to speak to a claims representative. In event of an accident, always call as soon as possible, regardless of who is at fault. Find out whether you are covered for this loss. Even if the accident appears minor, it is important that you let your insurance company know about the incident.

For Homeowner's / Renter's insurance, if you have a policy from Travelers, call **800-252-4633**. If you have a policy from Farmers, call **800-854-6011**.

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.

Program Administrator:

**Mercer Voluntary Benefits Service Center
12421 Meredith Dr.
Urbandale, IA 50398
Customer Service: 800-552-9670
(8:00 a.m. to 6:00 p.m. EST / EDT, Mon.-Fri.)
customer.service@mercer.com**

The Individual Life Insurance Plan

Existing Policyholders

Prior to January 1, 2020, Duke offered the convenience of payroll deduction for Individual Universal Life Insurance. Duke does not sponsor or endorse this coverage. In January 2020, payroll deduction was discontinued, except for those that had already enrolled with the respective vendors.

Eligibility for Coverage

You are eligible to purchase this coverage if you are an active, regular employee or faculty member regularly scheduled to work at least 20 hours per week.

Housestaff and employees covered by a collective bargaining agreement (unless coverage was mutually agreed to in the bargaining agreement) are not eligible to purchase this coverage.

Employees on an approved Workers' Compensation leave and receiving wage replacement are eligible to continue their coverage under this plan, while on leave. During this time, you will need to arrange for direct billing with the Holroyd Agency for your premium payment:

Existing Vendors

Holroyd Agency
919-819-0456

North Carolina Mutual Life
800-793-0223

Information on the following page outlines the provisions of the policies offered by the two vendors. You may contact either or both vendors to obtain additional information regarding coverage.

When Coverage Ends

Your coverage will end if any of the following events occurs:

- You are no longer classified as an eligible employee;
- You stop making the required contributions; or
- The coverage terminates.

Conversion of Coverage

You may convert the insurance to a direct pay policy when you terminate or retire from Duke.

Paying for Coverage

You pay the entire cost of this coverage using after-tax dollars.

Benefit Coverage

As an active employee at Duke, you have a choice of providers for this coverage.

Cash Value Accumulation Fund

Under the individual Universal Life Insurance Plan, you have the added feature of potential cash value accumulation. This policy builds cash value by setting aside a portion of your premium and crediting it with an interest rate of 4.5% or higher. You may defer taxes on any interest earnings. In addition, you may borrow against the cash value of your plan, or you may make an outright withdrawal.

Duke reserves the right to cease payroll deductions for the Universal Life Insurance Plan.

The Duke Housestaff Life Insurance Plan

The Duke Life Insurance Program offers the Duke Housestaff Life Insurance Plan, which also provides accidental death and dismemberment (AD&D) insurance for Housestaff and Physician Assistant Residents attending the Physician Assistance Surgical Residency Program. Life insurance coverage provides a benefit to your survivors in the event of your death, while AD&D insurance provides benefits in the event of your death as the result of an accident or if you suffer a covered loss.

Summary of Benefits

This section highlights the benefits provided under this insurance. The purpose is to give you quick access to the information you will most often want to review. **Please read all other areas of this section for a more detailed explanation of benefits and any limitations or restrictions that might apply.**

Member Life Insurance

If you die, your beneficiary will be paid the scheduled benefit then in force for you (however, see the exception noted below). The scheduled benefit is based on your class:

Class: ALL MEMBERS

Scheduled Benefit: 100,000

Member life insurance benefits are subject to all reductions provided in the group policy including reductions due to salary changes, age changes, and receipt of accelerated benefit payment.

Member Accidental Death and Dismemberment Insurance

If you are injured and otherwise qualify, the following percentages of your scheduled benefit (or approved amount, if applicable) in force will be paid:

- 50% if you lose a hand, a foot, or the sight of one eye;
- 100% if more than one of the above listed losses results from the same accident;
- 25% for loss of thumb and index finger on the same hand; or
- 100% if you lose your life.

Payment for loss of life will be to your beneficiary or as otherwise provided in the death benefit provision. Payment for any other loss will be to you. Your scheduled benefit is based on your class:

Class: ALL MEMBERS

Scheduled Benefit: 100,000

Eligibility for Coverage

To be eligible for insurance you must be a member (i.e., any physician assistant resident attending the physician assistance surgical residency program or housestaff person who is a full-time employee of Duke University and who regularly works at least 30 hours per week).

If you are a member on July 1, 2018, you will be eligible on that date.

If you are not a member until later, you will be eligible on the date you become a member (as defined in the **Definitions** section below).

In no circumstance will you be eligible for member life insurance under the group policy if you are eligible under any other group term life insurance policy underwritten by Principal Financial Services, Inc.

Effective Dates – Actively at Work

If you are not actively at work on the date your insurance would otherwise be effective, your insurance will not be in force until the day you return to active work.

This actively at work requirement will be waived for you if:

- You were absent from active work because of a regularly scheduled day off, holiday, or vacation day;
- You were actively at work on your last scheduled work day before the date of your absence; and
- You were capable of active work on the day before the scheduled effective date of your insurance or changes in your insurance, whichever is applicable.

This actively at work requirement may also be waived as described below.

When insurance under the group policy replaces coverage under a prior policy, the active work requirement may be waived for those members who:

- Are eligible and enrolled under the group policy on the date the group policy is effective; and
- Were covered under the prior policy on the date of its termination.

In no event will the active work requirement be waived for those members who, on the date of termination of the prior policy, either:

- Had the option, under the terms of the prior policy, to convert their coverage under the prior policy to an individual policy; or
- Were eligible under the terms of the prior policy to have their premiums waived due to total disability.

NOTE: When insurance under the group policy replaces coverage under a prior policy and the active work requirement is waived, any benefits payable will be the lesser of the scheduled benefit of the group policy or the amount that would have been paid by the prior policy had it remained in force.

Individual Incontestability

All statements made by any insured person will be representations and not warranties. These statements may not be used to contest an insured person's insurance unless:

- The insurance has been in force for less than two years during the insured person's lifetime; and
- The statement is in written form signed by the insured person; and
- A copy of the form, which contains the statement, is given to the insured person or the insured person's beneficiary at the time insurance is contested.

However, the above will not preclude the assertion at any time of defenses based upon the person not being eligible for insurance under the group policy or upon other provisions of the group policy.

In addition, if a person's age is misstated, Principal may, at any time, adjust premium and benefits to reflect the correct age.

Assignments

No assignments of member life insurance will be allowed under the group policy.

Effective Date for Initial Insurance

You must request initial insurance in a form provided by Principal.

Your insurance will normally be in force on the date you are eligible.

However, if you are not actively at work on the date insurance would otherwise be effective, your insurance will not be in force until the day you return to active work.

Effective Date for Benefit Changes Due to Change in Insurance Class

A change in your scheduled benefit amount because of a change in your insurance class will normally be effective on the date of the changes. However, if you are not actively at work on the date the scheduled benefit change would otherwise be effective, the scheduled benefit changes will not be in force until the day you return to active work. Exception: Any decrease in scheduled benefit amounts due to a change in your insurance class will be effective on the date of the change, whether or not you are actively at work.

Any termination of scheduled benefit amounts due to a change in your insurance class will be effective on the date of the change, whether or not you are actively at work.

Effective Date for Benefit Changes Due to Changes by Policy Amendment

A change in your Scheduled Benefit amount because of a change in the schedule of insurance (as described in the **summary of benefits** above) by amendment to the group policy will be effective on the date of changes. However, if you are not actively at work on the date an increase in the scheduled benefit would otherwise be effective, the scheduled benefit in force will continue to apply to you until the day you return to active work. When you return to active work, the scheduled benefit increase will then be in force for you. Exception: Any decrease in scheduled benefit amounts due to a change by amendment to the group policy will be effective on the date of change, whether or not you are actively at work.

Termination

Your insurance under the group policy will cease on the earliest of:

- The date the group policy terminates;
- The date the last premium is paid for your insurance;
- For contributory insurance, any date desired, if requested by you before that date;
- The date you cease to be a member;
- The date you cease to belong to a class for which insurance is provided;
- The date you retire; or
- The date you cease active work.

Termination for Fraud

We may at any time terminate a person's eligibility under the group policy:

- In writing and with 31-day notice, if the individual submits any claim that contains false or fraudulent elements under state or federal law;

- In writing and with 31-day notice, upon finding in a civil or criminal case that an individual has submitted claims that contain false or fraudulent elements under state or federal law; or
- In writing and with 31-day notice, when an individual has submitted a claim, which, in good faith judgment and investigation, an individual knew contains false or fraudulent elements under state or federal law.

Insurance While Outside of the United States

If you are temporarily outside the United States, you may choose to continue insurance, subject to premium payment for a period of 14 months or less for one of the following reasons:

- Travel;
- A business assignment;
- Full-time student status, provided you are either:
 - Enrolled and attending an accredited school in a foreign country; or
 - Participating in an academic program in a foreign country, for which the institution of higher learning at which you are enrolled in the U.S. grants academic credit.

If you are outside the United States for any other reason than those listed above, insurance for the person concerned will automatically terminate.

Continuation

If you cease active work because of sickness or injury, you may be eligible for limited continuation of insurance.

If you cease active work because of layoff or leave of absence, insurance may be continued on a limited basis.

Your insurance may also be continued under the **Other Continuation Provisions** described below and subject to the provision of the group policy.

Your insurance may also be continued as described in the **Portability** section below and subject to the provisions of the group life portability policy.

If you are interested in continuing your insurance beyond the date it would normally terminate, you should consult with Duke University before your insurance terminates.

Other Continuation Provisions

FMLA and Other Continuation Provisions

If you cease active work due to an approved leave of absence under the Federal Family and Medical Leave Act (FMLA), Duke University may choose to continue your insurance, subject to premium payment.

If the continuation portion of the FMLA applies to your insurance, these FMLA continuation provisions:

- Are in addition to any other continuation provisions of the group policy, if any; and
- Will run concurrently with any other continuation provisions of the group policy for sickness, injury, layoff, or approved leave of absence, if any.

If continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

Reinstatement

An eligible employee's terminated insurance may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA), subject to the actively at work requirements of the group policy.

Reinstatement of Insurance for You When Insurance Ends Due to Living Outside of the United States

If insurance for you terminates because you are outside of the United States you may become eligible again for insurance under the group policy, but only if:

- You return to the United States within six months of the date on which insurance terminated because the person is outside of the United States; and
- In your case, you return to active work in the United States for Duke University for a period of at least 30 consecutive days. You will be eligible for insurance on the day immediately following completion of the 30 consecutive days of active work.

The reinstated insurance will be on the same basis as that being provided on the date insurance is reinstated. However, any restrictions on this insurance, which were in effect before reinstatement, will continue to apply. If you do not complete the 30 consecutive days of residence, the insurance for such person concerned will not be reinstated.

Description of Benefits

Member Life Insurance

Death Benefit

If you die while insured for member life Insurance, this policy will pay your beneficiary the scheduled benefit (or approved amount, if applicable) in force on the date of your death, less any accelerated benefit payment as discussed later in this section. Any benefit due a beneficiary who does not survive you will be paid in equal shares to your surviving beneficiaries. If a beneficiary dies at the same time or within 15 days of you, but before the insurer receives Written proof of your death, payment will be made as if you survived the beneficiary. If no beneficiary survives you or if no beneficiary is named, the insurer will make your payment in the following order of precedence:

- To your spouse;
- To your children born to or legally adopted by you;
- To your parents;
- To your brothers and sisters;
- If none of the above, to the executor or administrator of your estate or other persons as provided in the group policy.

However, if a beneficiary is suspected or charged with your death, the death benefit may be withheld until additional information has been received or the trial has been held. If a beneficiary is found guilty of your death, such beneficiary may be disqualified from receiving any benefit due. Payment may then be made to any contingent beneficiary or to the executor or administrator of your estate.

No payment will be made before Principal receives written proof of your death.

Upon your death, the scheduled benefit (or approved amount if applicable) in force on the date of your death, less any accelerated benefit payment as discussed later in this section will be paid in a single lump sum. Upon request, Principal may consider other payment options.

Beneficiary

You should name a beneficiary at the time you enroll for insurance. You may name or later change your beneficiary by sending a Written request to the Duke University. A change in your beneficiary will not be in force until Duke University record(s) the change. Once recorded, the change will apply as of the date the request was signed. If Principal properly pays any benefit before a change request is received, that payment may not be contested.

Continuation (Member Life Insurance – Coverage During Disability)

If you cease active work for any reason, your insurance will normally terminate. However, if you cease active work because you are totally disabled, you might qualify to continue your Member Life and Member Accidental Death and Dismemberment Insurance. This continuation is called coverage during disability. This coverage during disability provision does not apply to you if you have a continued coverage as described in the **Portability** section below.

To be qualified for coverage during disability, you must

- Become totally disabled while insured for member life insurance;
- Become totally disabled before the earlier of retirement or attainment of age 60;
- Remain totally disabled continuously;
- Be under the regular care and attendance of a physician;
- Send proof of total disability to Principal within one year of the date total disability starts and as often thereafter as Principal may require;
- Return, without claim, any individual policy issued under your purchase rights as described below. Upon return of such policy, you will be refunded the premiums paid, less dividends and less any outstanding policy loan balance; and
- Submit to examinations by a physician or evaluations by an evaluator when required (Principal will pay for these examinations and will choose the physician).

Principal has the right to require you to undergo medical evaluations, functional capacity evaluations, vocational evaluations, and/or psychiatric evaluations during the course of a claim. The examinations or evaluations will be performed by a physician or evaluator Principal chooses as appropriate for the condition and will be conducted at the time, place and frequency Principal reasonably requires.

Principal will pay for these examinations and evaluations and will choose the physician or evaluator to perform them. Failure to attend a medical examination or cooperate with the physician may be cause for denial of your benefits. Failure to attend an evaluation or to cooperate with the evaluator may also be cause for denial of your benefits. If you fail to attend an examination or an evaluation, any charges incurred for not attending an appointment as scheduled may be your responsibility.

If you qualify, coverage during disability will be in force on the earlier of:

- The day nine months after the date your total disability began; or
- The date of your death.

Premium will not be charged for member life and member accidental death and dismemberment insurance while your coverage during disability is in force.

Coverage during disability will cease on the earliest of:

- The day nine months after the date your total disability began; or
- The date of your death.

Premium will not be charged for member life and member accidental death and dismemberment insurance while your coverage during disability is in force.

Coverage during disability will cease on the earliest of:

- The date your total disability ends;
- The date you fail to send any required proof of total disability;
- The date you cease to be under the regular care and attendance of a physician;
- The date you fail to submit to a required physician's examination or evaluation by an evaluator; or
- The date you are age 65.

If you die while coverage during disability is in force, Principal will pay your beneficiary the member life insurance benefit, if any, that would have been paid had you remained insured under the schedule of insurance in force on the date your total disability began. Member life insurance benefits are subject to all reductions provided in the group policy including reductions due to salary changes, age changes, and receipt of accelerated benefit payment.

Note that coverage during disability will not be in force and NO BENEFIT WILL BE PAID if written proof of total disability is not sent to Principal within ONE YEAR of the date total disability starts. However, failure to give written proof within the time specified will not invalidate or reduce any claim if written proof is given as soon as reasonably possible.

Coverage during disability will not be available for any disability that:

- Results from intentional self-inflicted bodily injury;
- Results from war or act of war; or
- Results from voluntary participation in an assault, felony, criminal activity, insurrection, or riot.

Accelerated Benefit

An accelerated benefit is an advance (before death) payment of a part of your member life insurance benefit. To qualify for an accelerated benefit, you must;

- Be insured for a member life insurance benefit of at least \$10,000;
- Be terminally ill (expected to die within 12 months);

- Send a request for accelerated benefit payment to Principal; and
- Send proof, satisfactory to Principal, of your terminal illness.

Proof of terminal illness will consist of a statement from your physician, and any other medical information that Principal believes is needed to confirm your status.

If you qualify, Principal will pay you any amount you request, except that:

- Only one accelerated benefit payment will be made during your lifetime; and
- You must request a payment of at least \$5,000;
- You will not be paid more than the lesser of (1) 75% of your member life Insurance benefit; or (2) \$100,000.

Accelerated benefits payments are paid as a lump sum.

If an accelerated benefit is paid, the member life insurance benefit otherwise payable to your beneficiary upon your death will be reduced by any accelerated benefit payment.

Following is an example of how this benefit affects the final death benefit.

Benefit Example	
Member Life Insurance Benefit Amount	\$ 100,000
Accelerated Benefit Amount Requested (Member would receive \$75,000)	\$ 75,000
Payment to Member's Beneficiary (\$100,000 - \$75,000)	\$ 25,000

During the two-year period following payment of an accelerated benefit:

- Termination of active work because of your terminal illness will not result in termination of your member life insurance; and
- Your member life and member accidental death and dismemberment insurance will be provided without premium charge.

Individual Purchase Rights

You will have the right to buy an individual life insurance policy without submitting proof of good health:

- If your total member life insurance, or any portion of it, terminates because you end active work or cease to be in a class eligible for insurance. In these instances, the maximum amount you may buy will be your Member life insurance amount in force on the date of termination or the portion of your Member Life Insurance that has terminated, less any individual amount purchased earlier under these rights, and less any accelerated benefit as discussed earlier in the section.
- If the group policy terminates or is amended to exclude your insurance class after you have been insured for at least five years. In these instances, the maximum amount you may buy will be the smaller of: (1) \$10,000; or (2) your member life Insurance amount in force on the date of termination, less any

accelerated benefit as discussed earlier in this section and less any amount for which you become eligible under any group policy within 31 days.

- If your coverage during disability ceases because total disability ends and you do not then become insured under the group policy within 31 days. In this instance, the maximum amount you may buy will be the coverage during disability benefit amount in force on the date total disability ends, less any individual amount purchased earlier under these rights, and less any accelerated benefit as discussed earlier in this section.
- If your accelerated benefit premium waiver period ceases and you do not qualify for coverage during disability. In this instance, the maximum amount you may buy will be the member life insurance benefit amount in force on the date you cease active work, less any individual amount purchased earlier under these rights, and less any accelerated benefit as discussed earlier in this section.

You must apply for individual purchase and pay the first premium to Principal within 31 days after your insurance or coverage during disability under the group policy ceases.

See the policyholder for the proper forms. Any individual policy issued will be effective on the 32nd day.

The individual policy will be for life insurance only (other than term insurance). No disability or other benefits will be included. The premium you pay will be at Principal's normal rate for your age and for the risk class to which you belong on the individual policy's date of issue.

If you die within the 31-day purchase period, your beneficiary will be paid the life insurance amount, if any, you had the right to buy. This payment will be made whether or not you have applied for an individual policy.

Member Accidental Death and Dismemberment Insurance

Benefit Qualification

To qualify for benefit payment, all of the following must occur:

- You must be injured while insured for member accidental death and dismemberment insurance;
- Your injury must be caused by accident;
- Your injury must be the direct and sole cause of a loss listed in benefit payable below;
- Your loss must occur within 365 days of your injury;
- The limitations listed below must not apply;
- You must satisfy the requirements listed in the Claim Procedures Section; and
- All medical evidence must be satisfactory to Principal.

Benefit Payable

If all of the above qualification are met, Principal will pay the following percentages of your scheduled benefit (or approved amount, if applicable) in force:

- 50% if one hand is severed at or above the wrist;
- 50% if one foot is severed at or above the ankle;

- 50% if the sight of one eye is permanently lost (For this purpose, vision not correctable to better than 20/200 will be considered loss of sight.);
- 100% if more than one of the above listed losses occurs;
- 25% for loss of thumb and index finger on the same hand; or
- 100% if you lose your life.

Total payment for all losses under benefits payable that result from the same accident will not exceed 100% of your scheduled benefit (or approved amount, if applicable). Payment for loss of life will be to the beneficiary you named for member life insurance. Payment for any other loss will be to you.

Limitations

Payment will not be made for any loss to which a contributing cause is:

- Intentional self-inflicted bodily injury;
- Disease, medical or surgical treatment of disease, or complications following the surgical treatment of disease (other than bacterial infection resulting from accidental injury or accidental ptomaine poisoning);
- Voluntary participation in a riot, assault, felony, criminal activity, or insurrection;
- Participating in flying, ballooning, parachuting, parasailing, bungee jumping or other aeronautic activities, except as a passenger on a commercial aircraft or as a passenger in a Duke University-owned or leased aircraft on company business;
- Duty as a member of a military organization;
- War or act of war;
- The use of alcohol if, at the time of the injury, your alcohol concentration exceeds the legal limit allowed by the jurisdiction where the injury occurs;
- The operation by you of a motor vehicle or motor boat if, at the time of the injury, your alcohol concentration exceeds the legal limit allowed by jurisdiction where the injury occurs; or
- The use of any drug, narcotic, or hallucinogen not prescribed for you by a licensed physician.

Portability

When insurance would otherwise end under the group policy as described below, you may be eligible to continue insurance under a Group Life Portability Insurance Policy underwritten by Principal. The Group Life Portability Insurance policy will contain provisions that differ from the group policy. If you elect to continue insurance under this option, you will receive a certificate outlining the Group Life Portability Insurance Policy provisions.

You may elect to purchase an individual policy of life insurance (see as described above) in place of this portability option.

Member Life and Member Accidental Death and Dismemberment Insurance

Eligibility

If member life and member accidental death and dismemberment insurance under the group policy ends because you cease to meet the definition of a member, you may be eligible to continue such insurance under the Group Life Portability Insurance Policy without submitting proof of good health.

In order to continue insurance under the Group Life Portability Insurance Policy:

- For Member Life and Member Accidental Death and Dismemberment insurance, you must be less than age 70.

Insurance may not be continued under the Group Life Portability Insurance Policy if:

- Your insurance has been continued under provisions described above;
- You have received a benefit under provision described above;
- Your insurance under the group policy ends because the group policy terminates for the, and is replaced by another group policy;
- You have exercised your as described above; or
- You die.

Amount of Insurance

The insurance amount that is available for continuation will be the member life and member accidental death and dismemberment insurance scheduled benefit amount (or approved amount, if applicable) in force on the date insurance terminates under the group policy.

Termination of Ported Insurance

Ported insurance under the Group Life Portability Insurance Policy will terminate on the earliest of:

- The date ending the period for which the last premium is paid; or
- For Member insurance, the May 1 next following your 70th birthday.

When insurance under the group life portability insurance ends, you may qualify and elect to purchase an individual policy of life insurance.

Application/Effective date

Notice of the portability option must be given to you by the before insurance under the group policy terminates, or as soon as reasonably possible thereafter.

When notice of eligibility to continue insurance under the Group Life Portability Insurance Policy is not provided to Principal following the termination of insurance under the group policy, you must apply for insurance and pay the first premium within 60 days of your termination date. Any continued coverage under the portability option will be in force on the day following termination of insurance under the group policy.

Payment of premium constitutes your consent to port your insurance.

If you die within the 60-day portability option period, Principal will pay the named beneficiary the scheduled benefit amount (or approved amount, if applicable) in force, if any, you had the right to continue. This payment will be made whether or not you have applied for the portability option.

Claim Procedures

Notice of Claim

Written notice of claim must be given to Principal or an authorized agent of Principal within 20 days after the date of loss. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

Claim Forms

Claim forms and other information needed to prove loss must be filed with Principal in order to obtain payment of benefits. The will provide forms to assist you in filing claims. If the forms are not provided within 15 days after Principal receives such notice, you will be considered to have complied with the requirements of the group policy upon submitting, within the time specified below for filing proof of loss, written proof covering the occurrence, character, and extent of the loss. A civil penalty may be imposed by the insurance commissioner if Principal does not acknowledge the claim within 30 days after receiving written notice of such claim, but only if notice contains sufficient information for Principal to identify the specific coverage involved.

Proof of Loss

Completed claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to Principal within 90 days after the date of loss. Proof required includes the date, nature, and extent of the loss. Principal may request additional information to substantiate your loss or require a signed unaltered authorization to obtain that information from the provider. Your failure to comply with such request could result in declination of the claim.

Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the date proof is otherwise required.

For purposes of satisfying the claims processing timing requirements of the Employee Retirement Income Security Act (ERISA), receipt of claim will be considered to be met when the appropriate claim form is received by Principal.

Payment, Denial, and Review

ERISA permits up to 45 days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information Principal will send a Written explanation prior to the expiration of the 45 days. A claimant is then allowed up to 45 days to provide all additional information requested. Two 30-day extensions may be granted for processing an incomplete claim. Written notification will be sent to a claimant regarding the extension.

If actual practice, benefits under the group policy will be payable sooner, provided the claim is received complete and proper proof of loss is included. Further, if a claim is not payable or cannot be processed, a detailed explanation of the basis for the denial will be provided.

A claimant may request an appeal of a claim denial by written request to Principal within 180 days of the receipt of notice of the denial. Principal will make a full and fair review of the claim. Principal may require additional information to make the review. Principal will notify the claimant in writing of the appeal decision within 45 days after receipt of the appeal request. If the appeal cannot be processed within the 45-day period because Principal did not receive the requested additional information, Principal is permitted a 45-day extension for the review. Written notification will be sent to the claimant regarding the extension. After exhaustion of the formal appeal process, the claimant may request an additional appeal. However, this appeal is voluntary and does not need to be filed before asserting rights to legal action.

For purposes of this section, “claimant” means you, your dependent, or beneficiary.

State time limits: Unless otherwise preempted by the Employee Retirement Income Security Act (ERISA), state time limits will apply. State law requires that benefits payable under the group policy will be payable immediately after receipt of proof and subject to due proof of loss.

Medical Examination

Principal may require the individual whose loss is the basis for claim to be examined by a physician during the course of a claim. Principal will pay for these examinations and will choose the physician to perform them.

Autopsy

If payment for loss of life is claimed, Principal may require an autopsy. Principal will pay for any such autopsy.

Legal Action

Legal action to recover benefits under the group policy may not be started earlier than 90 days after proof of loss if filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after that proof is required to be filed.

Time Limits

All time limits listed in this section will be adjusted as required by law.

Definitions

Several words and phrases used to describe your insurance are capitalized whenever they are used in this section. These words and phrases have special meanings as explained in this section.

Active Work; Actively at work means you will be considered actively at work if you are able and available for active performance of all of your regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered active work provided you are able and available for active performance of all of your regular duties and were working the day immediately prior to the date of your absence.

Group Policy means the policy of group insurance issued to the by Principal which describes benefits and provisions for insured members.

Insurance Month means calendar month.

Member means any physician assistant resident attending the physician assistance surgical residency program or housestaff person who is a full-time employee of Duke University and who regularly works at least 30 hours per week. The employee must be compensated by the and either the employer or employee must be able to show taxable income on federal or state tax forms. Work must be at the usual place or places of business, at an alternative worksite at the direction of the, or at another place to which the employee must travel to perform his or her regular duties. This excludes any person who is scheduled to work for the on a seasonal, temporary, contracted, or part-time basis.

An owner, proprietor, or partner of the business will be deemed to be an eligible employee for purposes of the group policy, provided he or she is regularly scheduled to work for the at least 30 hours per week and otherwise meets the definition of a member.

Physician means:

- A licensed Doctor of Medicine (M.D.), Osteopathy (D.O); or

- Any other licensed health care practitioner that state law requires be recognized as a physician under the group policy.

The term physician does not include you, one of your employees, your business or professional partner or associate, any person who has a financial affiliation or business interest with you, anyone related to you by blood or marriage, or anyone living in your household.

Policyholder means Duke University Medical Center housestaff.

Proof of Good Health means written evidence that a person is insurable under Principal's underwriting standards. This proof must be provided in a form satisfactory to Principal.

Qualifying Event means, for accelerated benefits, a medical condition, which would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span. Such conditions may include, BUT ARE NOT LIMITED TO, one or more of the following:

- Coronary artery disease resulting in an acute infarction or requiring surgery;
- Permanent neurological deficit resulting from cerebral vascular accident;
- End stage renal failure; or
- Acquired immune deficiency syndrome (AIDS).

Signed or Signature means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law and is agreed to by Principal.

Terminally Ill means, for accelerated benefits, you have experienced a qualifying event and you are expected to die within 12 months of the date you request payment of accelerated benefits.

Total Disability; totally disabled means for you, your inability, as determined by Principal, due to sickness or injury, to perform the majority of the material duties of any occupation for which you are or may reasonably become qualified based on education, training, or experience.

Written or Writing means a record which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

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DUKE LONG TERM CARE INSURANCE PROGRAM

Introduction

Effective July 1, 2013, the carrier discontinued offering the program to new members. Please use the information and resources in the following section to seek support for existing coverage or assist you in selecting an individual long term care product.

An accident or illness may strike at any age and at any time, leaving you or a loved one disabled and in need of long term care services. Disability coverage, which is designed to replace a portion of earnings lost due to disability, might cover your normal living expenses but may not be enough to pay someone to take care of you. Medicare and private health care plans pay for hospitalization and other medically necessary expenses, but typically do not cover extended long term care costs.

Group long term care coverage is designed specifically to cover the costs associated with extended long term care, including a variety of services for people who are unable to care for themselves. Long term care services include home health care, care in a community-based setting such as an adult day care or assisted living facility, and care in a nursing home.

Like other types of insurance, group long term care coverage is intended to protect you and your family from financial hardship as a result of an unexpected event. That's why Duke makes group long term care coverage available to you. Your spouse, Same Sex Spousal Equivalent, parents, parents-in-law, grandparents, and grandparents-in-law and adult children age 18 and older may also apply.

Effective July 1, 2008, the underwriter for Duke's Long Term Care Insurance Program changed to The Prudential Insurance Company of America (Prudential). Prior to this change, the underwriter for the Program was Aetna Life Insurance Company (Aetna). Some participants elected to transition to an individual, non-ERISA long term care policy with Aetna rather than change to Prudential's coverage. The term "Duke" is used throughout this booklet. "Duke" refers to the University, Duke University Health System, Inc. and any other corporation or entity that adopts the Plan with the duly authorized approval of the Board of Trustees. When used in this Plan document, "Employer" shall refer to all of the foregoing collectively except where the context requires that such term refer to the corporation or entity that actually employs an individual.

The benefit provided is based on an employee's company code and job code as reflected in the HR benefits administration system (SAP). Duke employees holding more than one position classification receive the benefits associated with their primary position classification as reflected in SAP. For example, a housestaff member who also works within DHIP, receives benefits associated with their housestaff position classification.

Existing Policyholders

Effective July 1, 2013, Prudential discontinued offering the coverage to new enrollees and Duke no longer offers a Group Long Term Care Insurance plan. Please use the information and resources below to seek support for existing coverage or assist you in selecting an individual long term care product.

In 2012, Prudential announced it would discontinue sales of its group long term care (LTC) insurance products, effective July 1, 2013. Existing group LTC insurance certificate holders will continue to be covered under the terms of their Prudential group LTC certificates, which are guaranteed renewable. This means that as long as premiums are paid on time and benefits are not exhausted coverage cannot be cancelled, although premiums can be changed based on experience, on a class basis, in accordance with the terms and conditions of the certificate.

Clients and certificate holders will continue to receive customer service and claims support through Prudential Customer Service: **800-732-0416**, available Monday through Friday from 8 a.m. to 8 p.m. (EST).

Spousal Discount

Rates for married persons or Same Sex Spousal Equivalents are discounted 10%. Enrollment in the plan is not required for the spouse / Same Sex Spousal Equivalent in order for the insured to receive the married person's discount.

When Coverage Ends

Your coverage under the Duke group long term care policy and/or that of your family members will end if any of the following events occur:

- You or your family member cancel the coverage;
- You die;
- You or the family member cease paying premiums for the coverage;
- You have reached your lifetime maximum benefit level; or
- The plan is terminated (see "Coverage Continuation," below).

Leaving Duke / Coverage Continuation

If you or your spouse / Same Sex Spousal Equivalent leave employment with Duke, you may continue coverage by paying premiums directly to Prudential.

Coverage will be continued under the policy with the same benefits and provisions.

Existing policyholders may continue the insurance by paying the premium for the coverage while on an unpaid leave of absence, sabbatical, or lay off status. They may also continue the insurance at retirement or termination by paying the premiums directly to Prudential.

As long as you continue paying your premiums and your lifetime maximum has not been exhausted, you will continue to be insured.

Coverage Continuation after Death, Divorce, or Termination of Domestic Partner Relationship

If you are no longer eligible for coverage due to the death of, or divorce from, your spouse, or the termination of your Same Sex Spousal Equivalent relationship, your coverage can continue in force for as long as you continue to pay the premiums directly to the insurer.

Paying for Coverage

Employees and their spouse or Same Sex Spousal Equivalent can choose from three different payment options: payroll deduction, electronic funds transfer from a checking or savings account, or direct billing on a quarterly, semi-annual, or annual frequency. There is a 2.83% premium discount with the semi-annual direct billing option and a 5.58% premium discount with the annual direct billing option.

Parents, parents-in-law, grandparents, grandparents-in-law, and adult children aged 18 and older will receive a bill for premiums at their home address. The family member will be given the option of having monthly automatic checking or savings account deductions (EFT), or direct billing on a quarterly, semi-annual, or annual frequency.

Premium discounts described above are also available for family members.

Premiums are based on the benefit plan chosen and on your age at the time Prudential receives your application. If the insured chooses a voluntary buy up offer or otherwise purchases additional coverage at a later age, additional premium will be required.

Buying additional coverage will not change the premium for current coverage.

For premium rates to change, the insurer would have to change rates for everyone in your age category who has the kind of coverage plan that you do.

You can never be singled out for a rate increase because of age, illness, or for filing claims under the plan.

No Cancellation for Any Reason

As long as you keep paying your premiums and you have not received benefits up to your lifetime maximum, your coverage cannot be cancelled.

Waiver of Premium

Your premiums will be waived after you have met the 90 days Benefit Waiting / Elimination Period. Payment of premiums will resume at the end of the close of 90 consecutive days during which the covered family member has not had a loss of functional capacity.

Loss of Benefits

You may experience a reduction or loss of benefits in any of the following circumstances:

- You fail to follow the plan's procedures;
- You fail to pay the required premiums;
- You are found to have committed a material misrepresentation of fact or a fraudulent act against the plan including, but not limited to, the fraudulent filing of a claim for benefits; or
- The plan is amended or terminated, and you do not elect to continue coverage, but only with respect to expenses incurred after the amendment or termination becomes effective, unless the claim continues without interruption.

Information for Those Seeking Coverage

Long term care refers to a very broad range of medical, personal and social services provided to people who are unable to care for themselves over a relatively long period of time. It usually involves assistance in

performing everyday functions such as toileting, bathing, eating and dressing. You must have a certified loss of functional capacity to receive benefits under this plan.

Long term care services can be provided in nursing homes or assisted living facilities or at home by caregivers such as home health care workers, nurses or therapists, or in community-based settings such as adult day care centers.

Duke no longer offers Long Term Care insurance, but below are resources to help you assess options for coverage.

- **National Association of Insurance Commissioners** — The mission of the NAIC is to assist state insurance regulators, individually and collectively, in serving the public interest. For more information, view “A Shopper’s Guide to Long Term Care Insurance” at: content.naic.org/sites/default/files/publication-ltc-lp-shoppers-guide-long-term.pdf.
- **National Clearinghouse for Long Term Care Information** — The U.S. Department of Health and Human Services has information and resources to help families plan for future long term care needs.
- **National Care Planning Council** — The goal of the National Care Planning Council has been to educate the public on the importance of planning for long term care.
- **North Carolina Partnership Program for Long Term Care Insurance** — The North Carolina Department of Insurance has a website to help consumers learn more about the state’s partnership program for long term care insurance.

How the Group Long Term Care Insurance Program Works

Long term care insurance helps you pay for costs associated with these kinds of services, whether at home, in an assisted living facility, adult day care center, or in a nursing home.

The ultimate purpose of long term care insurance is to help individuals retain their independence as long as possible, help assure that they may have freedom and choice in where they receive assistance, and help preserve their assets.

Sample Plan Options

Benefit	Option 1	Option 2	Option 3
Daily Benefit Maximum (DBM)	\$100	\$150	\$200
Nursing Home Care, Hospice Facility Care, Assisted Living Facility Benefit: The maximum amount of coverage your plan could provide each day.	100% of DBM	100% of DBM	100% of DBM
Home & Community-Based Care and Adult Day Care: The amount you would receive each day you receive community-based home health care or Adult Day Care (automatically 75% of the daily nursing home care benefit).	75% of DBM	75% of DBM	75% of DBM
Lifetime Maximum Benefit: Total benefits payable under the plan. Based on when and where you receive care, your Lifetime Maximum Benefit could be paid out in a minimum of the years on which your plan is based, or in a much longer period of time.	3 Years* \$109,500	3 Years* \$164,250	3 Years* \$219,000
	10 Years* \$365,000	10 Years* \$547,500	10 Years* \$730,000

*You may choose a daily benefit amount between \$100 — \$350 and a lifetime maximum of 3, 5, 10 years, or an unlimited lifetime maximum.

All of the options in the table above include the following benefits:

- **Respite Benefit** — Provides for substitute at-home care while your usual caregiver takes a break from providing care or otherwise is not attending to the covered family member's needs. The benefit pays up to 21 days per calendar year, 100 days per lifetime and will pay up to the Nursing Home Daily Maximum regardless of the type of services used.
- **Bed Reservation Benefit** — While you are receiving Long Term Care services in a Nursing Home or an Assisted Living Facility, you may incur charges for Bed Reservation by that institution to retain your bed while you are confined in an acute care facility for 24 hours or more. Benefits for eligible charges will be paid up to 21 days per calendar year. You must satisfy the Benefit Waiting / Elimination Period before benefits are payable.
- **Informal Caregiver Training** — Coverage is provided for training if someone will be providing care for the insured and requires training in how to be a caregiver. Benefits for eligible charges will be paid up to 5 times the Nursing Home Daily Benefit Maximum.

Benefit Waiting / Elimination Period

A 90 Day Benefit Waiting/Elimination Period must be met once during your lifetime before benefits are payable. This plan has one combined Benefit Waiting / Elimination Period for all covered services to which it applies. This is a period, counted in calendar days, which begins on the date you are assessed, if that assessment results in eligibility for benefits, and continues as long as you have a Chronic Illness or Disability. You do not need to incur charges to satisfy the Benefit Waiting / Elimination Period. The Benefit Waiting / Elimination Period can be satisfied over multiple periods of Chronic Illness or Disability.

What are Activities of Daily Living?

You are considered to have a qualifying loss of functional capacity if you are unable to perform at least two of the following activities described below without substantial assistance (i.e., Hands-On Assistance and Standby Assistance) of another person each time the activity is performed:

- **Bathing** — Washing yourself by sponge bath; or washing yourself in a tub or shower, including the task of getting into or out of the tub or shower.
- **Continence** — the ability to maintain control of bowel and bladder functions; and, when unable to maintain control, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag.
- **Dressing** — putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- **Eating** — Feeding yourself by getting food into your body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
- **Toileting** — getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

How You Qualify for Claim (Benefit Eligibility)

You are eligible to receive benefits if you are assessed by an Assessor (a Licensed Health Care Practitioner who is qualified to evaluate conditions relevant to your functional or cognitive ability).

Qualifications are based on training and experience, and may include health care industry, state or national standards) and confirmed as having a Chronic Illness or Disability. A Chronic Illness or Disability is one in which there is:

- A loss of the ability to perform, without Substantial Assistance, at least two Activities of Daily Living. This loss must be expected to continue for 90 days. Activities of Daily Living are Bathing, Continence, Dressing, Eating, Toileting, and Transferring; or
- A severe cognitive impairment which requires substantial supervision to protect you from threats to health or safety.

What is Severe Cognitive Impairment?

Severe cognitive impairment is a loss or deterioration in your intellectual capacity that is measured by clinical evidence and standardized tests that reliably measure impairment in the following areas:

- Short term or long term memory;
- Orientation as to people, places, or time; and
- Deductive or abstract reasoning, or judgement as it relates to safety awareness.

Substantial assistance is the physical assistance of another person without which you would not be able to perform an Activity of Daily Living or the constant presence of another person within arm's reach which is necessary to prevent, by physical intervention, injury to you while you are performing an Activity of Daily Living.

Substantial supervision is continual oversight that may include cueing by verbal prompting, gestures or other demonstrations by another person and which is necessary to protect you from threats to your health or safety.

Nursing Home Care

When independent living is no longer an option, a Nursing Home may be necessary. A Nursing Home is a facility that provides skilled, intermediate, or custodial care and meets at least one of the following criteria:

- Is Medicare-approved as a provider of skilled nursing care services.
- Is licensed by the state in which it is located as a skilled nursing home, an intermediate care facility, or a custodial care facility.
- Meets all of the following criteria.
- Its main function is to provide skilled, intermediate or custodial nursing care.
- It is engaged in providing continuous room and board accommodations for three or more persons.
- It has a physician on staff or available to it under contract.
- It is under the supervision of a Registered Nurse or Licensed Practical Nurse.
- It maintains medical records for each patient.
- It maintains control of and records of all medications dispensed.

Assisted Living / Residential Care Facility

For an Assisted Living / Residential Care Facility that is located in a state that licenses or certifies such a facility, an Assisted Living / Residential Care Facility is one which is licensed or certified by the state in which the facility is located. For facilities located in states that do not license or certify Assisted Living / Residential Care Facilities, an Assisted Living / Residential Care Facility is one that meets, in Prudential's judgment, the following minimum criteria:

- It is a group residence that maintains records for services to each resident.
- It provides services and oversight on a 24-hour a day basis, which support a resident in a manner that promotes dignity, independence, and privacy.
- It provides a combination of housing, supportive services, and personal assistance designed to respond to the resident's need for help with the Activities of Daily Living and instrumental Activities of Daily Living.
- It provides, at a minimum, assistance with Bathing, Dressing, and help with medications.
- It is NOT licensed as a Nursing Home.

Home and Community-Based Care

Home and Community-Based Care is home health care or personal care received from a home health care agency, a licensed referral agency, a licensed nurse registry or informal caregiver, or provided by an independent health care professional and adult day care received from an adult day care facility.

Cash Alternative Benefit

Under this benefit, at your option, your coverage will pay a monthly fixed benefit to you in lieu of reimbursement for eligible charges for home and community-based care as stated above. The Cash Alternative Benefit may be used for informal care services, which provides for personal care in your home by

family members, neighbors or other private-hire caregivers. The Cash Alternative Daily Benefit is payable for each day in the month in which you have chronic illness or disability, after you satisfy the Benefit Waiting / Elimination Period. The Cash Alternative Daily Benefit is equal to 50% of your daily maximum for home health care and reduces your lifetime maximum.

Hospice Care

Hospice care refers to the special attention those in the late stages of a terminal illness need. This care tries to help the whole person by alleviating physical discomfort and providing emotional, social, and spiritual comfort.

Benefits for eligible charges will be paid up to 100% of the Nursing Home Daily Maximum for institutional and non-institutional care. The Benefit Waiting / Elimination Period does not apply to Hospice Care benefits.

Private Care Management

This feature provides coverage for a Private Care Manager to provide information, resources or to coordinate your long term care. You must first meet the Benefit Eligibility Criteria in order to use this benefit. Benefits for eligible charges will be paid up to 12 times the Daily Benefit Maximum per calendar year. No Benefit Waiting / Elimination Period applies to Private Care Management benefits.

Alternate Plan Benefit

Due to emerging trends on the delivery of long term care, this plan takes into account the current institutional and Home Health Care based settings that are available. Prudential will consider a claim for benefits for care received in an alternate setting or non-institutional services designed to help an eligible person remain independent in their home. You must satisfy the Benefit Waiting / Elimination Period before benefits are payable.

Inflation Protection

So that your plan coverage may keep up with inflation, you periodically will be given opportunities to increase your benefit amount on a guaranteed-issue basis.

You determine which option:

- Voluntary Increase — (Standard feature) you may purchase increases in your coverage every 3 years without proof of good health to help keep pace with the rising cost of long term care. You may increase your coverage through this feature even if you are in claim status as long as you have not turned down two consecutive previous offers. The amount that you will be able to purchase is 5% of your current Daily Benefit Maximum compounded annually for the previous three years.
- Automatic Increase — (Optional for additional initial premium) coverage will automatically be increased every year without proof of good health to help keep pace with the rising cost of long term care. The amount of increase will equal 5% of your daily benefit maximum compounded yearly. Your coverage will be increased through this feature even if you are in claim status.

Coverage Exclusions

This Plan does not provide benefits for any of the following:

1. Work-connected Conditions Charge. A charge covered by a workers' compensation law, occupational disease law or similar law.
2. Government Plan Charge. A charge for a service or supply:

- a. furnished by or for the United States government or any other government, unless payment of the charge is required by law; or
 - b. to the extent that the service or supply, or any benefit for the charge, is provided by any law of governmental plan under which the patient is or could be covered. The (b) does not apply to a state plan under Medicaid or to any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program. When this (b) applies to Medicare, the benefits provided by Medicare will be deemed to include any amount that would have been payable by Medicare in the absence of a deductible or coinsurance requirement under that program.
3. War, Felony, Riot or Insurrection. Charges for a condition due to war or any act of war while you are insured or due to your participation in an act of felony, riot or insurrection. "War" means declared or undeclared war and includes resistance to armed aggression. "Riot" means a wild, violent, public disturbance of the peace.
 4. Self-inflicted Injury or Suicide. Charges arising from intentionally self-inflicted injury or attempted suicide, while sane or suffering from inorganic based insanity.
 5. Services and Supplies outside the United States. Charges for services or supplies outside of the United States and its possessions except as described in the International Coverage benefit.
 6. Treatment for Chronic Alcoholism or Chemical Dependency. Charges in connection with the treatment of chronic alcoholism or chemical dependency.

Lifetime Maximum Benefit

Not more than the Lifetime Maximum Benefit may be paid under this Plan to any one Covered Family Member, in the aggregate, during the lifetime of such Covered Family Member.

At the end of a Benefit Period, your Lifetime Maximum Benefit will be restored to its original value when you recover and resume premium payments, as long as the total Lifetime Maximum Benefit has not been exhausted. The restored amount may not be used to pay benefits for any expenses incurred prior to the date the Lifetime Maximum Benefit is restored.

Other Limitations

The plan may not cover all the expenses associated with your long term care needs.

Relationship of Cost of Care and Benefits

Because the costs of long term care will likely increase over time, you should consider whether and how the benefit level is guaranteed to increase over time.

How To File a Claim

It is important that you start the process of using your coverage by calling the Prudential Long Term Care Customer Service Center at **800-732-0416**. You are encouraged to call Prudential before you begin using Long Term Care services so that you know in advance whether your benefits will be available. Either you or your authorized or legal representative may call.

Prudential will arrange for a trained Assessor to assess you or you may select your own Assessor. As part of the assessment process, you and your caregiver may be interviewed. If Prudential arranges the assessment,

the interview may be by telephone or in-person depending on your condition. The assessment will be based on objective standards of measurement.

If you wish to select your own Assessor, you must notify Prudential when you call our Long Term Care Customer Service Center. Prudential will send you an assessment form that your Assessor must complete and return to Prudential at the following address:

**The Prudential Insurance Company of America
751 Broad St.
Newark, NJ 07102**

Based on the information obtained during the assessment, your eligibility will be confirmed or denied based on Prudential's use of objective standards of measurement. These may include the "Katz Index of ADL," "Folstein's Mini-Mental Examination," or any other equivalent objective standard of measurement currently in use at the time of assessment and acceptable to Prudential, subject to the terms and conditions of the Certificate. You will be sent a written notice to confirm your eligibility. If you are not eligible, you will be sent a written notice explaining the reasons you were not eligible.

If you are eligible, you will need a plan of care. Your plan of care will be used to determine benefits based on the Plan you have chosen.

You will be reassessed periodically to determine if you are still eligible for benefits.

To comply with federal income tax requirements, you must be assessed at least once each year.

Appealing Decisions about Eligibility

You have the right to appeal decisions made about your eligibility for benefits. When you are determined to be ineligible for benefits, you will be sent a notice that explains why you are not eligible. This notice will also explain the procedure you should follow if you choose to appeal the decision. Prudential will send you a written acknowledgment of your appeal. If no additional information is required and the appeal is denied, the acknowledgment will include a detailed explanation of the reason(s) for the denial. If additional information is required, Prudential will explain what information is needed. Upon receipt and review of the additional information, Prudential will notify you in writing of the results of the review.

If you still disagree with the appeal decision, you can request in writing within 60 days of the decision that the matter be submitted to the Benefit Appeal Committee. This Committee includes, but is not limited to, clinical consultants, legal consultants, and product management staff. After a thorough review, the Committee will send you written notification of its decision.

Your Rights Under ERISA

For a summary of your rights under the Employee Retirement Income Security Act of 1974 (ERISA), please refer to the "General Information" section in this booklet.

Other Important Information

Family and Medical Leave Policy

Employees who are eligible for this plan are subject to a federal law called the Family and Medical Leave Act (FMLA). Your Duke long term care coverage will continue for the duration of your approved leave of absence under FMLA, provided you continue to pay any required premiums. If you choose not to continue your long term care coverage, you won't receive benefits for any condition that occurs during the leave. When you return

to work, the long term care coverage that was discontinued or terminated will be reinstated only if you request reinstatement within 30 days of your return.

Tax Information

The Duke Long Term Care Insurance Program is a tax-qualified plan. This means that the plan must meet certain federal standards. It also means that, if you itemize deductions on your federal income tax return, you may deduct your premiums for this coverage as a qualified medical expense (subject to federal tax limitations).

Long term care benefits paid from a tax qualified plan generally are not taxable as income. See your tax advisor for additional information.

Please contact Prudential at **800-732-0416** to request a claim form.

Claims for the Long Term Care Insurance Program should be sent to the insurer at the address listed on the claim form.

NOTE: Prior to Prudential, the insurer for this program was Aetna Life Insurance Company. Some plan participants chose to remain with the Aetna program when the carrier changed effective July 1, 2008. These individuals can contact Aetna at **800-537-8521** should information be needed regarding their coverage.

DUKE DISABILITY PROGRAM

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DUKE DISABILITY PROGRAM

Introduction

The Duke University Disability Program provides eligible employees with income when unable to work due to a disability beyond a certain amount of time, called a benefit waiting period.

Your benefits will replace up to 60% of your base salary until you are eligible to retire, you can no longer show proof of your disability, or you default on a repayment agreement.

The Duke University Disability Program is a self-insured plan providing the disability coverage described in this document to certain eligible employees of Duke University and Duke University Health System.

The most current Summary Plan Description is the one that controls for benefit purposes.

Amendment and Termination of the Plan

The Duke University Disability Program is a welfare benefit plan. Duke expects to continue the plan indefinitely, but reserves the right to terminate the plan or to change the terms and benefits of the plan at any time in the future.

The term "Duke" is used throughout this booklet. "Duke" refers to the University, Duke University Health System, Inc. and any other corporation or entity that adopts the Plan with the duly authorized approval of the Board of Trustees. When used in this Plan document, "Employer" shall refer to all of the foregoing collectively except where the context requires that such term refer to the corporation or entity that actually employs an individual.

The benefit program provided is based on an employee's company code and job code as reflected in the HR benefits administration system (SAP). Duke employees holding more than one position classification receive the benefits associated with their primary position classification as reflected in SAP. For example, a housestaff member who also works within DHIP, receives benefits associated with their housestaff position classification.

The word "spouse" is used in this benefit program's summary plan description. This means legal spouse. In addition, it refers to an employee's registered Same Sex Spousal Equivalent providing the employee was hired prior to January 1, 2016 and registered his/her partner in Duke HR prior to January 1, 2016. This employee's registered partner remains eligible under Duke's Same Sex Spousal Equivalent Policy and is included in the meaning of "spouse" for the purpose of this benefit program wherever permissible under federal and state law. The eligible status continues for the course of this relationship only.

Eligibility, Enrollment, And Coverage

Who is Eligible for Coverage

If you meet the payroll / benefit classifications for eligible employees and are an active, regular full-time employee scheduled to work at least 30 hours per week, a faculty employee holding a regular rank appointment who is receiving wages for Social Security purposes, or a faculty employee holding other than a regular rank appointment and classified as a full-time member of the faculty who is receiving wages for Social Security purpose, you are eligible for coverage.

Effective the later of July 1, 2023 or the transition date, Duke's employer-provided long term disability program is modified as follows:

- Employees holding a full time, active, Private Diagnostic Clinic faculty position and receiving compensation from Duke immediately prior to the transition are no longer excluded from eligibility to participate in the program.

Who is Not Eligible for Coverage?

- Temporary employees,
- Non-faculty employees working less than 30 hours per week,
- A faculty employee holding other than a regular rank appointment and not classified as a full-time member of the faculty, who is receiving wages for Social Security purposes,
- Housestaff officers,*
- Employees covered for other monthly disability income coverage provided by Duke.

*Eligible housestaff receive long term disability coverage through the Housestaff Long Term Disability Program, they are not eligible to participate in the disability programs described here. Please contact the GME office for additional information regarding that program.

Paying for Coverage

Duke pays the entire cost of the plan.

How To Enroll

You are automatically enrolled in the plan on the date you become eligible.

When Coverage Begins

Your coverage begins on the latest of:

- The first day of the month after the completion of three years of full-time continuous service provided you are in a benefit eligible classification with Duke, or the first day of the month after you return to active work if you are not actively at work on the date coverage would otherwise start. If you have an FMLA leave from active work certified by Duke, for purposes of eligibility for coverage, you will be considered to be actively at work. Other non-FMLA leave, including leaves with pay, will not count towards completion of three years of full-time, continuous service or for eligibility of coverage. Exception: Your coverage may begin on a day when you are not actively at work if you were actively at work on your last scheduled day prior to the day coverage begins; or

- After qualifying for the Duke LTD service waiver requirement. The first day of the month after your hire date, without the three-year waiting period if you have had a group employer-provided / employer-paid long term disability coverage through your former employer within 90 days of starting your eligible position at Duke. Your prior employer's HR department must provide proper documentation to Duke Benefits within 90 days after your date of hire to be eligible for this waiver. The "Duke Disability Program-Request for Service Requirement Waiver" form is available at: hr.duke.edu/forms/duke-disability-program-request-service-requirement-waiver-form

It is your responsibility to ensure proof of prior employer-sponsored long term disability coverage is completed by your prior employer's HR department and to confirm receipt of proof by Duke Benefits Office within 90 days after your date of hire. **Important:** An individual (non-group) or converted LTD disability plan does not qualify for LTD waiver consideration.

PLEASE NOTE: The PDC continuous service date for employees that transitioned from the PDC on July 1, 2023 is included for purposes of determining eligibility to participate in this program. Additionally, PDC physicians / members who transitioned into Duke effective July 1, 2023 as full-time faculty receiving Duke pay are eligible for coverage under this plan beginning July 1, 2023. Please see the "Important Summary for Employees Transitioning to the Duke Health Integrated Practice (DHIP) on July 1, 2023" in the "General Information About Your Benefits" section of this summary plan description for additional details.

Continuation of Coverage

Your coverage will continue and, for purposes of this coverage, your employment will be deemed to continue, under the following conditions:

- Leave of absence with at least one-quarter pay (until the end of 24 months after the beginning of the leave of absence);
- Leave of absence with less than one-quarter pay authorized by the Duke Board of Trustees, for the purposes of engaging in full-time study for an advanced degree or for active work in the field of education or research such as Fulbright or foundation grant or government project (until the end of 24 months after the beginning of the leave of absence);
- Employees who work on an academic calendar at the convenience of the University;
- Your coverage may be continued during approved family medical leaves of absence under the Family and Medical Leave Act (FMLA). If you have an FMLA leave from active work certified by Duke, then for purposes of eligibility and termination of coverage you will be considered to be actively at work. Your coverage will remain in force so long as you continue to meet the requirements set forth in the FMLA; or
- Participation in the program is suspended during a personal (non-medical) leave of absence. If you return to work within 12 months and there is no break in service, coverage under the plan will resume and the three-year waiting period is waived.

When Coverage Ends

Your coverage will end on the earliest of the following dates:

- You are no longer an active employee on Duke payroll unless you meet one of the status requirements outlined under "Continuation of Coverage;"

- You are no longer eligible for coverage under the plan;
- You drop below 30 hours per week or become benefit ineligible for more than 90 days;
- You retire;
- The date you are laid off; or
- The plan terminates.

The plan stops providing a specific benefit to you on the date that benefit is no longer provided under the plan.

Conversion of Coverage

Conversion to an individual policy is not available for this plan. Coverage will cease when your active employment ends.

How the Disability Program Works

Disability coverage provides a valuable benefit — if an illness or injury keeps you out of work for an extended period of time, it can provide you with a portion of your pre-disability income until age 65 if needed, and in some cases, past age 65. Disability benefits are for income replacement (lost wages), not in addition to an employee's regular full salary.

Qualifying for Coverage

The plan pays benefits if you become disabled and qualify to receive benefits. The benefit payable is based on the Schedule of Benefits in effect on the date you became disabled.

To be considered qualified to receive benefits, you must:

- Be covered on the date you become disabled and the condition causing your disability is not excluded from coverage;
- Provide notice of a claim, in writing to Duke HR Benefits and file such claim within 180 days of you becoming disabled or while on Duke Workers' Compensation leave and receiving wage replacement in order to satisfy claim submission requirements;
- Be covered on the date the benefit waiting period begins;
- Be receiving regular and appropriate care and treatment intended to aid your recovery and your return to work. Regular and appropriate care and treatment means supervised care or treatment by a doctor for the sickness or accidental injury causing your disability.

Benefit Waiting Period

The benefit waiting period is the length of time you must be continuously partially or totally disabled before you qualify to receive any benefits.

The benefit waiting period begins on the first day your doctor states in writing that you are disabled because of sickness or accidental injury; no benefits are payable during the benefit waiting period. You must be under the continuous care of a doctor during your benefit waiting period for benefits to be payable after the benefit waiting period. During the waiting period, you can receive pay and benefits through your vacation, sick, Paid Time Off (PTO) benefit, Paid Parental Leave, Faculty Temporary Medical Leave, or donated hours through the Kiel Memorial Vacation / PTO Donation Program.

Benefit Waiting Periods

Duke University Health System 90 calendar days

All Other Employees 120 calendar days

Exception: You may return to work or continue to work in the case of a partial disability, for up to 30 days during the benefit waiting period without having to begin a new benefit waiting period. Any full days you work do not count toward meeting the benefit waiting period. If you return to work, or continue to work, for more than 30 full days before satisfying your benefit waiting period, you will have to begin a new benefit waiting period.

When Benefits Are Paid

After completion of the benefit waiting period (see additional information in this section), you will be paid a monthly benefit around the 15th of each month in which you qualify for benefits. Direct deposit is required for all benefit payments. If you are disabled for part of a month, the benefit payable is based on 1/30th of your monthly income benefit for each day you are disabled.

Approved claims are paid monthly, require ongoing medical review, and satisfaction of all terms and conditions of the plan.

Amount of Benefits

Total Disability

Total disability is defined as the following:

- For clinical faculty / physicians — You are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury, and you have a 20% or more loss in your monthly earnings due to the same sickness or injury. The loss of professional or occupational license or certification does not, in itself, constitute disability. For physicians, “regular occupation” means your specialty or subspecialty in the practice of medicine, in which you are both board certified (or the equivalent certification from another country) and practiced immediately prior to the start of your disability. Monthly earnings for clinical faculty includes his/her monthly base salary, plus where applicable, the regular, recurring monthly amount reflected in Duke’s payroll system as “supplemental pay.”
- For Licensed Commissioned Police Officers employed at the University on or after July 1, 1997 who have received a Company Policy Commission under NCGS Chapter 74E that is held by the Duke University Police Department — You are unable to do the essential duties of your own occupation because of sickness or accidental injury.
- For all other employees — You are unable to perform the essential duties of your own occupation during the first 24 months of disability payments due to sickness or accidental injury. After 24 months, you are unable to perform the essential duties of any occupation you are or could reasonably become qualified for by education, training, or experience.

If you are in an occupation that requires you to maintain a license, your failure to pass a physical examination required to maintain a license to perform the duties of your occupation alone does not mean that you are disabled from your occupation.

Who is a Qualified Doctor for Purposes of Providing Information Related to Your Medical Condition?

Doctor means a person who is:

- A doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that we recognize or are required by law to recognize;
- Licensed to practice in the jurisdiction where care is being given;
- Practicing within the scope of that license; and
- Not you or related to you by blood or marriage.

What is Your Occupation?

The activity that you regularly perform and that serves as your source of income. It is not limited to the specific position you held with Duke. It may be a similar activity that could be performed with Duke or any other employer.

Your monthly income benefit for total disability is equal to the lesser of 60% of your basic monthly earnings or \$35,000, minus any other income, such as employment income, unemployment income, Workers' Compensation, or Social Security payments.

PLEASE NOTE: Your disability benefits are considered taxable income and subject to federal and state taxes.

Partial Disability

You are partially disabled when your monthly earnings are reduced by more than 20% for hours worked and you are unable to work your full work schedule because of sickness or accidental injury.

Your monthly income benefit is equal to:

Your indexed basic monthly income minus your current monthly earnings

Divided by:

Your indexed basic monthly earnings times the benefit (60% of Basic Monthly Earnings) you would receive if you were totally disabled (before other income is subtracted)

Minus:

Any other income.

Basic Monthly Earnings — Total Disability

Basic monthly earnings are your base pay as of the day before your disability began. It does not include bonuses, mid-year rate changes, commissions, shift pay or overtime pay. However, in the event of part-time return to work, your partial disability benefit will be based on monthly earnings as defined below:

Current Monthly Earnings*

Current Monthly Earnings* are your Gross Earnings excluding PTO, vacation, sick, or holiday pay unless the amounts exceed 40% of Basic Monthly Earnings.

Indexed Basic Monthly Earnings — Partial Disability

Indexed basic monthly earnings are your basic monthly earnings increased by 5%. This increase occurs on the first anniversary of your first benefit payment for those on partial disability.

*For clinical faculty / physicians, your Current Monthly Earnings includes monthly base salary, plus where applicable, the regular, recurring monthly amount reflected in Duke's payroll system as "supplemental pay."

Maximum Benefit Period

If you are disabled prior to reaching age 61, the plan will pay you benefits until you reach age 65, as long as you continue to qualify under the applicable definition of total or partial disability.

If you become disabled after reaching age 61, your benefits will continue according to the following table:

Age at Disability	Maximum Benefit Period
Less than age 61	To age 65
61 but less than 62	48 months
62 but less than 63	42 months
63 but less than 64	36 months
64 but less than 65	30 months
65 but less than 66	24 months
66 but less than 67	21 months
67 but less than 68	18 months
68 but less than 69	15 months
69 and over	12 months

Other Income

Other income is income you and your dependents (minor children under the age of 18 and/or disabled children) receive or are eligible to receive because of your age, work for another employer or self-employment or Social Security disability or retirement. Other income is subtracted from the benefit you would otherwise receive as shown on the Schedule of Benefits. You are considered to be receiving other income if you are eligible for it — even if you have not applied for it — unless you send the plan written proof that other income benefits were denied or contested. When the plan receives this written proof, it will pay benefits you are qualified to receive. However, if the denial of other income benefits is not final, you must pursue the other income benefits to the fullest extent possible.

Other income includes but is not limited to:

- Social Security Disability / Retirement benefits for yourself and/or dependents;
- For Police Officers, the plan begins to subtract Social Security benefits after four years of disability, even if you are not receiving them;
- State disability benefits;
- VA disability income;

- Railroad Retirement Act benefits;
- Workers' Compensation benefits or settlement, including any amount paid to an attorney;
- No fault accident wage replacement plan benefits;
- Salary, commission, bonus, or any other income you earn from any work while receiving benefits (except as explained for partial disability or the Rehabilitative Work Benefit);
- Duke University or DUHS Temporary Medical Leave salary continuation for faculty;
- Unemployment compensation that you receive;
- The imputed value ascribed to bartered services;
- Donations received from the Kiel Memorial Vacation / PTO Donation Program after the benefit waiting period; and
- The portion of a settlement or judgment that compensates for your loss of earnings.

Benefits Will not be Reduced by:

- Benefits paid by a group or franchise creditor disability plan;
- Income received from a profit-sharing plan, thrift plan, Individual Retirement Account, tax-sheltered annuity, stock ownership plan, or a non-qualified plan of deferred compensation;
- Income received from rental property or other passive income;
- Social Security benefits if your disability begins after age 70 and you were receiving Social Security benefits while continuing to work;
- Social Security benefits you receive as a widow(er) or survivor;
- Increases due to a cost of living or legislated increase in Social Security benefits if your or your eligible dependents' Social Security benefits increase after your or your eligible dependents' initial Social Security benefit becomes payable;
- Survivor benefits you receive from the Employees' Retirement Plan;
- Retirement benefits attributable to employee contributions (see Duke Retirement Plans);
- Retirement or disability benefits you receive from a past employer;
- Benefits received from an individual disability policy or the LTD Income Enhancer;* or
- Any amount paid to an attorney to file or appeal Social Security disability benefits. The amount of your monthly benefit may change as a result of a change in your earnings. The new amount will take effect on the date of the change and will apply only to disabilities beginning thereafter.

*An optional insurance program known as the Long Term Disability (LTD) Income Enhancer was offered to full-time faculty and staff members in the 1990s but was discontinued in the early 2000s. The LTD Income Enhancer was designed as an individual policy that wrapped around the group Duke Disability plan and had benefits customized to each individual participant's needs. These are individual, non-ERISA policies and are not managed by Duke's group disability plan administrator.

Social Security Filing Requirements

You are required to apply for disability benefits that may be available to you under the U.S. Social Security Act. If you have reached your SSNRA and are no longer eligible for Social Security Disability Income (SSDI), you are still required to apply for Social Security benefits. The disability administrator is available to assist in your application for benefits. If there is a disagreement with the Social Security Administration's denial of your application, you will be required to follow the process set up by that agency to reconsider denials, and to continue in that process to the highest level of appeals through an Administrative Law Judge (ALJ) controlled proceeding to process this appeal. If denied again, you will be required to request a hearing. You will be provided with assistance in preparing for this hearing.

If you do not follow any part of the Social Security application process described above within 60 days of our written request to you, the amount of the Social Security disability benefit will be estimated and that estimated amount will be included as an "other income benefit" until notice is received that your application was denied at the first level of appeal after the initial denial.

Approval of Social Security benefits does not guarantee approved benefits from the Duke Disability Plan.

Paid Time Off and Duke Disability Benefits

Approved disability benefits may be supplemented with accrued paid time off (sick, vacation, paid parental leave or PTO).

The supplemental amount should not exceed 40% of your gross base salary (pre-disability).

PLEASE NOTE: Kiel Memorial Hours are not to be used to supplement disability benefits. Kiel donations can be used during the disability waiting period and donations used after the waiting period will be offset from any disability claim benefit, including retroactively approved claims.

- Duke University employees can supplement their income while receiving approved long term disability benefits until their accrued sick or vacation is exhausted.
- Duke University Heath System employees can utilize accrued paid time off for weeks 13 – 25 of disability only. Beginning week 26 of disability, accrued paid time off may not supplement approved Duke LTD benefits. Any remaining PTO balance(s) may be payable upon your leaving Duke depending on your years of service and reason for separation of service.

Recovery of Overpayments

If the plan pays you a larger benefit than you should have received or you receive other income which includes lump sum or other periodic payments, the plan may recover any overpayments it made. A lump sum is a payment made to you usually because of past due benefits, a reversal of a decision to deny you benefits, or as a result of a settlement, such as Social Security and/or Workers' Compensation.

The disability administrator has the right to recover any overpayment of benefits caused by, but not limited to, the following:

- Fraud;
- Any error made by the disability administrator in processing a claim; or
- The covered person's receipt of any Other Income benefits.

The disability administrator may recover an overpayment by, but not limited to, the following:

- Requesting a lump sum payment of the overpaid amount; or
- Taking any appropriate collection action.

PLEASE NOTE: In the event of returning to an active working status, Duke reserves the right to withhold any outstanding overpayment from Duke pay.

You will be notified by letter of the amount of overpayment by the disability administrator. You will have 30 calendar days to repay the overpayment in full. If overpayments based on other income are not repaid as required by the plan, all benefits under the disability plan will terminate, and you will be ineligible for reinstatement.

Benefits that will be discontinued include, but are not limited to:

- Monthly income from the disability plan;
- Employer contribution to health insurance and participation in health insurance if eligible and participating at the time of disability;
- Future accrual of retirement credit service under the Employees' Retirement Plan (ERP) or future contributions to the Faculty / Staff Retirement Plan;
- Eligibility for tuition grant benefits for dependent children; and
- Continuation of Duke-provided life insurance. Any person who defaults on an overpayment will also lose their eligibility to continue health coverage in retirement, if eligible under the Rule of 75 or the Age 45 + 15 Rule with Duke University Health System.

Recurrent Disability

If you have been receiving disability benefits and return to work, only to become disabled again within six months due to the same or a related condition, you will not have to begin a new benefit waiting period. If your return to work lasts longer than six months, you will have to begin a new benefit waiting period if you become disabled again.

A recurrent disability has:

- No additional benefit waiting period; and
- The same maximum benefit period as the previous disability.

Benefits payable under this recurrent disability provision will stop if benefits are payable to you under any other group disability plan.

Rehabilitative Work Benefit

You may receive adjusted benefits if you qualify and engage in rehabilitative work. To qualify for adjusted benefits, you must provide the plan with proof of your earnings upon request and you must be working:

- For pay or profit; and
- Under an approved rehabilitation program.

Your adjusted benefit will equal your regular monthly benefit less 50% of the income you receive from your rehabilitative work. The Rehabilitative Work Benefit is only for employees receiving benefits for total disability.

Re-Employment at Duke University and Duke Health System

Employment reinstatement rights at Duke end when your approved 12-week Family Medical Leave ends. If your disability claim is denied (you would have 180 days to appeal), contact Recruitment to reapply for employment at Duke. While you are on approved disability, vocational assistance is available from the disability administrator's rehabilitation case managers. However, if your disability benefit is terminated because you no longer meet the plan's definition of "disabled," there is no guarantee of employment with Duke. You may contact Recruitment so that your qualifications and skills can be compared to the requirements of current positions available at Duke. You may contact Recruitment at **919-684-5600** to assist you in applying for vacant positions at Duke for which you have training and experience.

Duke Retirement Plans

If you are eligible to receive Duke's contribution under the Duke Faculty and Staff Retirement Plan and have received disability benefits for two (2) years from the Duke Disability Plan, Duke will contribute to the Plan on your behalf in the amount based on your compensation and the contribution rate in effect at the onset of your disability. No employee contribution is required to receive the Duke contribution.

If you are an active participant in the Employees' Retirement Plan, you continue to earn credited plan service during your period of total disability.

However, while receiving disability benefits, you are not eligible to receive concurrent benefits from the Employees' Retirement Plan.

Health / Dental Insurance and Duke Disability

Employees participating in a Duke Health Plan or Dental Plan at the time of approval for Long Term Disability benefits may continue to participate while on an active claim with the Duke Long Term Disability Plan with the following qualifications:

- The disabled employee must be participating (in a fully paid-up status) in a Duke Health Plan / Dental Plan on their last day worked;
- Premiums must be paid in a timely manner, or deducted from the LTD check. If terminated for non-payment, there is no reinstatement;
- There must not be a break in coverage under the disabled employee's Duke Health Plan / Dental Plan. If disability claim is denied and subsequently approved through the appeal process, "no break in coverage" rules still apply. In order for coverage to continue, there must be no break in coverage. If coverage was not maintained, retroactive premiums from the date coverage ended to the date coverage is to be reinstated must be paid;
- Once the disabled employee is approved for Long Term Disability, the only dependent that can be added is a newly married spouse where the marriage occurred after January 1, 2020 and the request to add is made within 30 days of the marriage. Other dependents may not be added regardless of a qualifying event;
- When a family member is removed from coverage, she/he may not re-enroll;
- Once eligible for Medicare, the disabled employee must notify HR Benefits and immediately enroll in Medicare Parts A and B. Those who do not enroll in Medicare Part B in a timely manner will be responsible for payment of those claims that would have been attributable to Medicare B. (This is also true for a covered spouse who is or becomes eligible for Medicare;)

- All persons participating in the Duke Long Term Disability program will be enrolled in the Duke Plus Plan once Medicare becomes primary for them or a family member. This includes transferring all covered persons age 65 or older and their family at the time of the disability approval; Medicare becomes primary for those Medicare eligible and Duke Plus will be primary for those covered persons who are not Medicare eligible;
- If the disabled employee dies while on Duke Long Term Disability, health / dental coverage for family members will depend on the eligibility of the deceased individual for retiree health benefits. If the decedent was eligible at the time of death, the covered family members may continue under the survivor benefits. COBRA will be available to those who are not eligible.

Other Benefits

Please refer to the specific Summary Plan Description for additional information about how other benefits are impacted while on Duke Disability.

Post-Retirement Health Insurance Eligibility Requirements

Employees must be participating in a Duke Health Care Program and receiving Duke's contribution toward the premium at the time of retirement, and meet the below service criteria.

Eligibility Requirements for Duke University and Medical Center:

You must meet the Rule of 75. It requires that your age plus years of continuous service with Duke at retirement must be equal to or greater than 75 to continue Duke health insurance.

For employees that transitioned into the Duke Health Integrated Practice (DHIP) on July 1, 2023, please see the “Important Summary for Employees Transitioning to the Duke Health Integrated Practice (DHIP) on July 1, 2023” in the “General Information About Your Benefits” section of this summary plan description for additional details.

Eligibility Requirements for Duke University Health System (DUHS):

Employees hired on or after July 1, 2002, are eligible for retiree health coverage if they meet the following criteria:

- Have 15 years of continuous service after age 45
- DUHS employees approved for group long term disability benefits hired after July 1, 2002, may retain their health coverage until age 65, as currently permitted, but will not receive credit for years of continuous service while on disability.

Employees employed by DUHS prior to July 1, 2002, are eligible for retiree health coverage if they meet one of the following criteria:

- Met the Rule of 75 (age + years of continuous service + 75), as of July 1, 2002
- An employee who does not meet the Rule of 75, must have at least 15 years of continuous service or be at least 60 years of age with 10 or more years of continuous service as of July 1, 2002, to be carried over under the Rule of 75 eligibility provision.
- All other employees employed by DUHS prior to July 1, 2002, with no break in service are eligible for retiree health coverage at time of retirement if they meet one of the following eligibility criteria:
 - Have 15 years of service after age 45
 - Have met the Rule of 75

- An employee will not receive credit for years of continuous service while on disability.

For employees that transitioned into the Duke Health Integrated Practice (DHIP) on July 1, 2023, please see the “Important Summary for Employees Transitioning to the Duke Health Integrated Practice (DHIP) on July 1, 2023” in the “General Information About Your Benefits” section of this summary plan description for additional details.

Duke Disability and Duke Severance Pay Program

In order to receive a benefit under the Duke Disability program, you must not be receiving concurrent benefits under the Duke Severance Pay Program.

Termination of Benefits

You will stop receiving benefits on the earliest of the following:

- The date you are no longer disabled as defined, including:
- For any period of disability up to 24 months, the date your employment earnings are equal to or exceed 80% of your indexed basic monthly earnings; and
- For any period of disability longer than 24 months, the date your earnings ability is equal to or exceeds 70% of your basic monthly earnings;
- The end of the maximum benefit period for any one period of disability;
- The date you no longer qualify under all the conditions listed;
- The date of your death;
- The date you refuse to participate in an approved rehabilitation program;
- The date you refuse to repay in full an overpayment of plan benefits;
- The date you fail to provide written proof of disability that the disability administrator determines to be satisfactory;
- The date you cease to be under regular and appropriate care of a doctor, or refuse to undergo an examination by a doctor of the disability administrator’s choosing;
- Your benefit and eligibility for coverage in this plan will be immediately terminated if you provide fraudulent or misrepresented information. This includes, but is not limited to, fraudulent statements or material misrepresentation of facts. Your benefit and eligibility for the Duke Disability Program will be terminated and also your benefits and eligibility for coverage in other Duke-sponsored benefit plans including, but not limited to, Health Care Plans, Retiree Health Care Plans, Dental Plans, Life Insurance Plans (including Gratuity to Spouse / Estate Plan), Children’s Tuition Grant Plan, and Employee Tuition Assistance Plan;
- Your benefit and eligibility for coverage in this plan will be immediately terminated if you fail to report earned Other Income within 30 days of receipt; (see “Other Income” in this section for more detail);
- The date you refuse to undergo rehabilitation testing that the disability administrator requires;
- The date you refuse to receive medical treatment that is generally acknowledged by doctors to cure or improve your condition so as to reduce its disabling effect;

- The date you refuse to work with the assistance of modifications made to your work environment, functional job elements or work schedule, or adaptive equipment or devices, that a qualified doctor has indicated will accommodate the limiting factors of your medical condition;
- The date you retire; or
- The date you voluntarily end your approved disability claim.

For Licensed Commissioned Police Officers employed at the University on or after July 1, 1997, who have received a Company Policy Commission under NCGS Chapter 74E that is held by the Duke University Police Department, you will stop receiving disability benefits on the date you are eligible to receive full retirement benefits as defined in the Pension Plan.

If the Duke Disability Program or the disability income coverage part of the plan terminates after you qualify for benefits, you will continue to receive your benefits as long as you remain qualified according to the terms of the plan on the date you first qualified.

How Benefits Are Paid at Your Death

Any monthly income benefit remaining unpaid at the time of your death will be paid to your survivors or your estate in the following order:

- Your surviving spouse; or
- Your estate.

Limitations and Exclusions

General Limitations and Exclusions

The plan will not pay benefits if your disability results from any of the following:

- Sickness or injury which occurs while you are on military service for any country or government;
- Intentionally self-inflicted injuries or attempted suicide;
- Injury that occurs when you commit or attempt to commit a felony, or to which a contributing cause was your being engaged in an illegal occupation;
- Injury suffered in a fight in which you are the aggressor;
- Injury sustained as a result of doing any work for pay or profit for another employer, including self-employment, concurrent with your employment at Duke; or
- Injury sustained while on leave without pay.

The plan also will not pay benefits for the portion of any period of disability in which you are confined in a penal or correctional institution as a result of a conviction for a criminal or other public offense.

The plan will not pay an additional benefit for disability caused by both sickness and accidental injury or by more than one sickness or accidental injury.

Limitation for Subjective Conditions

When your disability is due in whole or in part to subjective conditions, the plan limits monthly benefits to a maximum of 24 months. This maximum applies to any and all such periods of disability during your lifetime.

What Is a Subjective Condition?

Subjective conditions are those which are based on self-reported symptoms and are not verifiable using objective medical tests and procedures. These include but are not limited to the following conditions:

- Musculoskeletal and connective disorders of the neck and back;
- Any disease or disorder of the cervical, thoracic and lumbosacral back and its surrounding soft tissue;
- Sprains and strains of joints and adjacent muscles;
- Chronic fatigue syndrome;
- Fibromyalgia;
- Environmental allergic illness;
- Chemical and environmental sensitivities; and
- Sick building syndrome.

How To File for Claim Benefits

The Plan Administrator (Duke) has designated Lincoln National Group (the “disability administrator”), to review all disability claims and appeals filed under the Plan. This means that the disability administrator has the discretionary authority to make all initial determinations with respect to claims filed under the Plan and to decide all appeals of any denied claims. The Plan Administrator has no discretionary authority with respect to reviewing disability claims and appeals. For additional information on filing a claim or filing an appeal, contact the disability administrator.

A Duke Disability / LTD claim kit with appropriate forms is available from the HRIC at **919-684-5600** or by completing an online Duke Disability / LTD claim kit request, hr.duke.edu/benefits/finance/disability.

Information is also available on the Duke website, hr.duke.edu/benefits.

In order to satisfy claim submission requirements, Duke Disability claim forms must be completed and filed within 180 calendar days of your becoming disabled and/or your last day worked due to disability or while on Duke Workers’ Compensation leave and receiving wage replacement.

All claims information must be submitted in English. You are responsible for any cost incurred in having medical records translated. All claim benefits will be paid in U.S. dollars.

If an overpayment from a prior Duke disability claim has NOT been recovered at the time of a newly filed claim, the plan administrator reserves the right to request payment in full before new claim benefits are payable if approved.

Claim Review Procedure

The disability administrator will make an initial determination on your claim within 45 days after the claim is received. This 45-day period may be extended up to an additional 30 days if the disability administrator (1) determines the extension is necessary because of matters beyond the Plan’s control, and (2) notifies you, before the end of the 45-day period, why the extension is needed and the expected decision date. If, before the end of the first 30-day extension, the disability administrator determines, due to matters beyond the Plan’s control, a decision cannot be rendered within that extension period, the determination period may be extended

for up to an additional 30 days, provided the disability administrator notifies you, before the end of the first 30-day extension period, why the extension is needed to process your claim. If an extension is necessary, you will be notified of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on your claim, the additional information needed to resolve the issues, and when the disability administrator expects to make a decision prior to the expiration of the initial 45-day period or first 30-day extension period, whichever the case may be.

If additional information is needed to process your disability claim, you will be provided with a description of the information requested and an explanation of why such information is needed. You will have at least 45 days to provide the information. If you provide the requested information within the 45 days, the disability administrator will notify you of its decision within 30 days after the requested information is received. If you do not provide the requested information within the 45-day period, your disability claim may be denied.

The claim determination time frames begin when your disability claim is filed, without regard to whether all the information necessary to make a claim determination accompanies the filing. If an extension is necessary because you failed to submit all required information, the days from the date the disability administrator sends you the extension notice until you respond to the request for additional information are not counted as part of the claim determination period.

Applying for disability does not guarantee that your claim will be approved. If your claim is denied, in whole or in part, you will receive a written or electronic notice of the denial including:

- The specific reasons for the denial;
- References to the plan provisions on which the denial was based;
- A description of any additional information or material necessary to perfect your claim and an explanation of why such information or material is needed;
- Either the specific internal rules, guidelines, protocols, standard or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;
- A description of the Plan's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse decision on appeal;
- If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request;
- If applicable, the reason for not following the views of the treating professional, medical or vocational experts, or a disability determination by the Social Security Administration;
- A statement that you are entitled, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim; and
- Notice in a culturally and linguistically appropriate manner.

Appeals Procedure

If your claim is denied, in whole or in part, you or your authorized representative must follow the administrative procedures for an appeal and exhaust such administrative procedures prior to seeking any other form of relief. The Plan provides for two levels of appeal.

A first level appeal must be filed with the disability administrator within 180 days of the receipt of the written or electronic notice of denial. If your appeal is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting your claim. A second level appeal must be filed with the disability administrator within 60 days of the receipt of the written or electronic notice of denial of the first level appeal. If your second level appeal is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting your claim. The appeal time frames begin when an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing.

Your first or second level appeal must be made in writing and may include written comments, documents, records, and other information relating to your claim even if you did not include that information with your original claim or, if applicable, your first level appeal. You may review all pertinent documents and, upon request, shall have reasonable access to or be provided free of charge, copies of all documents, records, and other information relevant to your original claim or, if applicable, your first level appeal. The disability administrator will assign a qualified individual who was not involved in the initial claim determination or, if applicable, your first level appeal (and is not that person's subordinate) to review and decide your first or, if applicable, second level appeal.

The disability administrator will take all comments, documents, records and other information into account even if it was not submitted or considered in the prior review and determination and will provide a review that does not afford deference to the initial adverse decision and which is conducted neither by the individual who made the adverse decision nor the person's subordinate. If the initial adverse decision was based in whole or in part on a medical judgment, the review will be done in consultation with a healthcare professional who has appropriate training and experience in the relevant field of medicine, who was not consulted in connection with the initial adverse decision nor the subordinate of any such individual. As part of the appeals process, you consent to this consultation and the sharing of pertinent medical claim information. If a medical or vocational expert is consulted in connection with an appeal, you have the right to learn the identity of such individual, without regard to whether the advice was relied upon in making the decision. You also have the right to a review and reasonable opportunity to respond to any new or additional evidence considered, relied upon, or generated, or any new or additional rationale in support of an adverse decision, before an adverse decision is rendered.

The disability administrator will provide written or electronic notice of its first level appeal decision or, if applicable, second level appeal decision within the 45-day period following receipt of your appeal. In each case, the 45-day period may be extended up to an additional 45 days if an extension is necessary to process your appeal. If an extension is necessary, you will be notified before the end of the initial 45-day period of the reasons for the delay and when the disability administrator expects to make a decision. If an extension is necessary because you failed to submit necessary information, the days from the date of the extension notice until you respond to the request for additional information are not counted as part of the appeal determination period.

If your appeal is denied in whole or in part by the disability administrator, you or your authorized representative will receive written or electronic notification that will include:

- The specific reason or reasons for the denial;
- References to the plan provisions on which the determination was based;
- If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision or a statement that such explanation will be provided free of charge upon request;
- A statement regarding your right to obtain, upon request and free of charge, reasonable access to, and copies of, all records, documents and other information relevant to your claim and appeal;
- Either the specific internal rules, guidelines, protocols, standard or other similar criteria of the Plan relied upon in making the adverse decision or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
- A statement describing any voluntary appeal procedures offered by the disability administrator and your right to obtain the information about such procedures, and a statement of your right to bring a civil action under Section 502(a) of ERISA.

Any action taken or any determination made by the disability administrator in the exercise of its authority to review and decide appeals is final and conclusive. The appeals procedures set forth above are intended to comply with Labor Regulation § 2560.503-1 and shall be construed in accordance with such regulation. In no event shall it be interpreted as expanding your rights beyond what is required by Labor Regulation § 2560.503-1.

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. A claim must be filed within 90 days following notice of your ineligibility to participate in the Plan. The Plan Administrator will decide whether the claim will be allowed. Send your claim to:

**Duke Disability Plan Administrator
Duke Benefits
705 Broad St.
Box 90502
Durham, NC 27708-0502**

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 to the Staff Fringe Benefits Committee (the "Committee") in writing within 60 days of the date you receive notice of denial.

Your appeal should be sent to:

**Staff Fringe Benefits Committee
Duke Benefits
705 Broad St.
Box 90502
Durham, NC 27708-0502**

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 Committee's decision is final and conclusive.

If you are dissatisfied with the 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 event for which the claim was made occurred.

Other Important Information

How Disability Coverage Affects Other Benefits

If you have sufficient vacation, sick, PTO, or donated hours through the Kiel Memorial Vacation / PTO Donation Program during the benefit waiting period, all your other benefit deductions should continue as usual. When your vacation, sick, PTO, or donated hours through the Kiel Memorial Vacation / PTO Donation Program run out, call the Human Resources Information Center for guidance on payment continuation.

If you are on an unpaid Family Medical Leave during the benefit waiting period, you are responsible for paying your portion of your health insurance premium and the premium for any other benefits that are normally payroll deducted. After 12 weeks of Family Medical Leave, you are responsible for pursuing Personal Leave and for paying the full health insurance premium under COBRA.

If your disability is approved, you will pay only the employee cost towards your health insurance at that time.

Free Choice of Doctor

You have the right to choose any doctor.

Assignment

You may not transfer to anyone else:

- Ownership of any booklet issued under the Plan; and
- Disability income coverage under the Plan.

Legal Action

Legal action may not be taken to receive benefits until 60 days after the date proof of loss is submitted according to the requirements of the Plan. Generally, legal action must be taken within three years after the date proof of loss must be submitted. However, state law will dictate the timeframe in which legal action can be taken.

Exam

When reasonably necessary, the Plan may have you examined while you are claiming benefits. The exam will be conducted by one or more doctors of the plan's choice. The Plan has the right to defer or suspend payment of benefits if you fail to attend an exam or fail to cooperate with the doctor. Benefits may be resumed, provided

that the required exam occurs within a reasonable time and benefits are otherwise payable. Exams are at the discretion of the Plan Administrator and may be requested as often as the Plan Administrator deems necessary.

Reimbursement

If the Plan pays disability income benefits for sickness or accidental injury caused in whole or in part by the act or omission of another, you or your covered dependent must:

- Reimburse the Plan for the expenses paid if you recover damages for lost income by settlement, court order, judgment, or otherwise. Damages for lost income will be any payments which in whole or in part can reasonably be considered compensatory for lost income, regardless of designation;
- Provide the Plan with a lien and order directing reimbursement for disability income benefits paid. The lien and order may be filed with the person whose act caused the sickness or accidental injury, their agent, the court, or your or your covered dependent's attorney; and
- Cooperate with the Plan, including execution, completion, and filing of any document deemed by the Plan necessary to protect the Plan's reimbursement rights.

The Plan has a first priority claim against amounts which are or may be subject to reimbursement and against any person who is or may be obligated to pay damages for lost income, including any insurer of you or your covered dependent.

The Plan will be reimbursed first before other claims against amounts recovered or recoverable from persons who are or may be obligated to pay damages to you arising from an act or omission causing in whole or part the sickness or accidental injury, even if the amounts are insufficient to reimburse the plan in full or compensate you or your covered dependent completely for damages sustained.

The Plan has no obligation to pay attorney's fees or other legal fees to your or your covered dependent's attorney for recovery of amounts subject to reimbursement.

A representative of the Plan will have the right to intervene in any suit or other proceedings to protect the reimbursement rights under this plan. Any settlement proceeds received by you, your covered dependent, or your attorney will be held in trust for the plan's benefit. The Plan's rights herein are binding upon and enforceable against your or your covered dependent's legal representatives, heirs, next of kin, and successors in interest.

Subrogation

If the Plan pays disability income benefits for sickness or accidental injury caused in whole or in part by the act or omission of another, the Plan will have a right of subrogation against any person, any insurer, you or your covered dependent, or any insurer of you or your covered dependent should you receive, or have a right to receive, any damages or payments.

You or your covered dependent will do nothing to prejudice the Plan's subrogation rights and will cooperate with the plan to protect such rights, including:

- Providing information;
- Signing an agreement documenting the plan's subrogation rights; or

- Taking other action the plan requests, including execution, completion, and filing of any document deemed by the Plan necessary to protect its rights.

The Plan's subrogation rights and amounts recoverable / recovered pursuant to such rights are a first priority claim. Such amounts will be reimbursed first even if all amounts recovered from whatever source are insufficient to compensate you or your covered dependent in part or whole for all damages sustained.

At the option of the Plan, action may be taken to preserve the Plan's subrogation rights, including:

- The right to bring any legal action in your or your covered dependent's name; or
- The right to seek reimbursement out of any amount from any source recovered by you or your covered dependent.

Any settlement proceeds received by you, your covered dependent, or your attorney will be held in trust for the Plan's benefit. The Plan has no obligation to pay any attorney or other legal fees to your or your covered dependent's attorney for any subrogation recovery received. A representative of the Plan will have the right to intervene in any suit or proceeding to protect its subrogation rights. The Plan's rights herein are binding upon and enforceable against your or your covered dependent's legal representatives, heirs, next of kin, and successors in interest.

Other Definitions

Accidental Injury

Bodily injury resulting from a sudden, violent, unexpected, and external event. All injuries are considered to be received in one accident as one accidental injury. Infection resulting from a cut or wound caused by an accident is also an accidental injury. Accidental injury does not include poisoning, disease, or any other type of infections, except as stated above.

Active Work, Actively at Work

The employee is physically present at their customary place of employment with the intent and ability of working the scheduled hours and doing the normal duties of their job on that day.

Approved Rehabilitation Program

A process of receiving medical, psychological, or vocational services intended to restore you to a condition that allows you to perform your own occupation or any occupation which you are or could reasonably become qualified to do by education, training, or experience. The program must have the plan and doctor approval for your return to work.

Close Relative

You, your spouse, and a child, brother, sister, or parent of you or your spouse.

Complication of Pregnancy

A condition that requires hospital confinement and that is distinct from pregnancy, but is adversely affected or caused by pregnancy. Examples are: acute inflammation or disease of the kidney or bladder, cardiac decompensation, missed abortion, an ectopic pregnancy, non-elective caesarean section, and eclampsia. Complication of pregnancy does not include: normal delivery, elective caesarean section, miscarriage, elective abortion, false labor, occasional spotting, morning sickness, excessive vomiting, preeclampsia, and other conditions associated with a difficult pregnancy.

Contract holder

Duke University.

Disability Administrator

The entity responsible for administration of the Duke Disability Program and its claims payments.

Doctor

A person, other than a close relative, licensed to practice medicine in the state in which treatment is received. State law may require that benefits be paid for professional services of a practitioner other than a medical doctor. If so, the term "doctor" also includes persons recognized as qualified to treat the sickness or accidental injury for which the claim is made, by the state in which treatment is received.

Layoff Date

The last day of the 60-day notification period.

Nonworking Day

A day on which the employee is not regularly scheduled to work, including time off for the following:

- Vacations;
- Personal holidays;
- Weekends and holidays; and
- Approved nonmedical leave of absence.

Nonworking day does not include time off for any of the following:

- Medical leave of absence;
- Temporary layoff;
- The employer suspending its operations, in part or total; and
- Strike.

Participant

An individual becoming covered under the terms and provisions of the contract.

Partial Disability, Partially Disabled

You are partially disabled when your indexed basic monthly earnings are reduced by more than 20% because of sickness or accidental injury.

Period of Disability

All periods of disability that have the same cause are considered one period of disability. A new period of disability begins when any of the following happen:

- You become disabled due to the same cause after you have been actively at work on a full-time basis with the employer continuously for at least six months; or
- The new disability results from a cause or causes unrelated to that of any previous disability, separated by active work with the employer.

Plan

Duke University's Monthly Disability Income Coverage, GHF-13312-4.

Plan Administrator

Associate Vice President for Total Rewards

Regular Occupation

The occupation you are routinely performing when your disability begins. For physicians, "regular occupation" means your specialty or subspecialty in the practice of medicine, in which you are both board-certified (or the equivalent certification from another country) and practiced immediately prior to the start of your disability.

Sickness

Any physical illness, mental disorder, normal pregnancy, or complication of pregnancy.

Subrogation

While the benefits outlined under the Disability Plan are designed to cover salary replacement in case of injury, illness or sickness suffered by you, if a third party or organization may be responsible for the injury, illness or sickness, it is Duke's intention that the plan will pay your benefit with the understanding and expectation that the plan will be repaid in full through the plan's subrogation and reimbursement rights.

Total Disability, Totally Disabled

- For Licensed Commissioned Police Officers employed at the University on or after July 1, 1997, who have received a Company Policy Commission under NCGS Chapter 74E that is held by the Duke University Police Department: You are unable to do the essential duties of your own occupation, because of sickness or accidental injury.
- For Clinical Faculty / Physicians: You are limited from performing the material and substantial duties of your regular occupation due to sickness or accidental injury and you have a 20% or more loss in your monthly earnings due to the same sickness or injury. The loss of professional or occupational license or certification does not, in itself, constitute disability. For physicians, "regular occupation" means your specialty or subspecialty in the practice of medicine, in which you are both board certified (or the equivalent certification from another country) and practiced immediately prior to the start of your disability.
- For All Other Employees: Until you have qualified for monthly income benefits for 24 months, you are unable to do the essential duties of your own occupation, due to sickness or accidental injury. Or, after you have qualified for monthly income benefits for 24 months, you are unable to work at any occupation you are or could reasonably become qualified to do by education, training, or experience.

Your Rights Under ERISA

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that

is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with a plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court. If it should happen that plan fiduciaries misuse a plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory. You may also contact the Department of Labor's Division of Technical Assistance and Inquiries by writing to:

**Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210**

You also may obtain certain publications about your rights under ERISA by calling the publications hotline of the Employee Benefits Security Administration at **800-998-7542**.

Controlling Effect of Plan Documents, Governance, and Interpretation

The plan document for the Duke Welfare and Fringe Benefits Plan consists of the Duke Welfare and Fringe Benefits Plan document, the Benefit Program Description, any Member Guide to the extent provided to employees, and any insurance contract through which benefits are provided. To the extent there is conflict between the Summary Plan Description and the actual terms and conditions as described in the plan document, the plan document will govern. If you would like to review the plan document, need more information, or have any questions please contact Benefits.

All legal questions pertaining to the Plan shall be determined in accordance with the provisions of the Internal Revenue Code, the laws of the State of North Carolina, and to the extent required, the provisions of ERISA.

The provisions of the plans and programs shall in all cases be interpreted in a manner that is consistent with the respective plans constituting a single "employee welfare benefit plan."

Your Rights Under FMLA

The Family and Medical Leave Act of 1993 (FMLA) allows eligible employees to take up to 12 weeks of unpaid leave time for the following family or medical reasons:

- Care of your child after birth, or placement for adoption or foster care;
- Care of your spouse, son, daughter, or parent who has a serious health condition; or
- Your own serious health condition, which causes you to be unable to perform your job.

To be eligible for FMLA leave, you must be a part- or full-time employee who has:

- Been employed by Duke for at least one year (12 continuous months); and
- Worked at least 1,250 hours in the previous 12 months.

This plan is intended to comply with the FMLA.

Plan Information

Plan Name

Duke Disability Program

Employer Identification Number Assigned by IRS

56-0532129

Plan Number Assigned by Plan

524

Plan Sponsor and Address

Duke University is the Plan Sponsor of Duke's benefit plans. These plans have been extended to or adopted by certain Duke affiliates. A complete list of the Duke affiliates participating in Duke's benefit plans is available upon written request to the Plan Administrator. The address and telephone number of the Plan Sponsor is:

**Duke University
705 Broad St.
Box 90502
Durham, NC 27708-0502
919-684-5600**

Plan Administrator

The Associate Vice President for Total Rewards is the Plan Administrator. The Plan Administrator has the exclusive power and discretionary authority to interpret the terms of the Plan and make necessary rules for its administration, including but not limited to, eligibility, participation and contribution provisions. The Plan Administrator also has the exclusive responsibility and complete discretionary authority to control the operation and administration of the Plan, with all powers necessary to enable it to carry out such responsibility properly. These powers include, but are not limited to, the discretionary power and authority to construe the terms of the Plan, to determine all questions relating to eligibility to participate in the Plan, to determine status and eligibility for benefits and to resolve all interpretive, equitable, and other questions that arise in the operation and administration of the Plan. Any determinations made by the Plan Administrator or its designee shall be final and binding. The Plan Administrator, acting through Benefits, is responsible for the day-to-day operations of the Plan. However, the Plan Administrator has delegated to the Vendor certain administrative functions such as payment of the benefits from the Plan.

Plan Administrator Name, Address, and Phone Number:

**Duke University
705 Broad St.
Box 90502
Durham, NC 27708-0502
919-684-5600**

Named Fiduciary: Plan Administrator

Type of Benefit Plan Provided

Welfare and Fringe Benefits Plan. All benefits under the Plan are provided through employer paid, unfunded / general assets.

Agent for Service of Legal Process

**Associate Vice President for Total Rewards
Duke University
705 Broad St.
Durham, NC 27708-0502
919-684-5600**

Funding of the Plan

Plan is funded by the employer with general assets.

Assignment of Benefits

The Plan does not give you a right to any benefit or interest in the plan except as specifically provided herein. You may not assign your rights, benefits, or any other interest in the plan to a provider or any other individual or entity.

No Guarantee of Tax Consequences

Neither Duke nor the Plan Administrator makes any commitment or guarantee that any amounts paid to you or for your benefit under the benefit plan shall be excludable from your gross income for federal or state tax purposes, or that any other federal or state tax treatment shall apply or be available. It shall be your obligation to determine whether each payment under a benefit plan is excludable from your gross income for federal and state income tax purposes and to notify Duke if you have reason to believe that any of the payment is not so excludable. Benefit Plan Year Begins on January 1 and ends on the following December 31.

ERISA and Other Federal Compliance

It is intended that this Plan meet all applicable requirements of ERISA and other Federal regulations. In the event of any conflict between this Plan and ERISA or other federal regulations, the provisions of ERISA and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

Plan Amendment or Termination

Duke intends to continue this plan indefinitely. However, Duke reserves the right, in its sole discretion under circumstances that it deems advisable (including, but not limited to, a need to address law changes, cost, or plan design considerations), to terminate or amend any benefit plan or underlying benefit program (including reducing or changing contribution rates) for all participants or for a specific class of participants, including current employees, at any time and for any reason, without notice. In the event of termination or amendment or elimination of benefits, the rights and obligations of participants prior to the date of such event shall remain in effect, and changes shall be prospective, except to the extent that Duke or applicable law provides otherwise.

This Benefit Program Description, which is part of the Duke University Welfare and Fringe Benefits Plan along with any applicable insurance contracts, shall constitute the written plan document for the Duke Disability Program. Duke reserves the right to change or terminate these benefits or your eligibility for benefits under the Duke Disability Program. The written plan documents for the Duke Disability Program are not employment contracts or any type of employment guarantee.

DUKE'S VOLUNTARY DISABILITY COVERAGE

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DUKE'S VOLUNTARY DISABILITY COVERAGE

Introduction

As a staff member of Duke University or Medical Center you earn sick leave, which may be used if you become disabled and cannot work. If you are a full-time employee with three or more years of continuous service, Duke's Long Term Disability Program provides an employer provided group disability plan that replaces up to 60% of your base salary and begins after 120 calendar days.

As a staff member of Duke University Health System, you earn paid time off (PTO), which may be used if you become disabled and cannot work. If you are a full-time employee with three or more years of continuous service, Duke's Long Term Disability Program provides an employer provided group disability plan that replaces up to 60% of your base salary and begins after 90 calendar days.

See the Duke Disability Program section for further details.

The term "Duke" is used throughout this booklet. "Duke" refers to the University, Duke University Health System, Inc. and any other corporation or entity that adopts the plan with the duly authorized approval of the Board of Trustees. When used in this Plan document, "Employer" shall refer to all of the foregoing collectively except where the context requires that such term refer to the corporation or entity that actually employs an individual.

The benefit program provided is based on an employee's company code and job code as reflected in the HR benefits administration system (SAP). Duke employees holding more than one position classification receive the benefits associated with their primary position classification as reflected in SAP. For example, a housestaff member who also works within DHIP, receives benefits associated with their housestaff position classification.

Additional Disability Coverage you can Purchase

The voluntary disability plans, which are insured by Hartford Life and Accident Insurance Company, replace a portion of your income if you cannot work due to an accident or illness. Two voluntary disability plans are available to protect your income as a full-time, benefit-eligible employee.

Duke University or Medical Center Employees

Voluntary Short Term Disability coverage (STD) is for those who have not accumulated many sick leave days and/or do not have enough emergency savings to manage up to 120 days without a paycheck.

Voluntary Long Term Disability coverage (LTD) is for those with fewer than three years of full-time continuous service who are not eligible for the Duke Long Term Disability (LTD) Plan or have not satisfied the Duke LTD 3-year waiver requirement. These plans are among the MOST IMPORTANT benefits you can purchase because they can help protect your financial future.

Your Voluntary STD benefits cover disabilities that are not job related. Your Voluntary LTD benefits cover disabilities whether or not they are job related.

However, both Voluntary STD and Voluntary LTD benefits will be reduced by the amount of other income benefits you receive while disabled (beyond the waiting period), such as Social Security, sick leave, vacation pay, paid time off, paid parental leave or hours donated through the Kiel Memorial Vacation / PTO Donation Program. Regardless of these offsets, the minimum benefit is \$15 per week for Voluntary STD, and the greater of 10% of the Voluntary LTD benefit or \$100 for Voluntary LTD.

Voluntary Short Term Disability (STD) Plan

Voluntary STD benefits begin after four weeks of disability and continue for up to 13 weeks of total disability. The plan replaces up to 60% of your weekly base salary to a maximum weekly benefit of \$2,885. You may use any or all of your accrued benefit time during the four-week waiting period.

Voluntary Long Term Disability (LTD) Plan

This plan is for employees with fewer than three years of full-time, continuous service, unless the employee already qualifies for the Duke-provided Long Term Disability Plan. The plan replaces up to 60% of your base salary to a maximum monthly benefit of \$12,500. Voluntary LTD benefits begin after you have been totally disabled for 16 weeks.

Duke University Health System Employees

Voluntary Short Term Disability coverage (STD) is for those who have not accumulated much paid time off and/or do not have enough emergency savings to manage without a paycheck for an extended period of time.

Voluntary LTD is for those with fewer than three years of full-time continuous service who are not eligible for the Duke Disability Plan or have not satisfied the Duke LTD 3-year waiver requirement.

These plans are among the MOST IMPORTANT benefits you can purchase because they can help protect your financial future.

Your Voluntary STD benefits cover disabilities that are not job related. Your Voluntary LTD benefits cover disabilities whether or not they are job related.

However, both Voluntary STD and Voluntary LTD benefits will be reduced by the amount of other income benefits you receive while disabled (beyond the waiting period), such as Social Security, sick leave, vacation pay, paid time off, paid parental leave or hours donated through the Kiel Memorial Vacation / PTO Donation

Program. Regardless of these offsets, the minimum benefit is \$15 per week for Voluntary STD, and the greater of 10% of the Voluntary LTD benefit or \$100 for Voluntary LTD.

Voluntary Short Term Disability (STD) Plan

For employees with fewer than three years of full-time continuous service, your voluntary STD benefits begin after four weeks and continue for up to 22 weeks of total disability. The plan replaces up to 60% of your weekly base salary to a maximum weekly benefit of \$2,885.

For employees with three or more years of full-time continuous service, your voluntary STD benefits begin after four weeks and continue for up to nine weeks of total disability. The plan replaces up to 60% of your weekly base salary to a maximum weekly benefit of \$2,885.

Voluntary Long Term Disability (LTD) Plan

This plan is for employees with fewer than three years of full-time continuous service, unless the employee already qualifies for the Duke Disability Plan. The plan replaces up to 60% of your base salary to a maximum monthly benefit of \$12,500. Voluntary LTD benefits begin after you have been totally disabled for six months.

Eligibility and Enrollment

Who is Eligible for Coverage

Duke University or Medical Center Employees

- Voluntary STD — Active full-time employees in a benefit eligible classification excluding housestaff. Full-time Clinical Associates and Consulting Associates are eligible for this program.
- Voluntary LTD — Active full-time employees in a benefit eligible classification with less than three years of full-time continuous service or who haven't satisfied the Duke LTD service waiver requirement, excluding housestaff. Full-time Clinical Associates and Consulting Associates are eligible for this program.

Regular Rank Faculty within the University and School of Medicine are encouraged to review the Duke Faculty Handbook, chapter 4 regarding temporary medical leave provisions, which can provide additional income protection, and may also provide a bridge between the onset of disability and the elimination period for the long term disability benefits. Information regarding Temporary Medical Leaves for faculty may also be available within your local HR department and/or Dean's office. Please note, the voluntary short and long term coverages have offset provisions for other income you may receive while unable to work (ex. temporary medical leave salary continuation).

Duke University Health System Employees

- Voluntary STD — Active full-time employees in a benefit eligible classification, excluding housestaff. Full-time Clinical Associates and Consulting Associates, including full-time faculty employed by Duke Health Integrated Practice, are eligible for this program. Full-time employees within Duke Health Integrated Practice are eligible to enroll in this coverage effective July 1, 2023.
- Voluntary LTD — Active full-time employees in a benefit eligible classification with less than three years of full-time continuous service or who have not satisfied the Duke LTD service waiver requirement, excluding housestaff. Full-time Clinical Associates and Consulting Associates, including full-time faculty employed by Duke Health Integrated Practice, are eligible for this program. Full-time employees within Duke Health Integrated Practice are eligible to enroll in this program effective July 1, 2023.

PLEASE NOTE: Faculty within the Duke Health Integrated Practice (DHIP) are encouraged to review the DUHS Temporary Medical Leave (DUHS TML) program which can provide additional income protection prior to enrolling in the voluntary short term disability coverage. The DUHS TML program is intended to provide a bridge between the onset of disability and the elimination period for the long term disability benefit. Please note, the voluntary short and long term coverages described below have offset provisions for other income you may receive while unable to work (ex. temporary medical leave salary continuation).

How To Enroll

If you submit an enrollment form within 30 days after date of hire or transfer to a benefit eligible status, you are guaranteed coverage without having to answer medical questions.

Complete the enrollment form, found online at hr.duke.edu/forms/voluntary-disability-enrollment-form, and return it to our plan record keeping administrator:

The MGIS Companies
111 South Main St., Suite 400
Salt Lake City, UT 84111-2176

Send the completed enrollment form and keep a copy of it for your records. MGIS will mail you a letter regarding your enrollment request, if you elect to enroll. Questions about plan administration, record keeping, and payroll deductions may be referred to MGIS at: **800-969-6447, ext. 139** (9:30 a.m. to 6:15 p.m. EST)

If you submit enrollment more than 30 days after your date of hire or transfer to a benefit eligible status, you will be subject to underwriting and must also complete a "Hartford Personal Health Statement" for evidence of insurability. The Hartford Personal Health Statement can be found here:

hr.duke.edu/forms/hartford-personal-health-statement.

When Coverage Begins

The effective date of your coverage depends on the date you enroll and whether proof of good health is required. If you:

- Are a newly hired employee and you enroll within 30 days after your date of hire, coverage will begin on the first of the month following the date your enrollment form is received by MGIS.
- Enroll after this initial eligibility period, you are required to complete a Personal Health Statement, which must be approved by Hartford Life and Accident Insurance Company before coverage can begin.

If you are absent from work because of a disability on the day your coverage is to become effective, your coverage will begin when you have returned to active work for one full day.

Your coverage continues as long as you remain an eligible employee, the group policy remains in effect, and premiums are paid. If the group policy or your employment at Duke terminates while you are receiving benefits, your payments will continue as long as you are disabled and eligible for benefits.

Certificate of Coverage

You may view the certificate(s) of coverage and plan provisions about the voluntary short term or voluntary long term disability plans on the Duke website:

hr.duke.edu/benefits/finance/disability/voluntary-disability.

PLEASE NOTE: There is a certificate for University employees and a separate certificate for Health System employees.

How the Voluntary Short Term Disability and Voluntary Long Term Disability Plans Work

Benefits

Pre-existing condition limitations are included for conditions for which you received medical care during the 12 months prior to your coverage date. No benefits will be payable for that condition unless disability begins after 12 months of coverage.* The first two weeks of Voluntary STD benefits will not have this limitation.

*Important note for former PDC employees/members transitioning to DHIP effective July 1, 2023. The Hartford has agreed to recognize PDC disability covered service towards the 12 months period.

All plans provide benefits for total disability.

Approved benefit payments by the Hartford will be based on the following salary information:

Voluntary Short Term Disability

“Pre-disability earnings” mean your regular weekly rate of pay not counting bonuses, mid-year rate changes, commissions, and tips, overtime pay or any other fringe benefits or extra compensation in effect on the January 1st prior to the date you became disabled. All premiums and benefits payable are based on salary information as of January 1st.

If you were hired after January 1st, pre-disability earnings mean your regular monthly rate of pay as of your date of hire, not counting bonuses, mid-year rate changes, commissions, and tips, overtime pay or any other fringe benefits or extra compensation. If you were hired after January 1st, all premiums and benefits payable are based on salary information as of your date of hire during your first year of coverage until the following January 1st.

Voluntary STD benefits will be reduced by the amount of other income benefits you receive while disabled, such as sick leave, vacation pay, Faculty Temporary Medical Leave, hours donated through the Kiel Memorial Vacation / PTO Donation Program, paid parental leave, or paid time off (PTO) taken, and other sources of income shown in the booklet- certificate.

Voluntary Long Term Disability

“Pre-disability earnings” mean your regular monthly rate of pay not counting bonuses, mid-year rate changes, commissions, and tips, overtime pay or any other fringe benefits or extra compensation in effect on the January 1st prior to the date you became disabled. All premiums and benefits payable are based on salary information as of January 1st.

If you were hired after January 1st, pre-disability earnings mean your regular monthly rate of pay as of your date of hire, not counting bonuses, mid-year rate changes, commissions, and tips, overtime pay or any other fringe benefits or extra compensation. If you were hired after January 1st, all premiums and benefits payable are based on salary information as of your date of hire during your first year of coverage until the following January 1st.

PLEASE NOTE: If an employee opts to enroll in the plan, she/he authorized Duke to make the appropriate payroll deductions from their wages on a post-tax basis. It is the responsibility of the employee to be aware of the voluntary disability premiums being deducted and to notify MGIS / Duke in a timely manner if an error in premiums has occurred. For any premium adjustment that result in a refund, the refund period is a maximum of 24 months form date of coverage corrections.

Voluntary LTD benefits will be reduced by the amount of other income benefits you receive while disabled, such as Social Security, sick leave, vacation pay, DUHS or Duke Temporary Medical Leave, hours donated through the Kiel Memorial Vacation / PTO Donation Program, paid parental leave, or paid time off (PTO) taken, and other sources of income shown in the booklet-certificate.

Hartford Life's Voluntary STD and Voluntary LTD benefits are tax-free based on current federal tax laws.

If you are on an approved voluntary short term disability (STD) claim, no premiums are due for voluntary STD coverage. However, if enrolled under Hartford's voluntary long term disability (LTD) plan, you must continue premium payments in order to maintain voluntary long term disability coverage.

If you are on a voluntary long term disability (LTD) claim with The Hartford, no premiums are due for Hartford's voluntary STD and/or LTD plan.

The insurer, Hartford Life, has vocational rehabilitation counselors that offer return-to-work assistance when appropriate.

The certificate contains a complete description of the plan provisions outlined in this brochure as well as your rights under ERISA. You may view on the Duke website here:

hr.duke.edu/benefits/finance/disability/voluntary-disability

Total Disability

Voluntary Short Term Disability

Total disability generally means you are unable to engage in the essential duties of your occupation due to accidental bodily injury, sickness, mental illness, substance abuse or pregnancy. Work related injuries are not covered.

Conversion to an individual policy is not available for this plan. Coverage would cease when your active employment ends.

A survivor income benefit is not provided if you die while receiving Voluntary STD benefits.

Voluntary Long Term Disability

During the four-month (Duke University) or six-month (Duke University Health System) waiting period and the first two years that benefits are payable, total disability generally means you are unable to engage in the essential duties of your occupation due to accidental bodily injury, sickness, mental illness, substance abuse, or pregnancy.

After the waiting period and the first two years that benefits are payable, total disability is defined as the inability to perform any occupation for which you are qualified by education, training, or experience.

Benefits for mental illness and substance abuse are limited to a total of 24 months for all disability periods during your lifetime. This limitation does not apply to periods of confinement in a hospital or other place licensed to provide care for the disabling condition.

As long as you remain totally disabled, Voluntary LTD benefit payments will continue according to the following schedule:

Long Term Disability Payment Schedule

Age When Disabled	Benefits Payable
Prior to age 63	To Normal Retirement Age or 48 months, if greater
63	42 months
64	36 months
65	30 months
66	27 months
67	24 months
68	21 months
69	18 months

Normal Retirement Age by Date of Birth

Year of Birth	Normal Retirement Age
1937 or before	65
1938	65 + 2 months
1939	65 + 4 months
1940	65 + 6 months
1941	65 + 8 months
1942	65 + 10 months
1943 through 1954	66
1955	66 + 2 months
1956	66 + 4 months
1957	66 + 6 months

Normal Retirement Age means the Social Security Normal Retirement Age as stated in the 1983 revision of the United States Social Security Act.

Underwritten by:

**Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, CT 06115**

A conversion plan is available if you terminate employment after being covered at least 12 months. You must apply for such coverage within 31 days of termination.

hr.duke.edu/forms/hartford-voluntary-ltd-conversion-form

A survivor income benefit is provided if you die while receiving Voluntary LTD benefits. The benefit pays a lump sum amount to your surviving spouse, your children in equal shares if there is no surviving spouse, or your estate if there are no survivors.

How To File for Claim Benefits

How To File a Claim

To start a voluntary disability claim, call The Hartford at **866-945-4558** or log on to mybenefits.thehartford.com/login. For claim processing, the Duke's group number is 043211. For a voluntary long term disability claim, please file your written claim within 60 days after your date of disability to allow for proper processing.

Appeals Procedure

If your claim is denied, in whole or in part, you or your authorized representative must follow the administrative procedures for an appeal and exhaust such administrative procedures prior to seeking any other form of relief.

You have the right to appeal the claim administrator's decision and receive a full and fair review. You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim. If you do not agree with a denial of your claim, in whole or in part, and you wish to appeal the decision, you or your authorized representative must file an appeal within one hundred eighty (180) days from the receipt of the denial of your claim. Your appeal letter should be signed, dated and clearly state your position. Please include your printed or typed full name, policyholder, and copy of your denial letter. Along with your appeal letter, you may submit written comments, documents, records, and other information related to your claim.

Under the Policy, legal action cannot be taken against the administrator more than 3 years after the date Proof of Loss is required to be given according to the terms of the Policy. Please consult the Policy's Legal Actions and Sending Proof of Loss provisions for more information.

Once your appeal is received, a review of your entire claim, including any information previously submitted and any additional information received with your appeal will be done. Upon completion of the review, you will be advised of the determination. After the appeal, if your claim is again denied, you have the right to bring a civil action under Section 502(a) of ERISA.

All appeals should be sent to:

The Hartford
P.O. Box 14087
Lexington, KY 40512-4087

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

All other eligibility claims or issues, including the right to participate under the Plan, 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. A claim must be filed within 90 days following notice of your ineligibility to participate in the Plan.

Send your claim to:

**Duke Disability Plan Administrator
Duke Benefits
705 Broad St.
Box 90502
Durham, NC 27708-0502**

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 to the Staff Fringe Benefits Committee (the "Committee") in writing within 60 days of the date you receive notice of denial. Your appeal should be sent to:

**Staff Fringe Benefits Committee
Duke Benefits
705 Broad St.
Box 90502
Durham, NC 27708-0502**

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 Committee's decision is final and conclusive.

If you are dissatisfied with the Committee's decision after you have pursued these steps, you have the right to bring civil action under Section 502(a) of ERISA.

Your Rights Under ERISA

For a summary of your rights under the Employee Retirement Income Security Act of 1974 (ERISA), please refer to the "General Information" section of this booklet.

This brochure explains the general purposes of the insurance described, but in no way changes or affects the policy as actually issued. In the event of any discrepancy between this brochure and the policy, the terms of the policy apply. Complete details are in the certificate of insurance issued to each insured individual. Please read it carefully and keep it in a safe place with your other important documents.

DUKE HOUSESTAFF DISABILITY PROGRAM

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DUKE HOUSESTAFF DISABILITY PROGRAM

Introduction

The Duke Housestaff Disability Program provides eligible employees with income when unable to work due to a disability beyond a certain amount of time, called a benefit waiting period.

The most current Summary Plan Description is the one that controls for benefit purposes.

Amendment and Termination of the Plan

The Duke Housestaff Disability Program is a welfare benefit plan. Duke expects to continue the plan indefinitely, but reserves the right to terminate the plan or to change the terms and benefits of the plan at any time in the future.

The term "Duke" is used throughout this booklet. "Duke" refers to the University, Duke University Health System, Inc. and any other corporation or entity that adopts the Plan with the duly authorized approval of the Board of Trustees. When used in this Plan document, "Employer" shall refer to all of the foregoing collectively except where the context requires that such term refer to the corporation or entity that actually employs an individual.

The benefit program provided is based on an employee's company code and job code as reflected in the HR benefits administration system (SAP). Duke employees holding more than one position classification receive the benefits associated with their primary position classification as reflected in SAP. For example, a Housestaff member who also works within DHIP, receives benefits associated with their Housestaff position classification.

The word "spouse" is used in this benefit program's summary plan description. This means legal spouse. In addition, it refers to an employee's registered Same Sex Spousal Equivalent providing the employee was hired prior to January 1, 2016 and registered his/her partner in Duke HR prior to January 1, 2016. This employee's registered partner remains eligible under Duke's Same Sex Spousal Equivalent Policy and is included in the meaning of "spouse" for the purpose of this benefit program wherever permissible under federal and state law. The eligible status continues for the course of this relationship only.

Eligibility, Enrollment, And Coverage

Eligible Employees

To be eligible for coverage under this plan, you must meet the following conditions:

- (a) You must be an active full-time resident employed by Duke University Medical Residents Center;
- (b) You must hold the degree of Doctor of Medicine; and
- (c) You must be a member of, or eligible for membership in, the American Medical Association.

“Active full-time resident” means you are performing all the duties associated with a program of residency, for at least the number of hours in a normal work week established by Duke University Medical Residents Center for persons engaged in such program.

When Your Coverage Starts

Employee benefits that do not require proof that you are insurable are scheduled to start on your effective date.

Employee benefits that require such proof will not start until you send Guardian proof and Guardian approves coverage in writing. Once Guardian has approved coverage, the benefits are scheduled to start on the effective date shown in the endorsement section of your application. A copy of the approved application is furnished to you.

You must be actively at work on a full-time basis on the scheduled effective date or dates, and you must have met all of the applicable conditions explained above, as well as any applicable waiting period. If you are not actively at work on any date part of your insurance is scheduled to start, Guardian will postpone that part of your coverage until the date you return to active full-time work.

Sometimes, your effective date is not a regularly scheduled work date. However, coverage will still start on that date if you were actively at work on a full-time basis on your last regularly scheduled work day.

When Your Coverage Ends

Your long term disability coverage ends on the date your active full-time service ends for any reason. Such reasons include disability, death, retirement, layoff, leave of absence and the end of employment.

Coverage also ends on the date you stop being a member of a class of employees eligible for insurance under this plan, or when this plan ends for all employees. Coverage also ends when this plan is changed so that benefits for the class of employees to which you belong ends.

Read this booklet carefully if your coverage ends. You may have the right to replace certain group benefits with converted policies.

How the HouseStaff Disability Program Works

Program Highlights

This section provides a quick guide to some of the Long Term Disability plan features which people most often want to know about. This is not a complete description of your Long Term Disability plan. Read the following pages carefully for a complete explanation of what Guardian pays, limits and excludes.

Elimination Period

For disability due to injury.....90 days.

For disability due to sickness..... 90 days.

Gross Monthly Benefit

66 2/3% of your prior monthly earnings, rounded to the nearest \$1.00, if not already a multiple thereof, limited to a maximum of \$4,000.00.

Note: Guardian integrates your gross monthly benefit with certain other income you may receive. Read all of the terms of this plan to see what income is integrated and how it is integrated.

Maximum Payment Period

See the following table.

Age When Disability Starts	Maximum Payment Period
Under Age 60	To age 65
Age 60	5.00 years
Age 61	4.00 years
Age 62	3.50 years
Age 63	3.00 years
Age 64	2.50 years
Age 65	2.00 years
Age 66	1.75 years
Age 67	1.50 years
Age 68	1.25 years
Age 69 or older	1.00 year

Survivor's Benefit

3 times the last net monthly payment a deceased employee received.

Loan Payoff Benefit

\$200,000.00 lifetime benefit

When and How This Plan's Net Monthly Payments Start

To start receiving net monthly payments under this plan, you must meet all of the following conditions:

- You must: (a) become disabled while insured by this plan; and (b) stay both disabled and insured by this plan continuously throughout the elimination period.
- You must be: (a) under a doctor's regular care for the cause of your disability; and (b) receiving appropriate medical care for the cause of your disability and for any other sickness or injury which exists before, or occurs during, the period you are disabled under the plan.
- You must send Guardian acceptable written proof of: (a) your disability; (b) your prior monthly earnings; and (c) any current monthly earnings.

Guardian reserves the right to determine when you meet the above conditions.

Failure to pass your regular occupational physical checkup does not constitute disability under the plan. Guardian does not accept, as proof of disability, certification from a doctor who is: (a) yourself; or (b) your business associate, spouse, parent, child, brother or sister.

Once Guardian approves your initial proofs of disability and earnings, Guardian starts to make net monthly payments. The first net monthly payment is made one month after the end of the elimination period.

The Elimination Period

The elimination period is the period of time you must be continuously disabled before long term disability benefits are payable.

- For disability due to injury, the elimination period is 90 days.
- For disability due to sickness, the elimination period is 90 days.

Any days of disability which result from a disability for which this plan does not pay benefits will not count toward the elimination period. Any days during which you are not disabled will not count toward the elimination period.

The elimination period will be considered continuous if you return to work in your regular occupation for not more than 45 consecutive days during the elimination period. The elimination period will be extended by one day for each day you temporarily return to work. This interruption of the elimination period will not apply if you become eligible under any other group long term disability plan.

Continued Payment of This Plan's Net Monthly Payments

To continue to be entitled to net monthly payments under this plan, you must continue to provide adequate proof of:

- (a) Your continued disability;
- (b) Continued regular doctor's care for the cause of the disability;
- (c) Any current monthly earnings; and
- (d) Any other income for integration that you are entitled to receive.

In addition, Guardian may, at any time, require you to be examined by a doctor or medical professional of Guardian's choosing.

Your net monthly payments under this plan can be terminated or suspended if at any time you fail to comply with any of the above requirements.

See "Accident and Health Claims Provisions" for how often Guardian can require continued proof of the items shown above.

How long Guardian continues to make net monthly payments under this plan will be subject to all the terms of this plan.

When Disability Ends

Your disability ends on the earliest of: (a) the date you earn or Guardian determines you are able to earn at a rate of at least 80% of your indexed prior monthly earnings; or (b) the date Guardian determines you are able to perform the major duties of your regular occupation or employment on a full-time basis, even if you choose not to perform such duties.

When This Plan's Payments End

This plan's net monthly payments end on the earliest of;

- (a) The date your disability ends
- (b) The date you die
- (c) The end of the maximum payment period
- (d) The date you fail to give Guardian any proof of disability Guardian requires
- (e) The date your refuse to allow any physical exam Guardian requires
- (f) The date you are no longer under the regular and continuing care of a doctor
- (g) The date benefits end in accord with any rehabilitation provision of this plan

Maximum Payment Period

See the following table.

Age When Disability Starts	Maximum Payment Period
Under Age 60	To age 65
Age 60	5.00 years
Age 61	4.00 years
Age 62	3.50 years
Age 63	3.00 years
Age 64	2.50 years
Age 65	2.00 years
Age 66	1.75 years
Age 67	1.50 years
Age 68	1.25 years
Age 69 or older	1.00 year

Recurring Disability

Benefits for disability cease when your disability ends, as described above. If your benefit ceased because your disability ended, and you become disabled again under this plan Guardian will consider the later period of disability to be a recurring disability if:

- (a) You return to active, full-time work right after a period of disability for which this plan has paid benefits;
- (b) Your disability recurs less than six months after the end of the period for which you were last entitled to a net monthly payment under this plan;
- (c) Your later disability is due to the same sickness or injury that caused the earlier period of disability;
- (d) You do not become covered under any other group long term disability income plan during the period you are performing active full-time work;

- (e) This plan does not terminate during the time that you are performing active full-time work; and
- (f) You remain insured under this plan and the employer resumes premium payment for the coverage during any time you are performing active full-time work.

If Guardian considers the disability to be a recurring disability, the disability will be treated as a continuation of the earlier disability. This means you will not be required to satisfy a new elimination period before benefits will be payable under this plan for the later disability. It also means that if, during any period of time you are receiving benefits under this plan, or during the period of active work that separates an earlier disability and a recurring disability: (a) any of the benefit provisions under this plan change; or (b) your basic monthly earnings or class change; those changes will not apply to the recurring disability. The benefits payable for the recurring disability will be based on the terms of the plan that applied to the earlier disability.

Income Guardian Integrates With

When you receive, or are entitled to receive, certain other income while this plan pays benefits, Guardian integrates your gross monthly benefit with that other income. See “How Net Monthly Payments Are Calculated” for how this is done.

Guardian integrates this plan’s benefits with:

- Commission or monies received, eligible to be received, or paid after disability benefits commence.
- All disability benefits you are entitled to receive from any compulsory benefit act or law. This includes any applicable temporary disability or state disability benefits required by state law.
- All disability benefits you are entitled to receive from any group plan sponsored by the employer, whether insured or self-insured. This includes payments made under a group life insurance plan because of your disability. This does not include payments made under a group life insurance plan’s accelerated death benefit or similar provision which allows payment of that plan’s proceeds because of your terminal illness.
- All disability benefits you are entitled to receive from any other group plan.
- All disability income you are entitled to receive under any other plan issued to you because of your employment by, or association with, the employer; or as a result of your membership in any: (a) union; (b) fraternal benefit society; (c) association; or (d) other similar organization.
- All income from a sick leave or salary continuation plan to which you are entitled. This includes lump sum or periodic payments of accumulated sick leave benefits, regardless of whether such plan is sponsored on a formal or informal basis.
- Benefits from the United States Social Security Act, the Railroad Retirement Act, or any other like U.S. or Canadian plan or act, as follow:
 - (a) All disability benefits that: (i) you are eligible for; and (ii) your spouse and children are eligible for as a result of your disability;
 - (b) All unreduced retirement benefits that: (i) you are eligible for; and (ii) your spouse and children are eligible for as a result of your eligibility; and
 - (c) All reduced retirement benefits paid to: (i) you; and (ii) your spouse and children as a result of your receipt of such benefits.

This plan will integrate with any benefits shown above to which your spouse or children are entitled on account of your disability or eligibility for disability benefits regardless of: (a) your marital status; (b) your place of residence; (c) your spouse's place of residence; (d) your child(ren)'s place of residence; or e) any custody arrangements made on behalf of your children.

- All retirement plan retirement benefits funded by the employer's deposits for your benefit.
- All retirement benefits or retirement plan disability benefits payable under any other government plan not otherwise show, to which you are entitled as a result of your disability.
- All benefits to which you are entitled from: (a) a Workers' Compensation law; (b) an occupational disease law; or (c) any other act or law of like intent. This includes: (i) the Jones' Act; (ii) the Longshoreman's and Harbor Workers' Compensation Act; or (iii) any Maritime doctrine of Maintenance, Wages or Cure.

Lump Sum Payments of Income Guardian Integrates With

If any of the benefits described above are paid in a lump sum, we will integrate this plan's gross monthly benefit by the equivalent monthly rate stated in the award. If no equivalent monthly rate is specified, then the lump sum will be equally prorated over the lesser of: (a) 60 months; or (b) your maximum payment period.

Application for Other Income Required

You must apply for any disability or retirement benefits that integrate with this plan if Guardian believes you may be entitled to receive these other benefits. If such benefits are denied, Guardian will require you to apply for them again. You are required to continue to appeal all denials until: (a) you receive written notification from Guardian that no further appeals are necessary; or (b) all possible appeals have been exhausted.

If Guardian believes that you are entitled to any of the benefits shown above, we will: (a) assume you are receiving such benefits; and (b) integrate the gross monthly benefit with the estimated amount of such benefits payable to you and any applicable dependents on behalf of your disability. However, Guardian will not do this if you sign their agreement concerning benefits under which you promise: (a) to apply for any benefits that integrate with this plan; and (b) at Guardian's request, to reapply for such benefits or appeal any denial of such benefits until no further appeals can be made; and (c) repay any overpayment due to an award of such benefits.

If Guardian estimates integrated income benefits, they will adjust your net monthly payments when they receive written proof: (a) of the amount awarded; or (b) that such benefits are denied after any reapplications or appeals we require. In the case of (b), if such adjustment shows Guardian underpaid you, Guardian will pay you the full amount of the underpayment in a lump sum.

Guardian will assist you in applying for other income benefits.

How Net Monthly Payments Are Calculated

Your net monthly payment under this plan is based on the plan of benefits that applied to you on the date your disability began. For the duration of your disability, including recurring disabilities as defined by this plan, your gross monthly benefit, net monthly benefit, or net monthly payment will not be affected by changes in the plan of benefits for your classification. However, your net monthly payment will be adjusted when your current monthly earnings change.

When Guardian computes your net monthly payments, they will first calculate your gross monthly benefit and net monthly benefit.

Computing Your Gross Monthly Benefit from This Plan

Your gross monthly benefit is 66 2/3% of your prior monthly earnings rounded to the nearest \$1.00, if not already a multiple thereof, and is limited to a maximum of \$4,000.00.

The amount of your prior monthly earnings used in computing your gross monthly benefit may be less than your actual prior monthly earnings used in computing your gross monthly benefit and may be less than your actual prior monthly earnings right before the start of your disability. This will happen if:

- (a) This plan has a maximum gross monthly benefit which does not allow the full amount of your prior monthly earnings to be used in the benefit calculation; or
- (b) Your employer has not reported to Guardian your most current salary on the last scheduled reporting date. When this happens, your gross monthly benefit will be based on the amount of your basic monthly earnings reported to Guardian by the employer on that last scheduled reporting date.

Computing Your Net Monthly Benefit from This Plan

Your net monthly benefit under this plan is your gross monthly benefit, as determined on your initial date of disability, integrated with any other income with which this plan integrated that you are entitled to receive. This plan integrated with specified other income only to the extent that such income, plus the gross monthly benefit, exceeds the total income limit. The total income limit is the lesser of: (i) 70% of your prior monthly earnings; and (ii) \$15,000.00. Your net monthly benefit under this plan will be the lesser of (a) and (b):

- (a) Your gross monthly benefit as shown above; and
- (b) The total income limit shown above reduced by the sum of all other income with which this plan integrates that you are entitled to receive.

Computing Your Net Monthly Payment from This Plan

Your net monthly payment is your net monthly benefit reduced by the amount of current monthly earnings you earn while disabled. Your net monthly payment under this plan is computed as follows:

- (a) If you are eligible to receive any income resulting from return to work, and the sum of your gross monthly benefit and current monthly earnings is not more than 100% of your indexed prior monthly earnings, your net monthly payment under this plan is your net monthly benefit from the 12 consecutive months following the date you first receive such income.
- (b) If you are eligible to receive any income resulting from return to work, and the sum of your gross monthly benefit and current monthly earnings is greater than 100% of your indexed prior monthly earnings, your net monthly payment from this plan is your net monthly benefit reduced by the part of such sum which exceeds 100% of your indexed prior monthly earnings for the 12 consecutive months following the date you first receive such income.
- (c) If, after 12 consecutive months, your current monthly earnings do not exceed 20% of your indexed prior month earnings, your net monthly payment from this plan is your net monthly benefit.
- (d) However, if after 12 consecutive months, your current monthly earnings are more than 20% of your indexed prior monthly earnings, your net monthly payment from this plan is your net monthly benefit reduced by 50% of your current monthly earnings.

If, during any month for which this plan pays benefits, the sum of the following:

- (a) Your net monthly payment, as figured above;
- (b) The total amount of all other income with which this plan integrates that you are entitled to receive; and
- (c) The amount of your current monthly earnings;

Is greater than the amount of your indexed prior monthly earnings, your net monthly payment for that month will be further reduced by that portion in excess of 100% of your indexed prior monthly earnings. This will not apply during any period of time that you are a participant in the Guardian rehabilitation program, as described in this plan, and have signed a valid rehabilitation agreement with us.

Cost of Living Freeze

After Guardian computes the first net monthly benefit, they will not reduce your benefit due to cost of living increases in social security benefits or other income benefits with which we integrate. Guardian will not adjust net monthly payments if: (a) your current monthly earnings change; or (b) your social security benefits or other income benefits with which we integrate change due to a recalculation of the benefit when updated information is received after the initial benefit is calculated.

Minimum Net Monthly Payment

This plan's minimum net monthly payment is \$100.00.

Payments for Partial Months

When disability lasts part of a month, Guardian pays 1/30 of the net monthly payment and cost of living benefit for each day for which we are liable. In no event will benefits be paid for any more than 30 days for any one month.

Waiver of Premium

All premiums for your long term disability income insurance which fall due while you are entitled to receive a net monthly payment from this plan are waived.

If This Plan Ends

This insurance ends when the group plan ends. It also ends when this insurance is dropped from the group plan for all employees, or for your class. If either happens while you are disabled, Guardian pays you benefits as if your insurance did not end. What is paid will be based on all of the terms of this plan.

Overpayments – Guardian's Recovery Rights

If Guardian determines that you were overpaid, you must reimburse Guardian in full. In addition, Guardian has the right to stop paying benefits until the overpayment is satisfied. Guardian has the right to recover overpayments made for any reason, including those that result from lump sum awards by any of the income benefits Guardian integrates with.

The Cost of Living Benefit

You are entitled to this plan's cost of living benefit from the first July 1:

- (a) On which you are entitled to a net monthly payment from this plan;
- (b) That next follows, or coincides with, your entitlement to 48 consecutive net monthly payments from this plan.

The first cost of living benefit is computed by multiplying your most recent net monthly payment by the cost of living factor and rounding the result to the nearest dollar. Each later cost of living benefit is computed by multiplying the same net monthly payment on which the original cost of living benefit was based by the most recent cost of living factor and rounding the result to the nearest dollar.

Guardian computes the factor each July 1, until the maximum number of cost of living factor computations are made. The maximum number of times that we compute a new cost of living factor is unlimited adjustments.

The annual cost of living factor is 4%.

Once you qualify for the cost of living benefit, it is paid monthly, for as long as you get net monthly payments from this plan. We add the first cost of living benefit payment to the first net monthly payment you are entitled to, after you qualify for the cost of living benefits. Later cost of living benefit payments are added to your most recent net monthly payment.

If you receive net monthly payments from this plan after the maximum number of cost of living factor computations are made, then the cost of living benefit payments are based on the last computed factor.

The Indexing Benefit

If you return to work while disabled, an indexing benefit is applied to your prior monthly earnings as described below. This benefit increases the amount of current monthly earnings you may earn while disabled. The indexing benefit does not increase your gross monthly benefit, net monthly benefit or net monthly payment.

You are eligible for this plan's indexing benefits after: (a) this plan's elimination period; (b) you have received 12 consecutive net monthly payments from this plan; and (c) you have returned to work.

When you first become eligible for this plan's indexing benefit, Guardian multiplies your prior monthly earnings by the indexing factor to obtain your indexed prior monthly earnings.

For each later year for which you are eligible for this plan's indexing benefit, your indexed prior monthly earnings will be determined by multiplying your indexed prior monthly earnings for the previous year by the current indexing factor.

The indexing factor is the lesser of: (a) 10%; or (b) one half the percentage change in the CPI-W for the prior calendar year of coverage.

While you are eligible for this indexing benefit, Guardian calculates a new indexing factor once a year.

The Survivor's Benefit

A survivor's benefit is paid if you:

- (a) Die while entitled to a full net monthly payment from this plan; and
- (b) Have received at least six consecutive full net monthly payments under this plan prior to your death.

The Survivor's Benefits is 3 times the amount of the last net monthly payment you received.

If an overpayment that has not been fully repaid exists at the time of your death, the balance remaining from such overpayment will be deducted from the amount of the survivor's benefit.

If you have no living spouse, your eligible children will be paid in equal shares. To be eligible, each child must be unmarried and: (a) less than age 20; or (b) if enrolled as a full-time student at an accredited school, less than age 26.

This benefit is not paid if you have no living spouse or eligible children.

Rehabilitation Benefits Under This Plan

If you are disabled under this plan and meet selection criteria as established by the Guardian, you may be selected to enter into a rehabilitation agreement with us. This agreement starts when Guardian informs you in writing that you have been accepted into the rehabilitation program. You may be chosen for this program anytime you are disabled according to the terms of this plan. This includes during the plan's elimination period.

The exact terms of the rehabilitation agreement may be different for each employee, but all agreements will set forth a plan designed to return you to gainful employment. Gainful employment is employment that is appropriate to your disability, skills, experience and prior monthly earnings.

If you are chosen for a rehabilitation agreement, you will be entitled to an enhanced benefit based on 110% of the net monthly payment to which you would have been entitled had you not entered into the rehabilitation agreement. If you are chosen for such an agreement, you will continue to be subject to all the terms of this plan.

The enhanced benefit will start on the later of:

- (a) The effective date shown on the rehabilitation agreement; or
- (b) The date you complete the elimination period.

Your eligibility for the enhanced benefit will extend until the earliest of:

- (a) The date you are no longer disabled under this plan;
- (b) The date you earn or are able to earn at a rate of at least 80% of your indexed prior monthly earnings;
- (c) The date you die;
- (d) The end of this plan's maximum payment period;
- (e) The date you violate any of the terms of the rehabilitation agreement;
- (f) The date you elect to end the rehabilitation program; or
- (g) The date the rehabilitation agreement expires.

If you end a rehabilitation agreement on a basis that is not agreeable to the Guardian, you may be required to repay any benefits paid that are in excess of what this plan would have paid had you not participated in the rehabilitation agreement.

Loan Payoff Benefit

Guardian provides a loan payoff benefit if you become functionally disabled, as defined by this plan. The loan payoff benefit is explained below. What is paid is subject to all the terms of this plan.

To be eligible for a loan payoff benefit, you must meet all of the following conditions:

- (a) You must be disabled, according to the terms of this plan, and be entitled to receive net monthly payments under this plan;
- (b) You must meet the definition of functional disability for a period of 12 consecutive months; and
- (c) You must have an eligible loan(s).

Once your proofs of disability and eligible loan(s) are approved, Guardian will start to repay your eligible loan(s). If the terms of an eligible loan(s) change after the onset of disability, loan payoff benefit payments will be based on the lesser of the loan re-payment requirements. Guardian has the right to repay eligible loan(s) in installments. Payments will be made to the financial lending institution that made the loans.

To be eligible for payoff (an "eligible loan"), a loan:

- 1) Must have been made to the employee/resident by a financial lending institution;
- 2) Must have been made to cover educational expenses for college and/or medical school, including tuition fees, textbooks, and equipment;
- 3) Must have been made prior to the onset of disability;

- 4) Must have been made prior to the date the resident graduated from medical school; and
- 5) Must not be a loan which the resident is not required to repay.

The resident must provide proof of eligible debt.

Loan payoff benefits end on the earliest of:

- (a) The date you are no longer functionally disabled;
- (b) The date you fail to provide continued proof of disability as required by this plan;
- (c) The date you are no longer entitled to net monthly payments from this plan;
- (d) The end of the maximum payment period; or
- (e) The date the maximum loan payoff benefit is reached.

Special Limitations and Exclusions

Mental or Emotional Conditions, Alcohol Abuse and Drug Abuse

If you are disabled, as defined by this plan, by a mental or emotional condition, alcohol abuse or drug abuse, Guardian limits the duration of this plan's benefits. For the long term disability income coverage of this plan, a mental or emotional condition will include, but is not limited to, any of the following:

- Bipolar affective disorder (manic depressive syndrome).
- Schizophrenia.
- Delusional (paranoid) disorders.
- Psychotic disorders.
- Depressive disorders.
- Anxiety disorders.
- Somatoform disorders (psychosomatic illness).
- Eating disorders.
- Mental illness.

For each disability due to a mental or emotional condition, alcohol or drug abuse, disability payments stop at the earliest of: (a) the date during any one period of disability that you have received 24 net monthly payments; (b) the end of the maximum payment period; or (c) the date disability ends.

Benefits will be limited to a total of 24 months of benefits in your lifetime for all disabilities contributed to, or caused by, any combination of the conditions shown above.

If at the end of benefit payments as shown above, you are being treated for the cause of your disability as an inpatient in a qualified institution for at least 14 consecutive days, Guardian will extend disability payments. Payments are extended until the earliest of: (a) 90 days from the date of your discharge; (b) the end of the maximum payment period; or (c) the date disability ends.

"Qualified institution" means a legally operated hospital or other public or private facility licensed to provide inpatient medical care and treatment for the cause of your disability.

Pre-Existing Conditions

A pre-existing condition is a sickness or injury, including all related conditions and complications, for which, in the three months before your insurance under this plan starts, you: (a) receive advice or treatment from a doctor; (b) take prescribed drugs; or (c) receive other medical care or treatment, including consultation with a doctor.

A pregnancy which exists on the date your insurance under this plan starts is also a pre-existing condition.

Guardian does not pay benefits for disability caused by such a condition, unless it starts after you are insured under this plan for 12 consecutive months.

Guardian does not cover any disability which begins before your insurance under this plan starts.

If This Plan Replaces Another Plan

The pre-existing condition limitation shown above will not apply if you: (a) were insured on the day before this plan started under a long term disability plan the employer had with another insurer; and (b) meet the requirements shown below. However, this plan must start right after the old plan ends.

The pre-existing condition limitation will be waived if you: (a) are actively working on a full-time basis on the effective date of this plan; and (b) have fulfilled the requirements of any pre-existing condition exclusion or limitation of the old plan.

If you: (a) are actively working on a full-time basis on the effective date of the plan but (b) have not fulfilled the requirements of any pre-existing condition exclusion or limitation of the old plan.

If you: (a) are actively working on a full-time basis on the effective date of the plan but (b) have not fulfilled the requirements of any pre-existing condition limitation or exclusion of the old plan, then Guardian will apply any period of time credited toward the satisfaction of the pre-existing condition limitation or exclusion under the old plan toward satisfaction of this plan's pre-existing condition limitation.

Guardian will deduct all payments made by the old plan under an extension provision. Any benefits for a disability caused by a pre-existing condition that we agree to pay will be subject to all other terms of this plan.

Exclusions

- Guardian does not cover any period of disability caused, directly or indirectly, by: (a) declared or undeclared war or act of war or armed aggression; (b) your service in the armed forces, National Guard, or military reserves of any state or country; (c) your taking part in a riot or other civil disorder; (d) your commission of, or attempt to commit, a felony; (e) your unlawful use or threat of force on another person without his or her consent; or (f) intentional self-injury or attempted suicide while sane or insane.
- Guardian does not pay benefits for any period during which you are confined to any facility as a result of your conviction of a crime or public offense.
- Guardian does not pay benefits for any period during which you are not under the regular care and treatment of a doctor.
- Guardian does not pay benefits for any period of disability which starts before you are insured by this plan.
- Guardian does not pay benefits for any period of disability which starts before you are insured by this plan.

In addition, no benefits will be payable for any period during which your loss of earnings is not solely due to your disability.

How To File for Claim Benefits

Filing a Claims for Benefits

You must send Guardian a written notice of an injury or sickness for which you intend to file a long term disability claim within 30 days of the injury or start of the sickness for which a claim is being made. This notice should include your name and Social Security number and the plan number.

Guardian will furnish you with claim forms for filing proof of disability within 15 days of Guardian's receipt of the initial notice of your intent to file a claim. The completed claim forms must be returned to Guardian within a reasonable period of time. If Guardian does not furnish the forms within the time stated, Guardian will accept a written description of the injury or sickness that is the basis for the claim in place of Guardian's form. You must detail the nature and extent of the disability for which the claim is being made. If necessary to determine our liability, as part of the proof of loss, we may require:

- (a) Certification of the extent and nature of your disability from all doctors who have treated you for the cause of your disability.
- (b) Certification of income from any other sources of income to which you may be entitled which may affect Guardian's benefit payments.
- (c) Satisfactory evidence that you have applied for all benefits and payments from other income sources to which you may be entitled; and
- (d) Proof of any income from other sources that you have received.

Guardian may require you to authorize release of medical and income data by the sources of such data, including the providers of medical and/or dental services. Any information not furnished or for which the release of authorization to obtain data is not obtained can result in suspension or delay of long term disability benefit payments until such information or authorization is received by Guardian.

Time Limit for the Filing of a Claim

Any claim not filed within a reasonable period of time following the end of the elimination period will be denied and no long term disability benefits will be payable unless written proof is submitted showing that you lacked the legal capacity to file the claim or that it was not reasonably possible for you to file the claim. In no event will benefits be payable for more than one year retroactively from the date the claim is filed.

Continued Proof of Disability

Additional proof will be required. Written proof of your continued disability and doctor's care must be provided to Guardian within 30 days of each date requested.

Payment of Benefits

Benefits for the long term disability income insurance are payable once every month, provided you continue to submit periodic written proof of loss and any current earnings as required by Guardian. Guardian pays all long term disability benefits to you, if legally competent. If you are not legally competent, Guardian will pay all benefits to which you are entitled to the legal representative of your estate. Guardian has the right to pay any benefits to which you are entitled which remain unpaid at your death to one of the following: (a) your estate; or (b) your spouse, parents, children or brothers and sisters.

Examination and Autopsy

If you make a claim for benefits, Guardian has the right to require that you be examined by a doctor as often as necessary; Guardian has the right to have an autopsy performed in the case of death, where allowed by law. Guardian also has the right to terminate or suspend your net monthly payments if you fail to attend such an

examination. In such case, your net monthly payments may be resumed, provided that: (a) the required examination occurs within a reasonable period of time; and (b) you continue to be entitled to net monthly payments under all other provisions of this plan. Guardian will pay for all such examinations.

Accident and Health Claims Provisions

Your right to make a claim for any accident and health benefits provided by this plan, is governed as follows:

Notice

You must send Guardian written notice of an injury or sickness for which a claim is being made within 20 days of the date the injury occurs or the sickness starts. This notice should include your name and the plan number.

Proof of Loss

Guardian will furnish you with forms for filing proof of loss within 15 days of receipt of notice. However, if Guardian does not furnish the forms on time, a written description and adequate documentation of the injury or sickness that is the basis of the claim as proof of loss will be accepted. You must detail the nature and extent of the loss for which the claim is being made. You must send Guardian written proof within 180 days of the loss.

Late Notice of Proof

Guardian will not void or reduce your claim if you cannot send notice and proof of loss within the required time. However, you must send notice and proof as soon as reasonably possible.

Payment of Benefits

Guardian will pay benefits for loss of income once every 30 days for as long as they are liable, provided you submit periodic written proof of loss as stated above. Guardian will also pay all other accident and health benefits to which you are entitled as soon as written proof of loss is received.

Guardian pays all accident and health benefits to you, if you are living. If you are not living, Guardian has the right to pay all accident and health benefits, except dismemberment benefits, to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; (e) your brothers and sisters; and (f) any unpaid provider of health care services. See "Your Accidental Death and Dismemberment Benefits" above for how dismemberment benefits are paid.

When you file proof of loss, you may direct Guardian, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. Guardian may honor such direction at our option. However, Guardian cannot advise if a particular provider must provide such care. You may not assign your right to take legal action under this plan to such provider.

Other Important Information

Definitions

Active Work – For the Long Term Disability Income Insurance "active work" means you are physically able to perform and are performing all of the regular duties of your work for the employer in the usual way and on a full-time basis, either at one of the employer's usual places of business or at some location to which the employer's business requires you to travel. Any changes in your long term disability benefits that are scheduled to occur on a date you are not actively working will not take place until the date you return to active work. However, if your return to active work is followed by a later period of disability which is considered a recurring disability, as described in this plan, changes which occur before or during that period of active work will not take place.

Cost of Living Benefit means a benefit under this plan which supplements this plan's net monthly payments. It is not part of the gross monthly benefit. And, it is not subject to any income limit this plan has. Read "The Cost of Living Benefit" for details.

Cost of Living Factor means the factor Guardian uses when computing the amount of this plan's cost of living benefit. Read "The Cost of Living Benefit" for details.

CPI-W means that part of the United States Department of Labor Consumer Price Index, which measures the relative value of the cost of a typical urban wage earner's purchase of certain goods and services. The change in cost is expressed as a percentage of the cost of those goods and services in a base period. In computing the value of our indexing factor, we use the percentage that the CPI-W published in December of that year changes from the CPI-W published in December of the prior calendar year. If the Department of Labor stops publishing the CPI-W, we have the right to use some other similar standard.

Disability means, solely due to your sickness or injury:

- (a) You are completely unable to perform the major duties of your regular occupation on a full-time basis; and
- (b) Your current monthly earnings, if any, are less than 80% of your indexed prior monthly earnings.

While you are disabled, you can engage in: (i) any other occupation full or part-time; (ii) some, but not all, of the major duties of your regular occupation full or part-time; or (iii) all of the major duties of your regular occupation part-time.

This plan only covers disability that starts while you are insured by this plan.

You will not be considered disabled under this plan if you are not under the regular care and treatment of a doctor.

In no event will the loss of a professional or occupational license, in itself, constitute disability.

Doctor means any medical provider Guardian is required by law to recognize, who: (a) is properly licensed or certified as such by the laws of the state where he or she practices; and (b) provides services that are within the lawful scope of his or her practice.

Earnings has the following meanings for this plan's long term disability income insurance:

- "Basic monthly earnings" are based on the amount of your earnings received from the employer as reported to Guardian. These earnings are used in determining the amount of premiums due for the coverage and for projecting your gross monthly benefit under this plan. Basic monthly earnings means an employee's rate of monthly earnings on the day before disability begins. Bonuses, commissions, expense accounts, overtime pay and any other extra compensation are excluded. Any employee compensation based on your monthly earnings which is deposited into a cash or deferred compensation plan, or a salary reduction plan, qualified under IRC Section 401(k) is included. Any employee compensation based on excluded income listed above and any employer contributions deposited into such 401(k) is excluded. In case of weekly earnings, it refers to those earnings for a normal work week not exceeding forty hours. Such weekly earnings are multiplied by 4.333. Subject to any of this plan's proof of insurability requirements as of the date of each change in an employee's earnings, we use the employee's then current monthly earning to set rates and to project the employee's gross monthly benefit for billing purposes. But the employee must be actively at work on a full-time basis on that date. If he or she is not, we do this on the date the employee returns to active full-time work.

- “Current monthly earnings” are the exact amount of monthly earnings you earn from working while disabled. Your current monthly earnings will include any income you earn while disabled but which is returned to your employer, partnership or any other similar business arrangement to cover any business or overhead expenses. Your current monthly earnings are used in determining your net monthly payment.
- “Prior monthly earnings” means your rate of basic monthly earnings as last reported to us prior to the start of your disability. Your prior monthly earnings are used in determining your gross monthly benefit under this plan.
- “Indexed prior monthly earnings” means your rate of prior monthly earnings adjusted annually by an indexing factor. Your indexed prior monthly earnings are used in determining the maximum amount of current monthly earnings you can earn under this plan and still receive benefits. For more information on this plan’s indexing benefit see “The Indexing Benefit”.

As part of proof of loss that we require, you must give us acceptable proof of your earnings. If you do not, we will not pay any benefits. Such proof must consist of: (a) copies of your U.S. Individual Tax Returns; (b) a statement from a certified public accountant; or (c) any other records we agree to accept.

Employee means a person who works for the employer at the employer’s place of business, and whose income is reported for tax purposes using a W-2 form.

Employer means Duke University Medical Residents Center.

Financial Lending Institution means an organization duly chartered and licensed by the state or federal government and regularly engaged in the lending of funds.

Full-time means the employee regularly works at least the number of hours in the normal work week set by the employer (but not less than 30 hours per week), at his or her employer’s place of business.

Functional Disability means that, due to sickness or injury, an eligible employee:

- (a) Is physically unable to perform 2 or more Activities of Daily Living without continuous physical assistance; or
- (b) Is cognitively impaired and requires verbal cueing to protect himself or herself or others.

“Activities of Daily Living” means:

- 1) Bathing: the ability to wash oneself in a tub, shower or by taking a sponge bath and to towel dry, with or without equipment or adaptive devices.
- 2) Dressing: the ability to put on and take off all garments and those medically necessary braces or artificial limbs usually worn, and also to fasten or unfasten them.
- 3) Toileting: the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene and to care for clothing.
- 4) Transferring: the ability to move in and out of a chair or bed with or without equipment such as canes, walkers, crutches, grab bars or any other support devices including those that are mechanical or motorized.
- 5) Continence: the ability to voluntarily control bowel and bladder function; or, in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

- 6) Eating: the ability to get nourishment into the body by any means once it has been prepared and made available to the individual.

“Cognitively Impaired” means a person has suffered a deterioration or loss in intellectual capacity. Such loss may result from injury, sickness, Alzheimer’s disease or similar forms of senility or irreversible dementia, and is documented by clinical evidence and standardized tests that reliably measure impairment in the areas of short term memory, orientation to time, place and person, deductive or abstract reasoning, and judgment as it related to awareness of safety.

In no event will the employee be considered functionally disabled before he or she has met the above criteria for 12 consecutive months.

Government Plan means: (a) the United States Social Security Act; (b) the Railroad Retirement Act; (c) the Canadian Pension Plan; or (d) any other plan provided under the laws of a state, province or any other political subdivision. It also includes any public employee retirement plan; or any plan provided as an alternative to the above plan or acts. It does not include: (i) any Workers’ Compensation Act or similar law; (ii) the Jones’ Act; (iii) the Longshoreman’s and Harbor Workers’ Compensation Act; or (iv) the Maritime Doctrine of Maintenance, Wages or Cure.

Gross Monthly Benefit means this plan’s monthly benefit before it is integrated with other income and earnings.

Guardian means The Guardian Life Insurance Company of America.

Injury means: (a) all bodily injury due to an accident that occurs, independent of all other causes, while you are insured by this plan; and (b) all complications thereof. Disability will be considered caused by an injury only if that disability: (a) is directly caused by the injury; and (b) begins within 90 days of the date of such injury.

Maximum Payment Period means the longest period that benefits are paid by this plan for continuous disability.

Net Monthly Benefit means this plan’s monthly benefit after the gross monthly benefit is integrated with other income but before it is reduced by any current monthly earnings.

Net Monthly Payment means this plan’s net monthly benefit less any reduction by current monthly earnings. See “How We Compute Net Monthly Payments for details.

No-Fault Motor Vehicle Coverage means a motor vehicle plan that pays disability or medical benefits without considering who was at fault in any accident.

Plan means the Guardian group long term disability income insurance plan purchased by your employer, except in the provision entitled “Coordination of Benefits” where “plan” has a special meaning. See that provision for details.

Proof or Proof of Insurability means an application for insurance showing that a person is insurable.

Regular Occupation means your occupation as performed in the general labor market in the national economy. When determining the duties of your regular occupation Guardian uses both the job description provided for you by the employer as well as the duties of that occupation as shown in the most recent version of the Dictionary of Occupational Titles, published by the U.S. Department of Labor.

Rehabilitation Agreement means a signed, written agreement between you and the Guardian. It outlines a program of vocational rehabilitation in which you agree to participate. The program outlined in the rehabilitation agreement is designed to return you to gainful work.

Rehabilitation Specialist means a designated employee or representative of the Guardian who is trained in vocational rehabilitation.

Rehabilitative Work means any program of work or job training that we approve in writing for you. The aim of such work is to restore your wage earning abilities.

Retirement Plan means a defined benefit or a defined contribution plan funded wholly or in part by the employer's deposits for your benefit. The term does not include: (a) profit sharing plans; (b) thrift plans; (c) non-qualified deferred compensation plans; (d) individual retirement accounts; (e) tax sheltered annuities; or (f) stock ownership plans.

Retirement plan "retirement benefits" are lump sum or periodic payments by a retirement plan at normal or early retirement. Some retirement plans also make payments for disability (as defined by those plans) that start before normal retirement age. When such payments actuarially reduce the amount that would otherwise have been paid at normal retirement age, they are "retirement benefits." When such payments do not so reduce the normal retirement amount, they are "disability benefits."

Sickness means: (a) any illness or disease; (b) all related conditions; and (c) all complications and recurrences thereof. This plan treats pregnancy like a sickness.

Converting Your Group Long Term Disability Income Insurance

Eligibility for Conversion

When your coverage under this group long term disability income plan ends, you may obtain a converted individual disability income policy, subject to the conditions below. You will be eligible for the converted individual disability income policy if you: (a) are not disabled under the terms of this plan; (b) have been covered under this plan (or a prior group disability income plan which this plan replaced) for at least 12 consecutive months immediately prior to the date your group coverage ends; (c) have successfully completed the residency program in which you were enrolled; and (d) apply to us in writing within 31 days after the date on which your coverage under this plan ends. By residency program, we mean a program of internship or residency, in a medical specialty, accredited by the American Council for Graduate Medical Education.

You will not be eligible for a converted individual disability income policy if your group long term disability coverage ends because you: (a) fail to make a required contribution; (b) change to a class not eligible under this plan; (c) fail to complete a program of residency; (d) retire; or (e) because coverage ends for all persons or all persons in a class under this plan.

You do not have to provide evidence of good health to obtain the converted individual disability income policy, but you may be subject to other underwriting criteria. You must provide details concerning other disability income insurance in force or applied for, or for which you would become eligible under another plan within 31 days after the date that this group coverage ends. Guardian will not issue a converted individual disability income policy if such policy would result in your being overinsured by Guardian's standards.

To Obtain a Converted Individual Disability Income Policy

You must apply to Guardian in writing and pay any required premium to obtain a converted individual disability income policy. You must do this within 31 days of the date on which your group long term disability coverage ends. If you fail to apply to in writing and pay any required premium within 31 days of the date your group long term disability coverage ends, you are no longer eligible to obtain a converted individual disability income policy.

The Converted Individual Disability Income Policy

Your converted individual disability income policy, if issued, will be effective on the day your coverage under this group plan ends. The benefits, terms and conditions of the converted individual disability income policy will

be those of the policy in use for such purpose in the state where you then live. These may be different from the benefits, terms and conditions of this group long term disability plan. The premium for the converted individual disability income policy will be that in effect for your age and class of risk on the date the policy is issued.

Critical Disability Supplement Coverage

This plan is amended by this Critical Disability Supplement rider so that Guardian will provide additional coverage for an “eligible employee” who has a “functional disability”. What Guardian pays is subject to the terms below and to all of the terms of the plan.

As used in this rider:

“Eligible Employees” are employees who are eligible for coverage under The Guardian Long Term Disability Insurance plan.

“Functional Disability” means that, due to sickness or injury, an “eligible employee”:

- (a) Is unable to perform 2 or more activities of daily living without continuous physical assistance; or
- (b) Is cognitively impaired and requires verbal cueing to protect him/herself or others.

“Activities of Daily Living” means:

- 1) Bathing: the ability to wash oneself in a tub, shower or by taking a sponge bath and to towel dry, with or without equipment or adaptive devices.
- 2) Dressing: the ability to put on and take off all garments and those medically necessary braces or artificial limbs usually worn, and also to fasten or unfasten them.
- 3) Toileting: the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene and to care for clothing.
- 4) Transferring: the ability to move in and out of a chair or bed with or without equipment such as canes, walkers, crutches, grab bars or any other support devices including those that are mechanical or motorized.
- 5) Contenance: the ability to voluntarily control bowel and bladder function; or, in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.
- 6) Eating: the ability to get nourishment into the body by any means once it has been prepared and made available to the individual.

“Cognitively Impaired” means a person has suffered a deterioration or loss in intellectual capacity. Such loss may result from injury, sickness, Alzheimer’s disease or similar forms of senility or irreversible dementia, and is documented by clinical evidence and standardized tests that reliably measure impairment in the areas of short term memory, orientation to time, place and person, deductive or abstract reasoning, and judgment as it related to awareness of safety.

When Critical Disability Supplement Coverage Starts

An “eligible employee” will be covered for the additional coverage described in this rider on the later of: (a) the effective date of this rider; or (b) his or her effective date under this long term disability plan.

However, if on his or her effective date, an employee: (a) is physically unable to perform one or more activities of daily living, as described above, without another person’s assistance; or (b) is cognitively impaired, as described above, and requires verbal cueing to protect him/herself or others, this critical disability supplement coverage will not start. Critical disability supplement coverage will start on the date the employee: (a) is

physically able to perform all activities of daily living without another person's assistance; or (b) is no longer cognitively impaired and no longer requires verbal cueing to protect him/herself or others.

When Critical Disability Supplement Coverage Ends

An employee's additional disability coverage under this rider ends on the earlier of the following: (a) the date this rider is no longer in effect; or (b) the date his or her coverage under this long term disability plan ends.

When and How This Rider's Critical Disability Supplement Payments Start

To start receiving this rider's additional disability coverage payments, an employee must meet all of the following conditions:

- (a) He or she must be disabled according to the terms of this long term disability plan and stay both disabled and insured under this plan continuously throughout this plan's elimination period;
- (b) He or she must have a "functional disability";
- (c) He or she must be: (i) under a doctor's regular care for the cause of his or her "functional disability"; and (ii) receiving appropriate medical care for the cause of his or her "functional disability"; and
- (d) He or she must permit an assessment of his or her "functional disability" by an independent entity specializing in assessments of whether a person is able to perform activities of daily living or is cognitively impaired.

Once the conditions stated above have been met and we have approved the employee's proof of his or her "functional disability," we start to make the critical disability supplement payments.

The employee must comply with our requests for periodic reassessments of his or her "functional disability" status by an independent entity specializing in assessments of whether a person is able to perform activities of daily living or is cognitively impaired.

What Guardian Pays

Subject to all of the terms of this plan, the critical disability supplement payment is as follows:

- Critical Disability Supplement Benefit: 30% of an employee's prior monthly earnings, rounded to the nearest \$1.00 if not already a multiple thereof, to a maximum of \$3,000.00.

When This Rider's Critical Disability Supplement Payments End

This rider's additional disability benefit payments end on the earlier of:

- (a) The date the long term disability plan benefits end; or
- (b) The date the employee no longer has a "functional disability".

Your Rights Under ERISA

For a summary of your rights under the Employee Retirement Income Security Act of 1974 (ERISA), please refer to the “General Information” section of this booklet.

This brochure explains the general purposes of the insurance described, but in no way changes or affects the policy as actually issued. In the event of any discrepancy between this brochure and the policy, the terms of the policy apply. Complete details are in the certificate of insurance issued to each insured individual. Please read it carefully and keep it in a safe place with your other important documents.

DUKE LONG TERM DISABILITY INCOME ENHANCER

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DUKE LONG TERM DISABILITY INCOME ENHANCER

Introduction

This information pertains only to Duke employees holding Massachusetts Mutual Life Insurance Company (MassMutual®) Long Term Disability Income Enhancer contracts. **It is not available for new enrollments.**

This plan supplements Duke's long term disability group plan with an individual disability income policy from MassMutual. By "wrapping" an individual policy around the group plan, you can protect a much larger share of your income, including income from sources outside of Duke University or Duke University Health System.

Eligibility for Coverage

Eligibility

You are eligible to participate in this plan if you currently hold a MassMutual Long Term Disability Income Enhancer contract and are an active, regular employee scheduled to work at least 30 hours per week or a faculty member regularly scheduled to work at least 40 hours per week. Housestaff and employees covered by a collective bargaining agreement (unless coverage was mutually agreed to in the bargaining agreement) are not eligible for this plan.

Full-Time Employees NOT Covered by the Duke Long Term Disability Insurance Group Plan

A full-time employee with less than three years of service credit is not covered by the Duke Disability Insurance group plan. The Long Term Disability Income Enhancer offers these employees the opportunity to cover up to 70% of earnings. Optional waiting periods before benefits start can be satisfied with total or partial disabilities. The benefit is payable for your choice of two years, five years or longer.

When you become eligible for the Duke Disability Insurance group plan, you will have the option to reduce the original policy's benefit amount to reflect the coverage of 66 2/3% of your salary. This would reduce your premiums while increasing your level of coverage.

Employees Covered by the Duke Long Term Disability Insurance Group Plan

A variety of options are available to tailor a plan to your income and lifestyle. You can purchase an individual policy that supplements the Duke Disability Insurance group plan. This policy would pay up to 20% in addition to the Duke Long Term Disability Insurance benefit. It would pay even more, if you qualify, due to outside income.

- Benefits from the Enhancer become payable as early as one month after the occurrence of a disability. Other options are available, such as, two months, three months, or longer.
- Benefits are payable for optional periods such as, until the normal retirement age or even for life.

In the event you return to work in a reduced capacity, the Enhancer will continue to pay a benefit. For example, the total of the earnings from partial employment, the Duke plan, and the Enhancer, is actually greater than your earnings prior to becoming disabled.

The Long Term Disability Income Enhancer offers a benefit for everyone. Whether it is providing coverage during the three-year waiting period or supplementing the group plan, the Enhancer has an option for you.

Employees on an approved Workers' Compensation leave and receiving wage replacement are eligible to continue their coverage under this plan, while on leave. During this time, you will need to arrange for direct billing with MassMutual for your premium payment.

When Coverage Begins

Your coverage becomes effective on the date you are both actively at work at Duke and meet the eligibility requirements (see above). If you are not actively employed at Duke, benefits become effective when you return to active employment.

When Coverage Ends

Your coverage will end if any of the following events occurs:

- You are no longer classified as an eligible employee;
- You stop making the required contributions; or
- The plan terminates.

Paying for Coverage

You pay the full cost of this coverage using post-tax dollars withheld from your paycheck through regular payroll deductions.

How To File for Claim Benefits

Claims Information

In the event of a disability, you must file a claim in order to receive benefits.

To file a claim, you may log onto your [MassMutual.com](https://www.massmutual.com) account or contact the MassMutual Service Line at **800-272-2216**, 8:00am to 8:00pm ET, Monday through Friday.

Claim forms should contain a basic diagnosis and approximate date of disability so that the correct form is issued by mail, email, or electronically via the MassMutual online link.

Please specify whether the claim form needed is for cardiac health, mental health, or a general form in order for the correct form to be issued. Once claim forms are issued, the return information is contained on the form.

If a date of disability is not known, MassMutual will use a date two months prior to the date of receipt of the claims request when logging the request to the claims department.

When a claim is first sent over to Claims, it is in a Pre-Claim Status until the claim form is remitted. Once forms are in-house, an examiner will be assigned for review of the case.

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:

**Massachusetts Mutual Life Insurance Company Plan Administrator
Duke Benefits
705 Broad St.
Box 90501
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 a 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 or later than three years have passed after you file your claim.

Your Rights Under ERISA

For a summary of your rights under the Employee Retirement Income Security Act of 1974 (ERISA), please refer to the "General Information" section of this booklet.

This brochure explains the general purposes of the insurance described, but in no way changes or affects the policy as actually issued. In the event of any discrepancy between this brochure and the policy, the terms of the policy apply. Complete details are in the certificate of insurance issued to each insured individual. Please read it carefully and keep it in a safe place with your other important documents.

DUKE UNIVERSITY FACULTY AND STAFF RETIREMENT PLAN

The Duke University Faculty and Staff Retirement Plan is a 403(b) retirement savings plan offered by Duke. You can voluntarily contribute to your retirement through this 403(b) plan regardless of whether you are a non-exempt employee (paid on a biweekly basis) or an exempt employee (paid on a monthly basis). The Plan allows you to make voluntary contributions on a pre-tax basis, Roth after-tax basis or a combination of both. Contributions are made to a 403(b) savings account through salary reduction to help you save for retirement. You direct your own investments in this Plan. Duke has designed a simplified investment tiered structure to help you with your investment selection.

For faculty members and exempt employees, the program is funded by both your and Duke's contributions. Duke will make a contribution if you are in an eligible category, are at least age 21 and have completed one year of service.

For non-exempt employees, Duke does not make a contribution to this Plan; however, non-exempt employees may be eligible for the Employees' Retirement Plan (ERP), a pension plan funded entirely by Duke. For additional information about the ERP, please visit: hr.duke.edu/benefits/summaries.

The Summary Plan Description for the Duke Faculty and Staff Retirement Plan can be found at hr.duke.edu/benefits/summaries/retirement-sar.

EMPLOYEES' RETIREMENT PLAN OF DUKE UNIVERSITY

The Employees' Retirement Plan of Duke University (the "Plan") is a traditional defined benefit pension plan offered by Duke University. The Plan plays an important role in your future by working with Social Security benefits and your personal savings (including your contributions to the Duke Faculty and Staff Retirement Plan) to help provide you with lifetime income when you retire. The cost of the Plan is paid entirely by Duke.

The Summary Plan Description ("SPD") for the Employees' Retirement Plan can be found at hr.duke.edu/benefits/summaries. You will find valuable information describing the features of the Plan, including:

- When you become eligible for plan membership;
- When you qualify for retirement;
- How your benefit is calculated and how it can be paid;
- How your spouse is protected in the event of your death; and
- Additional information that will help you plan ahead.

Please read the SPD carefully and share it with your family.

DUKE EMPLOYEE TUITION ASSISTANCE PROGRAM

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DUKE EMPLOYEE TUITION ASSISTANCE PROGRAM

Introduction

Duke offers an Employee Tuition Assistance Program (ETAP) that provides reimbursement of tuition for classes taken at Duke or any other higher educational institution. Beginning January 1, 2023, the Watts College of Nursing is included as an eligible higher educational institution. Beginning July 1, 2023, the limitation of a physical presence in North Carolina for the higher educational institution is removed and the eligible accreditation broadened to include regional accrediting agencies recognized by the U.S. Department of Education. The purpose of the program is to encourage and increase professional development opportunities for faculty and staff and provide reimbursement of tuition for classes at community colleges or other higher educational institutions that may be closer to home, evening classes, or classes otherwise not available at Duke.

This program provides reimbursement of tuition for a maximum of three classes per semester or quarter (limit nine classes per calendar year) up to \$5,250 per calendar year for full-time employees with at least six months of continuous full-time service, effective July 1, 2023. Please note IRS guidelines allow the individual to exclude up to \$5,250 from taxable income per calendar year for tuition reimbursement programs such as this one. If you receive tuition assistance outside of this program, within Duke or external, please let HR Benefits know so the amounts received under this program can have taxes withheld, as needed.

The term "Duke" is used throughout this booklet. "Duke" refers to the University, Duke University Health System, Inc. and any other corporation or entity that adopts the Plan with the duly authorized approval of the Board of Trustees. When used in this Plan document, "Employer" shall refer to all of the foregoing collectively except where the context requires that such term refer to the corporation or entity that actually employs an individual.

The benefit program provided is based on an employee's company code and job code as reflected in the HR benefits administration system (SAP). Duke employees holding more than one position classification receive the benefits associated with their primary position classification as reflected in SAP. For example, a housestaff member who also works within DHIP, receives benefits associated with their housestaff position classification.

Eligibility and Enrollment

Eligibility for Coverage

You are eligible to apply for the program if you:

- Have completed six months or more of consecutive full-time service at Duke University or Duke University Health System in a benefits-eligible category.
- Are an active regular, full-time staff member scheduled to work at least 30 hours per week, a faculty employee holding a regular rank appointment who is receiving wages for Social Security purposes, or a faculty employee holding other than a regular rank appointment and classified as a full-time member of the faculty, who is receiving wages for Social Security purposes.
- Meet the six-month service requirement and are actively working on or before the following dates:
 - September 1 for fall semester;
 - January 1 for spring semester; and
 - May 1 for summer school
- In good standing with a satisfactory performance record at the time of application, and your application is approved by your supervisor, prior to requesting reimbursement for the course. (Disciplinary actions remain in employee files for one year and are not relevant after that period unless a subsequent disciplinary action is issued.) Health system employees must have approval of supervisor / manager and associate operating officer, or equivalent designee, within 90 days of the last day of class.

Participants must be in an actively at work employment status, with a work schedule of at least 30 hours per week, at the time the application is submitted and at the time reimbursement is made.

Housestaff are not eligible for the Employee Tuition Assistance Program (ETAP). However, once a Housestaff member moves into a regular faculty position, prior to any break in service, the continuous service date as Housestaff is used for calculating eligibility for this program.

ELIGIBILITY PROVISION: The PDC continuous service date will count towards the six-month eligibility for employees transitioning from the PDC on July 1, 2023.

PLEASE NOTE: Your benefit and eligibility for coverage in this plan will be immediately terminated if you provide fraudulent or misrepresented information. This includes, but is not limited to, fraudulent statements or material misrepresentation of facts. Your benefit and eligibility for the Employee Tuition Assistance Program will be terminated and also your benefits and eligibility for coverage in other Duke-sponsored benefit plans including, but not limited to, Health Care Plans, Retiree Health Care Plans, Dental Plans, Vision Plan, Reimbursement Account Programs, Life Insurance Plans (including Gratuity to Spouse / Estate Plan), Children's Tuition Grant Plan, and Disability Plans). Employment with Duke may also be terminated for providing fraudulent or misrepresented information.

Assignment or Alienation of Coverage Benefits under this plan may not be assigned to anyone else.

Leaves of Absence

Participation in the program is suspended during an unpaid personal leave of absence. However, if an employee takes a paid leave of absence, including personal LOA, the employee retains eligibility for ETAP. During an unpaid leave of absence (with the exception of FMLA) the employee will lose their eligibility for

ETAP throughout the period of the leave. Time away from work during an FMLA period is counted toward your eligibility. If you are a regular full-time faculty member who is on a sabbatical leave approved in writing by Duke, you will be considered to be employed as a regular full-time employee.

Likewise, if you are a regular full-time faculty member or a regular full-time non-faculty employee who is in Duke's Workers' Compensation Program and receiving wage replacement, you will also be considered to be employed as a full-time employee or faculty member for as long as you are actually receiving benefits under this program.

How the Employee Tuition Assistance Program Works

What the Program Covers

To be eligible for reimbursement, courses must meet the following guidelines:

- Must be related to the employee's current job or continued career growth at Duke; this is determined by your supervisor;
- Must provide academic course credit that can be used towards earning a degree;
- Must be listed in the institution's course catalog;
- Must be taken at Watts College of Nursing or a higher educational institution that is regionally accredited;
- Educational institutions that are accredited by a regional accreditor recognized by the U.S. Department of Education (USDE) will be considered eligible institutions. USDE-recognized regional accrediting organizations are:
 - Northwest Commission on Colleges and Universities (NWCCU);
 - Higher Learning Commission (HLC);
 - WASC Senior College and University Commission (WSCUC);
 - Southern Association of Colleges and School Commission on Colleges (SACSCOC);
 - Middle States Commission on Higher Education (MSCHE); and
 - New England Commission on Higher Education (NECHE);
- Must be documented as part of an employee's professional development plan;
- Must be completed with a grade of "C" or better, or "Pass" if a grade is not provided; and
- Must be approved by your supervisor prior to requesting reimbursement.

Courses can be classroom, video-based, distance learning, web based, E-Learning, and certain correspondence coursework. ESL (English as a Second Language) courses that are offered through any higher educational institution with regional accreditation are also eligible for reimbursement. Additionally, self-paced courses are reimbursable under the guidelines of the program. With these courses, there must be a designated start and end date on the application within a specific semester / term, it cannot take longer than the equivalent of one semester, and there will be no exceptions to these dates when it is time to process the reimbursement. See additional requirements for self-paced courses, below:

- A start and end date must be designated on the application within a specific semester / term;
- All courses on the application will abide by the same start and end dates;
- Separate applications for other courses with different start / end dates are acceptable as long as there are not more than 3 courses being reimbursed during the same time period (9 courses total for the year);
- Both a start and end date must be designated in order to be reimbursed and it cannot take longer than the equivalent of one semester;
- There will be no exceptions to these dates when it is time to process the reimbursement; and
- All other requirements will remain:
 - Application approved by supervisor must be submitted prior to requesting reimbursement and all documentation must be submitted within 90 days of the established end date.

One semester of coursework that is solely research is eligible for tuition reimbursement, provided the course is in pursuit of a Master's thesis or Doctoral dissertation. One semester of reimbursement for PhD research can be for dissertation or individual research, but not for both.

More information is available to assist in determining accreditation on the U.S. Department of Education Office of Postsecondary Education website: ed.gov/accreditation.

Completed applications and final grades must be submitted via the Duke@Work portal within 90 days of successfully completing the course and prior to requesting reimbursement. Your supervisor's approval is also required.

It is highly recommended that each participant receive approval from their supervisor **prior** to starting the course as supervisor approval is required prior to reimbursement. Having supervisor approval prior to starting your coursework will provide you the necessary assurance that the course is considered related to your current job or continued career growth. Your supervisor's approval that the coursework is related to your current job or continued career growth is one of the requirements of the program to be reimbursed. See above for additional requirements.

Reimbursement is available for a maximum of nine semester or quarter courses per calendar year, with a maximum of three courses taken in any one semester / quarter (i.e., spring, fall, summer). The maximum amount that can be reimbursed in a calendar year is \$5,250. The year in which the course begins is the year/semester/quarter used to determine tuition reimbursement eligibility. Reimbursement is limited to incurred tuition expenses. Transportation costs, late fees, parking costs, graduation fees, examination fees, textbooks, supplies, registration fees, student fees, and other similar costs are not eligible for reimbursement.

Please note that IRS guidelines allow the individual to exclude up to \$5,250 from taxable income per calendar year for tuition reimbursement programs such as this one. If you receive tuition assistance outside of this program, within Duke or external, please let HR Benefits know so the amounts received under this program can have taxes withheld, as needed.

In order to receive reimbursement under this program, the approved course must be successfully completed with a "C" or better in a course where a grade is provided or official documentation from the institution that the course was "Passed" or "Satisfactory" for coursework where a final grade is unavailable. An "Incomplete" is not

reimbursable. All documentation must be submitted via the Duke@Work web portal within 90 days following successful completion of the course, i.e., the last day of class, and reimbursement will only be made for the semester in which the course was approved.

Departments are not allowed to “float” loans for employee tuition. In the event of such an occurrence, there will be no tuition reimbursement made to the employee since it is required that the employee pay for tuition expenses and then be reimbursed. Payments will not be made directly to the school.

What the Program Does not Cover

Transportation costs, late fees, parking costs, graduation fees, examination fees, textbooks, supplies, registration fees, tuition surcharges, student fees, and other similar costs are not eligible for reimbursement. Additionally, tuition costs for courses that have been approved and reimbursed previously through this program are not eligible for reimbursement.

Certification programs that do not provide academic credit and correspondence courses are not eligible for tuition reimbursement.

Effect of Scholarships / Grants on Reimbursement

Scholarships / grants and departmental funding will be taken into consideration prior to determining tuition reimbursement. If a scholarship / grant is received, the employee is to provide a receipt for the cost of books upon submission of all completed documentation to Benefits.

If a scholarship / grant is not designated towards tuition and is not greater than the cost of books and fees, then the scholarship / grant has no impact on the Employee Tuition Assistance Program reimbursement.

If a scholarship / grant is not designated towards tuition and is greater than the cost of books and fees, then the amount exceeding the cost of books and fees will be deducted from the Employee Tuition Assistance Program reimbursement.

If the scholarship / grant is designated towards tuition, then the scholarship / grant will reduce the amount of the Employee Tuition Assistance Program reimbursement on a dollar-for-dollar basis.

If more than three courses are being taken, scholarships / grants will be applied towards the cost of the other courses in order for the employee to get the maximum tuition reimbursement for which they are eligible.

How To Apply for the Program

If you are interested in participating in the program, you should first discuss your professional development plan with your supervisor. It is highly recommended that you talk first with your supervisor prior to applying for the program. As noted in the “How the Employee Tuition Assistance Program Works” section, one criterion is the course must be job-related to be eligible for reimbursement, and your supervisor makes this determination. Once you and your supervisor have approved a course or courses that are related to your current job or will enable continued career growth at Duke and this is documented in your professional development plan, you must complete an online application via the Duke@Work web portal prior to requesting tuition reimbursement.

University employee applications must have approval of your supervisor / manager. Health system employee applications must have approval of your supervisor / manager and associate operating officer or equivalent designee.

Employees will be sent an automatic email confirmation upon approval of the application.

Reimbursements will not be processed without supervisor/manager approval.

How To be Reimbursed

Within **90 days of course completion (i.e., last day of class)**, upload official institutional documentation of successful completion, i.e., unofficial transcript (a “C” grade or better, “Pass” or “Satisfactory”) and proof of the tuition payment* (*Reimbursement Request Form or itemized statement via the Duke@Work web portal).

If you do not submit the required documentation within 90 days of course completion (i.e., last day of class), you will not be eligible for reimbursement under this program.

Employees are required to have direct deposit for reimbursement. Access to direct deposit enrollment is available via the Duke@Work web portal.

An email confirmation will be automatically sent to the employee advising of the pay date your reimbursement will be directly deposited into your designated bank account. The reimbursement amount will appear as a separate line item on your pay statement.

Payments will not be made directly to the school.

If you are voluntarily terminating employment during a period when a tuition reimbursement is pending and you owe a repayment, the pending reimbursement will not be processed.

Overpayment

In the event of overpayment, you agree to return the amount of the overpayment to the plan administrator or have the amount of the overpayment deducted from your paycheck.

What Happens if you Leave Duke

The ETAP Retention Agreement stipulates participants must agree to remain at Duke for two years following a total reimbursement of \$2,500 or more. If you voluntarily terminate employment before completing two years of service after receiving your last tuition reimbursement from Duke, you must repay 50% of the total amount reimbursed over \$2,500. Duke Benefits reviews the two years prior to your last day worked to determine if you have received total tuition reimbursement payments in excess of \$2,500. If you have received more than \$2,500 in payments during this period, you must repay 50% of the amount reimbursed over \$2,500. Refer to the “Repayment Calculation” chart for an example of the calculation.

If at the time of your resignation you owe a repayment based on prior program utilization, no unpaid requests for reimbursement will be processed. Applications submitted but not paid will not be processed for payment. If at the time of your resignation you do not owe a repayment based on prior program utilization and your final reimbursement results in a repayment, the amount reimbursed will be the difference between the amount requested and \$2,500.

The retention policy is not applicable to employees whose reason for termination is retirement or lay-off, as indicated in SAP.

Repayment Calculation Example

Employee's last day worked: April 8, 2024. Two-year look-back period: April 8, 2022 to April 8, 2024.

Date of Tuition Payment	Amount of Payment
May 15, 2021	\$3,500
December 15, 2021	\$1,500
May 16, 2022*	\$1,750
December 16, 2022*	\$2,400
*Total tuition payments made within two-year look back period	\$4,150
Minus	\$2,500
Sub-total	\$1,650
Amount to be repaid by employee (50% of \$1,650)	\$825

Departmental/Manager Responsibility

The supervisor / manager approval must be granted prior to the employee's request for reimbursement. By approving the employee's application, the supervisor / manager agrees to notify HR Benefits immediately via email when the employee gives notice of termination. If the supervisor / manager does not notify HR Benefits immediately, via email, when the employee gives notice of termination and the employee leaves before repaying the tuition benefit, the employee's department will be responsible for repaying the funds and the repayment amount will be charged to the department's fund code. If the employee transfers to another department, it is the approving department's responsibility to inform the hiring manager that they have assumed the responsibility of notifying HR Benefits immediately when this employee gives notice of termination. Otherwise, the approving department retains accountability and will be responsible for repayment of the benefit, if applicable.

Taxes and Withholding of Plan Benefits

Each employee approved for tuition reimbursement is eligible for a maximum benefit of \$5,250 for courses taken in a calendar year. The benefit is not considered taxable income for most eligible employees. However, any amount reimbursed which exceeds the program maximum in a calendar year (\$5,250), will be reportable by Duke as taxable income and it will be up to each individual in consultation with their tax advisor to determine the final tax status. Taxability is determined based on the date that the reimbursed payment is issued. Taxes are withheld up front and the employee receives the net amount. There may be instances where reimbursements are issued in a different tax year from which the courses were taken. Also, the \$5,250 is an individual limit, not an employer limit. For example, if you have received tuition assistance from another employer in the same calendar year you are receiving reimbursement under this program, the aggregate amount that you may exclude is still \$5,250 under current regulations. Please let HR Benefits know if you have received other tuition assistance so appropriate taxes are withheld, if needed.

The Duke Employee Tuition Assistance Program is administered by the University, which shall have final authority to construe the provisions of the program, to determine all questions of eligibility for benefits, and to establish any administrative rules for operation of the program. The University may amend or terminate the

program at any time, with respect to benefits not yet paid, for any reason that it deems appropriate in its discretion.

Appeals Procedure

If your Employee Tuition Assistance Program application or request for tuition reimbursement is denied, you are able to submit an appeal to the Plan Manager.

Mail appeals to:

**Duke Employee Tuition Assistance Program
Attention: Plan Manager
705 Broad St., Box 90502
Durham, NC 27708**

DUKE CHILDREN'S TUITION GRANT PROGRAM

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DUKE CHILDREN'S TUITION GRANT PROGRAM

Introduction

This program provides a grant for undergraduate tuition expenses incurred by children of eligible employees for full-time study at any accredited college or university.

The amount of the tuition grant is up to 75% of the weighted average of Duke's tuition, after applying a deductible. Each eligible employee may receive up to a maximum of 16 semesters of tuition assistance, no more than eight of which may be used by any one child.

Two earlier plans continue to be available to eligible faculty and senior administrative staff. The first plan is available to faculty and senior administrative staff who were hired prior to 1975 and provides a benefit of up to 100% of Duke's tuition that is taxable and does not limit the number of children eligible. The second plan provides faculty and senior administrative staff who were hired between 1975 and 1986 with a benefit of up to \$2,500 per child for up to two children with no deductible (this benefit is also taxable). If you qualify for one of these earlier plans, you can choose to participate in the current program with no limit on the number of children eligible for the benefit. However, this decision is irrevocable and we recommend that you review your options with the HRIC at **919-684-5600** prior to making that decision.

The term "Duke" is used throughout this booklet. "Duke" refers to the University, Duke University Health System, Inc. and any other corporation or entity that adopts the Plan with the duly authorized approval of the Board of Trustees. When used in this Plan document, "Employer" shall refer to all of the foregoing collectively except where the context requires that such term refer to the corporation or entity that actually employs an individual. **Please note, generally, this benefit is not available to employees within the Duke University Health System.** See the Eligibility section for specific details.

The benefit program provided is based on an employee's company code and job code as reflected in the HR benefits administration system (SAP). Duke employees holding more than one position classification receive the benefits associated with their primary position classification as reflected in SAP. For example, a housestaff member who also works within DHIP, receives benefits associated with their housestaff position classification.

The word "spouse" is used in this benefit program's summary plan description. This means legal spouse. In addition, it refers to an employee's registered Same Sex Spousal Equivalent providing the employee was hired prior to January 1, 2016 and registered his/her partner in Duke HR prior to January 1, 2016. This employee's registered partner remains eligible under Duke's Same Sex Spousal Equivalent Policy and is included in the meaning of "spouse" for the purpose of this benefit program wherever permissible under federal and state law. The eligible status continues for the course of this relationship only.

Eligibility and Enrollment

Eligibility for Coverage

You are eligible to participate in the Children's Tuition Grant Program if you:

- Meet the established Duke payroll / benefits classifications to be eligible for benefits coverage (staff members scheduled to work at least 30 hours per week, a faculty employee holding a regular rank appointment who is receiving wages for Social Security purposes, or a faculty employee holding other than a regular rank appointment and classified as a full-time member of the faculty, who is receiving wages for Social Security purposes); and
- Have at least five years of consecutive full-time service as a regular full-time employee during your current term of employment. You must remain in this employment status to maintain eligibility.
- For your child to be eligible for the fall semester, you must have completed five years of full-time service on or before September 1; for the spring semester, January 1; and for summer school, May 1.
- Are actively employed in a full-time benefits-eligible status on September 1 for the fall semester; January 1 for the spring semester; and May 1 for summer school.

Employees **must also** be either:

- A current Duke University employee who has completed service credit while employed within the University or Medical Center; or
- Have retained access to the program as an employee at an entity eligible to participate, which are: a Duke University, Duke Medical Center, or Duke Hospital employee, hired prior to January 1, 1999* with no break in service (this group will retain tuition benefits even after transferring to the Health System.)

Employees on an approved Workers' Compensation leave and receiving wage replacement, who met the eligibility requirements for this benefit prior to going out of work on Workers' Compensation, retain eligibility for this benefit while on leave.

PLEASE NOTE: *An employee of Duke Regional, Duke Raleigh, or DHIP (Company Code 44) for example, is not carried over for eligibility purposes.

Important

The Private Diagnostic Clinic (PDC) continuous service date (CSD) recognition related to the PDC integration into Duke University Health System or Duke University on July 1, 2023, for some benefit plans is NOT applicable for the Duke Children's Tuition Grant Program. The PDC continuous service date for employees that transitioned from the PDC on July 1, 2023 is excluded for purposes of determining eligibility for this program. Please see the "Important Summary for Employees Transitioning to the Duke Health Integrated Practice (DHIP) on July 1, 2023" in the "General Information About Your Benefits" section of this summary plan description for additional details.

Members of Local 77 who work within Duke University Health System are eligible for the Children's Tuition Grant Program benefit and have the same eligibility criteria as Duke University employees.

Housestaff are not eligible for the Children's Tuition Grant Program. However, once a Housestaff member moves into a regular faculty position, prior to any break in service, the continuous service date as Housestaff is used for calculating eligibility for this program.

Assignment or Alienation of Coverage

Any tuition costs you may become eligible to receive under this program may not be assigned to anyone else.

Leaves of Absence

The period of leave is added to the five-year service requirement. Participation in the program is suspended during a personal leave of absence, but will continue in the event of an approved Duke long term disability leave, family medical leave, or sabbatical.

If an employee has not met the eligibility requirements for the Children's Tuition Grant benefit prior to going out of work on Workers' Compensation and is receiving wage replacement, any time on an approved Workers' Compensation leave counts toward Children's Tuition Grant benefit eligibility.

Losing Your Eligibility

You will lose your eligibility for this benefit if you terminate your employment with Duke, move into an ineligible classification or company code/employer, or decrease your work schedule. If you meet the service requirement, but then move to a part-time position at Duke, or to any other ineligible classification prior to the payment of this benefit, you will also lose this benefit. However, your eligibility will be restored if you return to full-time work in an eligible position / classification.

If you work full-time in a campus department but fewer than 52 weeks per academic year at the convenience of Duke (campus positions for 9-10 months), you will still be eligible for this benefit after completing five years of continuous service.

Positions that are 100% grant-funded are not eligible for severance benefits and would, therefore, not be eligible for continuance of this program once lay-off status is established.

Your benefit and eligibility for coverage in this plan will be immediately terminated if you provide fraudulent or misrepresented information. This includes, but is not limited to, fraudulent statements or material misrepresentation of facts. Your benefit and eligibility for the Children's Tuition Grant Plan will be terminated and also your benefits and eligibility for coverage in other Duke-sponsored benefit plans including, but not limited to, Health Care Plans, Retiree Health Care Plans, Dental Plans, Vision Plan, Reimbursement Account Programs, Life Insurance Plans (including Gratuity to Spouse / Estate Plan), Employee Tuition Assistance Plan and Disability Plans). Employment with Duke may also be terminated for providing fraudulent or misrepresented information.

PLEASE NOTE: This is not a vested benefit program and eligibility to participate in the program or continue to be eligible can change based on your work schedule, primary position classification and/or transfer to a primary position (as reflected in SAP) outside Duke University (Company Code 10). Call the HRIC at **919-684-5600** if you are uncertain whether your position is reflected to be in Duke University (Company Code 10) in SAP.

Transfers

- Employees hired prior to January 1, 1999 within Duke University, Duke University Medical Center, or Duke Hospital will retain the tuition benefit when transferring to the Duke University Health System (DUHS).
- Employees hired as Duke University staff after December 31, 1998 will not retain the tuition benefit when transferring to the Duke University Health System (DUHS) or Duke Health Integrated Practice (DHIP) (Company Code 44). However, if the employee transfers back to Duke University with no break

in service, then all their full-time service as a Duke University employee will count towards meeting the 5-year eligibility requirement.

- Benefits-eligible employees who have met the Rule of 75 as a regular full-time employee and the five (5) year service requirement while employed by the University, and have otherwise met the eligibility requirements for the Children's Tuition Grant program, will retain the benefit when transferring to the Duke University Health System (DUHS). The sum of your age plus your years of service with Duke must be equal to or greater than 75 based only on your most recent continuous date of service
- The Private Diagnostic Clinic (PDC) continuous service date (CSD) recognition related to the PDC integration into Duke University Health System on or about July 1, 2023, for some benefit plans is NOT applicable for the Duke Children's Tuition Grant Program.

Your Eligible Children

Your eligible children include:

- Your biological, adopted, stepchildren, or children for whom you have legal guardianship, up to the semester or quarter in which they turn 26;* and
- The children of your legal spouse up to the semester or quarter in which they turn 26 (please note that according to Internal Revenue Service guidelines, the benefit provided for your partner's child may be considered taxable income to you).

*Children of employees who were hired before January 1, 1999, will not be subject to the maximum age limitation.

PLEASE NOTE: A copy of the legal guardianship papers is required. If not issued in the State of North Carolina, the provisions of guardianship must be equivalent to those of North Carolina (a permanent placement where the biological parents have permanently surrendered their parental rights). A child for whom you have legal custody (whether temporary or permanent) is not an eligible dependent for purposes of the Duke Children's Tuition Grant Program. Additionally, adoption or obtaining legal guardianship for the sole purpose of receiving the Children's Tuition Grant benefit is not allowed. Duke obtains the right in its sole discretion to determine whether the adoption or legal guardianship is bona fide.

A child's eligibility must be established by the following dates in order for tuition payments to be made:

- On or before September 1 for the fall semester;
- On or before January 1 for the spring semester; and
- On or before May 1 for the summer semester.
- In cases of adoption or legal guardianship, placement of the dependent child must occur five (5) years prior to submission of a Duke Children's Tuition Grant Program application.

Stepchildren

In the event of your death while actively working at Duke, your stepchildren retain eligibility until your spouse remarries.

Taxes and Withholding of the Plan Benefits

The benefit is not considered taxable income for most eligible employees. However, if your child does not qualify as a dependent in accordance with the Working Families Tax Relief Act ("WFTRA"), then the benefit will be considered taxable income to you.

Your child qualifies as a dependent in accordance with the Working Families Tax Relief Act ("WFTRA") if s/he: (1) lives in your home for over half the year, and (2) is your child, stepchild or adopted child, and (3) is a student under 24 years of age, and (4) does not provide over half of their own support for the year. To be your dependent, he or she must be a U.S. citizen or a resident of the U.S., Canada, or Mexico and must not file a joint return for the year. "Student" means full-time student for at least five months of the year (thus, a college senior graduating in May or June can qualify in the year of graduation.) For more details on dependents, you may wish to see IRS Publication 501. IRS Publication 504 may be helpful for divorced or separated individuals. You may also want to consult your own tax advisor if you have additional questions.

If your child is not a dependent, as defined by the Working Families Tax Relief Act ("WFTRA"), your child may still receive the benefit, however, such benefit will be net of taxes withheld, as the benefit will be taxable income to you. Duke will withhold an amount for applicable taxes from the benefit, although you are responsible for ensuring that the full amount of federal and state taxes is paid.

How the Children's Tuition Grant Program Works

The Children's Tuition Grant Program provides a grant for full-time study at the associate or baccalaureate level at any approved, accredited, degree-granting institution of higher education in the world. The grant is provided for the pursuit of your child's first Bachelor's degree, regardless of where that degree was obtained. Second Bachelor's degrees and graduate study are not covered.

You may receive up to 16 semesters of the tuition grant, no more than eight of which may be provided for any one child. Any semester in which a benefit is paid will count as one semester of utilization.

The grant amount is up to 75% of the weighted average of Duke's tuition after a deductible and other tuition scholarships your child may be eligible to receive. Only core tuition expenses are eligible for reimbursement. This program does not cover expenses associated with tuition surcharges. If the scholarship is not designated towards tuition and not greater than room, board and fees, then the scholarship has no impact on the Children's Tuition Grant payment.

In cases where a student needs less than a full-time course load to graduate, a benefit will be paid. However, the following conditions will apply: the full deductible will be deducted from the tuition expense (no pro-rating), payment will count toward a full semester's benefit, and no additional benefits will be paid for this student.

The Deductible

The deductible amount, which is subject to change every year, is deducted from your child's tuition expense to determine the amount of the grant your child may be eligible to receive. If your child receives a scholarship designated for tuition, it will be applied towards meeting the deductible. If your child receives an "undesignated scholarship," any excess over room, board, and fees will be deducted from the tuition grant payment and the deductible still applies.

Two full sessions (two classes each) of summer school are counted as one semester and have one deductible applied. Each summer session requires enrollment in a minimum of 6 credit hours to be considered full-time. Also, several universities are on a quarterly or trimester calendar rather than a semester.

Academic terms consist of one of the following:

- Two (2) semesters;
- Three (3) trimesters; or
- Four (4) quarters.

The annual deductible is adjusted on a pro-rata basis according to the academic term for the school.

When a child attends different schools and one school operates on a semester calendar and the other school operates on a quarter calendar, one semester will equal one- and one-half quarters.

You are responsible for the excess tuition expenses and other costs.

How the Grant is Paid

The grant is paid, in US dollars, directly to the qualifying institution when Duke receives enrollment confirmation from that institution. Duke is refunded any credit balance (up to the amount of the tuition grant) that may occur after this grant and all other scholarships, grants, or other forms of assistance (excluding loans and payments by the student or their parents) are applied.

Other Information About the Children's Tuition Grant Program

Medical Coverage for Children Who Attend School Out-of-State

- **IMPORTANT:** If your child is attending a college or university outside the state of North Carolina and the employee (parent) has a permanent home ZIP code in North Carolina, the **Duke USA and Duke Options PPO** are the only health plans through Duke that will cover dependents outside of North Carolina for non-emergency care.
- If you are covering a child under **Duke Select** or **Duke Basic**, and that child attends school outside of the Triangle area or outside of NC, please consider changing your medical plan to one that offers coverage where your child is attending school.
- Similarly, the **Blue Care HMO** only has access to providers within North Carolina. You have 30 days from the beginning of the semester to change plans or to disenroll members who have moved out of network, if your current medical plan does not have a network of providers where your child is attending school.
- If you do not want to enroll in one of Duke's national network PPO plans, please consider enrolling your child in student health insurance that will cover them while they are living away at school to cover non-emergency care.

If You Retire

To be eligible to participate in the Children's Tuition Grant Program after you retire from Duke, you must meet the following criteria:

- You must have been eligible for the benefit prior to retirement (you must have completed five years of full-time service at Duke, been full-time at the time of retirement, and either were paid 80% or more from funds of a division designated as tuition grant eligible or have been preauthorized as tuition grant eligible);

- You must be at least age 65 at retirement, or the sum of your age plus your years of service with Duke must be equal to or greater than 75 based only on your most recent continuous service date;
- Your separation of service from Duke must not have been due to disciplinary reasons;
- You must, when practicable, provide formal notice at the time of your termination to Duke that you have a child who is eligible to use the benefit, providing your child's name and date of birth; and
- You must not be eligible for a similar tuition grant program from a subsequent employer.

If at retirement you meet the Rule of 75 and/or are at least age 65, and providing you have met the other Children's Tuition Grant Program eligibility criteria (for example, are in a paid, full time status at the time of retirement with five years of consecutive service), you will retain eligibility to participate in the program should you subsequently return to employment with Duke, irrespective of whether that is on a full time or part time basis.

- Please note this is not applicable if at the time of your retirement you did not meet the Rule of 75 and/or were not at least age 65.
- If you meet the Rule of 75 and reduce your work schedule to less than 30 hours per week, you will lose your eligibility for the program, unless you are a working retiree who had previously met the Rule of 75 and/or are age 65 at the time of retirement and had also met the program's other requirements as described in the above paragraph.
- If you are a full-time faculty or staff member and have met the Rule of 75, you may begin a personal leave of absence, in lieu of retirement, and retain eligibility for the program, providing the leave does not extend beyond 12 months; and
- If you are a faculty or staff member who does not meet the Rule of 75 prior to beginning a personal leave of absence, you will not retain eligibility for the program unless you return to Duke in a full-time, benefits-eligible position prior to retirement and continue active employment until meeting the Rule of 75.

If Your Child Withdraws From School

If your child withdraws from school or becomes less than a full-time student and a benefit has been paid to the school for that semester, a full semester's benefit will be counted towards your 16 semesters of eligibility (no more than 8 semesters per child), if Duke does not receive a full refund from you or the school for that semester.

In the Event of Your Death

In the event of your death after retirement, your child will remain eligible for the tuition grant — per program guidelines — if you met eligibility at the time you retired.

In the event of your death while actively employed at Duke, your child will remain eligible for the tuition grant, assuming you were eligible for the grant at the time of your death.

In the event of your death while actively employed at Duke, your stepchildren retain eligibility (if you were eligible at the time of your death) until your spouse remarries.

If Both Parents Are Eligible for the Grant

If both parents are eligible for the grant, the number of eligible semesters increases from 16 to 32. The maximum grant amount remains the same, as does the eight semesters limit per child.

Overpayment

In the event of overpayment, the amount of the overpayment will be requested from the school. If the overpayment is not returned, the amount of the overpayment will be deducted from the next scheduled tuition grant payment. If there are no future tuition grant payments scheduled, you agree to return the amount of the overpayment to the plan administrator or have the amount deducted from your paycheck.

Appeals Procedure

If your Children's Tuition Grant Program application is denied, you are able to submit an appeal to the Plan Manager.

Mail appeals to:

Duke Children's Tuition Grant Program
Attention: Plan Manager
705 Broad St.
Box 90502
Durham, NC 27708

How To Apply for the Children's Tuition Grant Program

1. Determine whether you are an eligible employee.
2. Determine whether your child(ren) are eligible.
3. Once your child has been accepted and enrolled into a school, you can begin the application for the grant. Applications for the Fall term will be processed beginning July 1; applications for the Spring term will be processed beginning November 1.
4. All eligible active employees will begin the online application process for the grant by logging into Duke@Work and selecting the Children's Tuition Grant link under the MyBenefits tab. You will need to complete this step for each term / semester that you are requesting the benefit. Having the Children's Tuition Grant link is not a guarantee of eligibility.

Recertification of your continued eligibility, your child's enrollment, and the school's tuition costs is required each semester.

Complete the online grant application after July 1 for the Fall term and after November 1 for the Spring term.

Allow several weeks for this process, in order to minimize delays in your child's ability to register, avoid late fees, and avoid other restrictions your child's school may place for a late payment of the tuition bill.

The Duke Children's Tuition Grant Program is administered by the University, which shall have final authority to construe the provisions of the program, to determine all questions of eligibility for benefits, and to establish any administrative rules for operation of the program. The University may amend or terminate the program at any time, with respect to benefits not yet paid, for any reason that it deems appropriate in its discretion.

DUKE SEVERANCE PAY PROGRAM

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DUKE SEVERANCE PROGRAM

Introduction

Duke offers a Severance Pay Program to provide financial assistance in the form of severance pay and benefits to eligible employees who are terminated because of Duke's operational needs. This is an unfunded welfare plan providing severance pay and benefits.

The term "Duke" is used throughout this booklet. "Duke" refers to the University, Duke University Health System, Inc. and any other corporation or entity that adopts the Plan with the duly authorized approval of the Board of Trustees. When used in this Plan document, "Employer" shall refer to all of the foregoing collectively except where the context requires that such term refer to the corporation or entity that actually employs an individual.

The benefit program provided is based on an employee's company code and job code as reflected in the HR benefits administration system (SAP). Duke employees holding more than one position classification receive the benefits associated with their primary position classification as reflected in SAP. For example, a housestaff member who also works within DHIP, receives benefits associated with their housestaff position classification.

The Private Diagnostic Clinic (PDC) continuous service date (CSD) recognition related to the PDC integration into Duke University Health System on or about July 1, 2023, for some benefit plans is NOT applicable for the Severance Pay Program.

Eligibility and Enrollment

Eligibility for Coverage

This plan applies to any eligible employee whose “notification date,” or date on which you receive formal notification of your termination of employment, occurs on or after August 1, 1994. You are eligible to participate in the plan if, as of your notification date, you:

- Meet the established Duke payroll / benefit classifications to be eligible for the plan;
- Are a regular part-time or full-time employee paid biweekly and scheduled to work at least 20 hours per week;
- Are a regular part-time or full-time employee paid monthly and scheduled to work at least 20 hours per week;
- Are not a faculty member;
- Are not paid solely through monies funding a research contract or grant program;
- Are not a probationary, temporary, casual labor or student employee; a visiting student; or post-doctoral associate or scholar; and
- Are employed by Duke University or Duke University Health System, Inc.

You must also meet certain conditions as of both your “notification date” and your “termination date.” If you do not meet all of these conditions (described under “Notification Date,”) you will not receive any benefits under the plan.

Notification Date

Your notification date is the date Duke first gives you, either orally or in writing, formal notification of your termination of employment. Any date on which an informal or preliminary discussion is held with you concerning your employment will not be treated as your notification date. You must also meet the following conditions as of your notification date in order to receive any severance pay benefits under the plan:

- You must have been selected for termination by your department head in their sole discretion based on Duke’s operational needs and resources, or as part of an immediate reduction in Duke’s work force which occurs without prior notice;
- You must not have notified Duke, either orally or in writing, prior to your notification date of your decision to terminate your employment (whether due to your retirement or otherwise);
- Duke must not have made a decision prior to your notification date to terminate your employment “for cause” (e.g., due to your misconduct or poor performance);
- You are not in a position where seasonal fluctuations are part of your employment;
- Duke must not have made a decision prior to your notification date to terminate your employment as a result of a temporary layoff that is expected to be of a duration of 30 calendar days or less; and
- You must not be entitled to receive benefits from any other Duke voluntary or involuntary severance, separation, or outplacement program.

Termination Date

Your termination date is the earlier of the:

- 60th calendar day following your notification date; or
- Date following your notification date that you actually cease employment with Duke — for any reason other than death — if you elect to terminate your employment during the 60-day period immediately following your notification date.

You must meet the following conditions as of your termination date in order to receive any severance pay benefits under the plan:

- You must not have accepted another job with Duke, either through a job transfer or otherwise, and must not have refused a “comparable position”^{*} offered by Duke during or subsequent to the 60-day notice period;
- You must not be entitled to receive benefits from any other Duke voluntary or involuntary severance, separation, or outplacement program;
- You must not be considered disabled under the Duke Disability Program;
- You must not have died on or before your termination date; and
- You must not have been offered employment by a “successor employer” in the same or a similar position to the position you held with Duke as of your termination date. A successor employer is any employer to whom Duke has sold or transferred all or any portion of any department, graduate or undergraduate school, college or program of continuing education, or support organization or any other organization or entity affiliated with Duke.

***A “comparable position” is one with a base rate of pay that is not less than 10% of the base rate of pay of the position you held on your notification date.**

Assignment or Alienation of Coverage

Any severance pay benefits you may become eligible to receive may not be assigned or alienated. This means that severance benefits may not be paid to a third party. Any attempt to do so will be void and of no effect and, at Duke’s discretion, may result in the termination of your benefits.

How the Severance Pay Program Works

Severance Pay

If eligible, your severance pay will be equal to one week of your regular base pay or salary, multiplied by your completed, whole years of continuous service as of your termination date. No more than 26 years of service will be considered in calculating the amount of your severance pay. You will receive a minimum severance benefit equal to at least two weeks of your regular base pay or salary.

PLEASE NOTE: The PDC continuous service date for employees that transitioned from the PDC on July 1, 2023 is excluded for purposes of determining the amount of the benefit for this program. Only Duke University, Duke University Health System, and DHIP service is counted for determining service under this program. Please see the “Important Summary for Employees Transitioning to the Duke Health Integrated Practice (DHIP) on July 1, 2023” in the “General Information About Your Benefits” section of this summary plan description for additional details.

The weekly base rate of pay or salary used in calculating your severance will be the one in effect on your termination date. It will not include any overtime, bonus, premium, shift differential, or other similar pay. The actual calculation of the rate of pay will depend on whether you were paid on a biweekly or monthly basis as of your notification date. If you were paid on a biweekly basis, the weekly rate of your base pay will be calculated by multiplying your regular hourly rate of base pay times the total number of hours you were regularly scheduled to work during a normal work week as of your notification date. If you were paid on a monthly basis, the weekly rate of your base salary will be calculated by multiplying your regular monthly base salary as of your notification date by 12 and dividing that number by 52.

You will be credited with one year of service for each complete 12-month period of continuous employment at Duke beginning with the later of your initial date of employment, date of reemployment, or date of initial eligibility to participate in the plan and at the anniversary of that date. In calculating your years of service, you will not receive credit for any accrued sick leave, unused accrued vacation time, accrued carry-over bank time, unused accrued short term bank time, unused accrued long term bank time, or period of employment of fewer than 12 consecutive months.

How Benefits Are Paid

Your eligible accrued benefit time is paid first. Eligible severance pay is paid next. Your severance pay will be paid according to your regular biweekly or monthly payroll schedule.

The amount of each biweekly or monthly payment of your severance pay will be approximately equal to the amount of your gross biweekly or monthly paycheck prior to your notification date. No interest or earnings will be paid on or credited to your severance pay for the period between your termination date and the date your severance pay is actually paid to you.

Taxes and Withholding of Plan Benefits

Severance pay is subject to federal and state income and employment taxes. Duke will withhold the appropriate amount of such taxes from each payment of your severance pay under the plan. If you owe any debt or obligation to Duke as of your termination date, this amount will be deducted from your severance pay. This includes, but is not limited to, outstanding loans and travel advances. Deductions will be made proportionately from each payment of your severance pay.

If You Are Reemployed by Duke

If you are reemployed by Duke after your termination date, you will be entitled to receive severance pay for the period of time immediately preceding your reemployment date. You will forfeit any severance pay that would have been payable to you after your reemployment date.

You also would owe Duke any portion of your severance pay over the amount you were entitled to receive. You could repay Duke via a personal check before you return to work or through deduction of your future paychecks. If you choose payroll deduction, the amount that is deducted from your paycheck must be at least \$100 if you are paid biweekly or \$200 if you are paid monthly. If you are reemployed by Duke after the period of time in which you would have been eligible for severance pay, you will not be required to repay Duke any portion of your severance pay. If you refuse a comparable position offered by Duke University during the time you are receiving severance pay, your severance pay will stop.

If You Die

No severance pay will be paid to your estate if you die after your notification date and on or before your termination date. If you should die after your termination date, but before your severance pay is paid in full, your estate will be paid only the severance pay that was payable to you under the plan through the date of your

death. This amount will be paid to your estate in a single lump sum as soon as practicable following the date of your death. Any severance pay that would have been payable to you after the date of your death will automatically be forfeited.

Other Severance Benefits

If you are covered under Duke's group health, dental, and/or vision insurance plans on your notification date, your coverage will continue at least through the last day of the coverage period for which you made a payroll deduction to the plans. You may also elect to continue your coverage under the Duke group health, dental, and/or vision insurance plans. This continuation coverage is known as COBRA coverage. If you make a timely election for COBRA coverage under a Duke group health plan, Duke will continue to pay its share of the premium cost, if any, for the group health coverage for you and your dependents for six months after the date you would have otherwise lost coverage. However, Duke will not contribute toward the premium cost of COBRA coverage for any of your dependents for any period during which COBRA coverage is not in effect for you. If you decline a comparable position, you will also lose the employer contribution to the health care plan for the remainder of the six month period. You will receive the appropriate COBRA notice and election forms for the group health, dental, and/or vision insurance plans shortly after your termination date. For additional information concerning your COBRA coverage rights, please refer to the "General Information" section of this booklet.

Duke will also continue your coverage under the Basic Life Insurance Plan for six months following the date your coverage would otherwise have ended, regardless of whether you elect COBRA coverage under the group health, dental, and/or vision insurance plan.

If you are covered under the Duke Faculty and Staff Retirement Plan, Duke will discontinue making contributions and you may not make any contributions to the Plan while receiving severance benefits.

If you were eligible for tuition grants for your children through the Duke Children's Tuition Grant Program as of your termination date due to a lay-off, your children will continue to be eligible for assistance for up to two semesters of study, provided that each semester begins within 12 months of your termination date. In addition, such tuition grants will be subject to (a) the overall and individual limits on the number of semesters for which tuition grants are available under the Children's Tuition Grant Program and (b) the other terms and conditions of the Children's Tuition Grant Program. Additionally, if you receive a lay-off notice you will retain the benefit for 12 months / 2 semesters following your termination date if you transfer to Duke University Health System or to Duke Temporary Services before your lay-off date. If your termination date occurs following the commencement of a semester for which you have received a tuition grant, that semester will not count against the remaining two semesters of tuition grants. Solely for purposes of this plan, a semester is deemed to commence on the following applicable dates:

- September 1 for the fall semester;
- January 1 for the spring semester; and
- May 1 for the summer session.

If you were eligible for the Employee Tuition Assistance Program, coursework started after your last day of work will not be reimbursed. However, coursework that began prior to your last day worked and that was approved prior to your last day worked will be reimbursable as long as all other eligibility criteria (employee and course) under the Employee Tuition Assistance Program are met, with the exception of that which is

associated with the layoff. Reimbursed coursework will not be subject to the two-year retention agreement in the case of termination due to a layoff.

PLEASE NOTE: Positions that are 100% grant-funded are not eligible for severance benefits and would, therefore, not be eligible for continuance of the Children's Tuition Grant nor the Employee Tuition Assistance Program benefit once layoff status is established.

How To File for Benefits

Filing a Claim

If you meet the eligibility requirements for severance pay, your claim for pay will automatically be filed with Duke.

Appealing a Denied Severance Pay Claim

In the event Duke should determine that you are not entitled to have any or a portion of severance pay and you disagree, you may file a claim for severance pay benefits. You will be notified within 90 days after Duke receives your claim, if your claim is denied. Send your claim to:

**Severance Plan Administrator
Duke Benefits
705 Broad St.
Box 90502
Durham, NC 27708**

If special circumstances require that Duke be given additional time to make a decision on your claim, Duke may have an additional 90 days by notifying you before the end of the first 90-day period. If your claim is denied in whole or in part, you will receive a statement which includes:

- The specific reasons for the denial;
- Specific reference to applicable sections of the plan on which the denial is based;
- A description of any additional material or information you will need to supply in order to perfect your claim and why such material or information is necessary; and
- An explanation of the plan's claims review procedure.

If Duke does not provide you with any notice or statement about your claim within 90 days of the time it is received, you may consider your claim denied.

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. 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. Send your appeal to:

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

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 or later than three years have passed after you file your claim.

Your Rights Under ERISA

For a summary of your rights under the Employee Retirement Income Security Act of 1974 (ERISA), please refer to the "General Information" section of this booklet.

This Benefit Program Description, which is a part of the Duke University Welfare and Fringe Benefits Plan along with the underlying insurance contracts, shall constitute the written plan document for the Duke Severance Pay Program. Duke reserves the right to change or terminate these benefits or your eligibility for benefits under the Duke Severance Pay Program. The written plan documents for the Duke Severance Pay Program are not employment contracts or any type of employment guarantee.

DUKE COMMUTER BENEFITS PROGRAM

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DUKE COMMUTER BENEFITS PROGRAM

Introduction

Currently only available to employees with a Washington, DC work address.

The voluntary Commuter Benefits Program sponsored by Duke University is provided through HealthEquity, in accordance with IRS Code 132(f). This program lets you pay for eligible commuting costs through automatic, before-tax payroll deductions; it is convenient and easy to use with online ordering and home delivery plus direct-payment — you do not have to wait for reimbursement.

In addition, you can save money on payroll taxes. Your fare and parking still cost the same, but because the money to pay for them comes out of your paycheck before taxes are deducted, your tax withholding is where you see your savings. You can save on federal income tax, FICA (Social Security) tax and state income tax (except in MS, NJ, and PA).

Exactly how much you save will vary depending on your commuting expenses, your tax situation and IRS limits. Generally, however, for every \$100 of eligible commuting expenses, you can save from \$30 to \$40 each month.

You pay no fees and you can start, change or stop your participation at any time. However, you must enroll by the 1st of the month to take advantage of the Program for the following month. This monthly cutoff date is the same deadline for making changes and cancellations.

The term “Duke” is used throughout this booklet. “Duke” refers to the University, Duke University Health System, Inc. and any other corporation or entity that adopts the Plan with the duly authorized approval of the Board of Trustees. When used in this Plan document, “Employer” shall refer to all of the foregoing collectively except where the context requires that such term refer to the corporation or entity that actually employs an individual.

The benefit program provided is based on an employee’s company code and job code as reflected in the HR benefits administration system (SAP). Duke employees holding more than one position classification receive the benefits associated with their primary position classification as reflected in SAP. For example, a housestaff member who also works within DHIP, receives benefits associated with their housestaff position classification.

Eligibility and Enrollment

Eligibility

You are eligible to participate in the commuter benefit program if you:

- Have a Washington, DC work address;
- Are a regular employee scheduled to work at least 20 hours per week;
- Are a faculty employee holding a regular rank appointment who is receiving wages for Social Security purposes; or
- Are a faculty employee holding other than a regular rank appointment and classified as a full-time or part-time member of the faculty, who is receiving wages for Social Security purposes.

If you are on any type of extended leave, you are not eligible to participate; however, your eligibility for the program will be reinstated upon return to active status.

When Participation Begins

You are eligible effective the first of the month following your date of hire / eligibility with Duke. Otherwise, you are eligible to enroll at any time.

Enrolling for the Benefit

There is no annual enrollment period, so you can sign up or make changes whenever you choose — online or by phone. Any change will be implemented as soon as administratively possible.

You can enroll online with the Duke HR Benefits single sign-on link. The first time you visit the single sign-on link, you will be asked for your ID Code in the self-identification process.

hr.duke.edu/benefits/reimbursement/account.

Please use the last four digits of your Duke Unique ID Number. Once you've completed your HealthEquity profile, follow these steps to complete your enrollment:

1. From the Welcome page, click on the Commuter icon.
2. Click on the "Place Commuter Order" link.
3. Step through the process to place your order.
4. An order confirmation email will be sent after the order is placed.

Any order placed by the 1st of the month will become effective the following month. Enter your email address to receive confirmations electronically. Note that it is up to you to make changes through HealthEquity — your transit or parking provider cannot notify Duke if you stop parking or riding. If you do not have easy internet access or just want to talk to someone, you can sign up or make changes over the phone by calling HealthEquity at **877-924-3967**, Monday through Friday, from 8:00 a.m. to 8:00 p.m. ET.

Making Changes

You can start, change or stop your participation at any time. You do not need to enroll each month; you may elect to have deductions made on a continuing basis. However, if you choose to make a change or cancel deductions, the deadline for changes or cancellations is always the 1st of the month for the following benefit month, the same as the monthly cutoff date for placing an order.

Choose Modify or Cancel Commuter Order from the menu:

- Click Cancel to cancel your order or change to a different type of pass or parking provider and start over with a new order.
- To change the dollar amount, frequency or mailing address, follow the instructions and place your order.

Besides making changes, you can also log in to wageworks.com to review your order history, update your contact information, change your user name and password and even set up direct deposit of reimbursements into your bank account.

When Participation Ends

You may cancel participation in the Duke Commuter Benefit program at any time. To continue your participation in the accounts, you must enroll or make changes by the 1st of the month for the upcoming benefit month.

- Your participation also will end on the date any of the following events occurs:
- You are no longer an active employee on the payroll;
- The plan terminates;
- You are no longer regularly scheduled to work at least 20 hours per week;
- You become eligible for Long Term Disability or Workers' Compensation Insurance; or
- You are no longer a member of the class of employees eligible to participate

How the Commuter Benefits Program Plan Works

2024 Contribution Limits

The IRS establishes maximum monthly limits for qualified transportation expenses (which are subject to change). If your expenses exceed these limits, you can elect to have your total monthly commuting costs withheld from your pay, using before-tax contributions up to the IRS maximum and then deducting the balance on an after-tax basis. That way, you can still enjoy the convenience of home delivery and automatic payments.

For 2024, the IRS allows up to \$315 per month for transit / vanpool expenses and up to \$315 per month for parking expenses. These limits apply monthly; remaining Commuter Card balances can roll over from month to month (see "Transit / Vanpool and Parking Options" in this section for information on the HealthEquity Commuter Card. Any unused funds on the card will remain available for future use and roll over from month to month up to the \$1,500 maximum balance on the Commuter Card.)

The total cost of your election will be deducted from your pay each month.

Eligible Expenses

It is important to make sure you spend your Commuter Benefits Program dollars only on expenses deemed eligible by the IRS. The following list identifies common eligible expenses you incur to commute to and from work:

- Bus, train, streetcar, trolley, subway, or ferry
- Vanpool
- Parking at or near work
- Parking at or near public transportation for your commute.

Ineligible Expenses

Expenses that are reimbursed not related to commuting are not eligible for this program. In addition, some expenses that are not eligible include:

- Parking costs that are not work-related.
- Gas, mileage and tolls.
- Taxis and limousines.
- Parking at an airport for air travel.

Transit / Vanpool and Parking Options

You can pay for your commuting expenses in different ways:

Transit Options:

- **Buy My Pass** — Order your transit passes or ticket books through HealthEquity and have them mailed to your home every month, in time for the month they are valid. HealthEquity will mail your pass in a plain business envelope, so be careful not to mistake it for junk mail. The exact date of delivery may vary depending on your transit agency and the U.S. Mail.
- **HealthEquity Commuter Card (Transit)** — The HealthEquity Commuter Card is a reusable stored-value card. The Transit Card is used to buy your transit pass or ticket book at ticket windows or vending machines that accept credit / debit cards. Funds automatically become available the 20th day of the month before each benefit month. Any unused funds automatically roll over and remain on the card for future expenses.
- **Load My Smart Card** — Load money onto transit agency smart cards (where available) directly from your account.

Parking Options:

- **Pay My Parking** — If you have a monthly parking arrangement, HealthEquity can automatically pay your parking facility. You just need to register with HealthEquity to tell them where and how much you pay to park.
- **HealthEquity Commuter Card (Parking)** — The Parking Card is used to pay for parking at or near your workplace, public transportation or park-and-ride facilities that accept credit / debit cards. Funds will automatically become available the first day of the benefit month. Any unused funds automatically roll over and remain on the card for future expenses.

- **Parking Pay Me Back** — If your parking expenses vary each month or you use metered parking, you can submit claims for reimbursement by check or direct deposit. You must submit claims within 180 days after you pay your expenses. If you miss the deadline, your unused funds will be turned into a credit on your account and can be applied towards a future order. If a request is for less than \$5, payment will not be made until the total reimbursement requested is \$5 or more.

GENERAL INFORMATION ABOUT YOUR BENEFITS

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Plan Details

Plan Sponsor

Duke University is the Plan Sponsor of Duke's benefit plans. These plans have been extended to, or adopted by, certain Duke affiliates. A complete list of the Duke affiliates participating in Duke's benefit plans is available upon written request to the Plan Administrator. The address and telephone number of the Plan Sponsor is:

Duke University
705 Broad St.
Box 90502
Durham, NC 27708-0502
919-684-5600

The Employer Identification Number (EIN) for Duke University is 56-0532129.

Benefit Plans

Duke sponsors the following benefit plans:

The Duke University Welfare and Fringe Benefits Plan, under which the following welfare and fringe benefits programs are offered:

- Health Care Programs,
- Dental Program,
- Vision Program,
- Premium Conversion Program,
- Reimbursement Account Programs,
- Life Insurance Programs,
- Disability Programs,
- Long Term Care Insurance Program,
- Severance Pay Program,
- Employee Tuition Assistance Program, and
- Children's Tuition Grant Program.

Please refer to the Benefit Program Descriptions included in this booklet for more details regarding Duke's welfare and fringe benefits programs listed above.

The Duke University Faculty and Staff Retirement Plan, through which retirement benefits are funded by employee voluntary contributions and/or employer contributions through individually owned and annuity contracts or custodial accounts, as described in Section 403(b) of the Internal Revenue Code.

Please refer to the Summary Plan Description, which is separate from this document, for more details about this Plan. The Summary Plan Description for the Duke University Faculty and Staff Retirement Plan can be obtained at hr.duke.edu/benefits/summaries/retirement-sar.

The Employees' Retirement Plan of Duke University (ERP), through which retirement benefits are funded by Duke, for biweekly paid employees, through a defined benefit pension plan that is intended to qualify under Section 401(a) of the Internal Revenue Code.

Please refer to the Summary Plan Description for the ERP for more details. The Summary Plan Description can be obtained at hr.duke.edu/spd.

The Duke University Commissioned Police Officer Supplemental Plan, through which retirement benefits are funded by Duke for Duke University Commissioned Police Officers ("Police Officers") who are eligible for the special provision applicable to Police Officers under the Employees' Retirement Plan of Duke University, through vested custodial accounts as described in Section 403(b) of the Internal Revenue Code.

Please refer to the Summary Plan Description for the above plan for more details. The Summary Plan Description can be obtained by calling **919-684-5600**.

Eligibility and Enrollment

The eligibility and enrollment requirements for each benefit program offered under the Duke University Welfare and Fringe Benefits Plan, the Duke University Faculty and Staff Retirement Plan, the Duke University Commissioned Police Officers Supplemental Retirement Plan and the Employees' Retirement Plan of Duke University are set forth in the applicable Benefit Program Descriptions / Summary Plan Descriptions. Please refer to these documents as the eligibility, enrollment, and participation requirements vary among the benefit plans and programs.

Plan Names, Numbers, Type, and Funding

The following charts show the legal plan names (including a description of underlying benefit programs), plan numbers, type of plan, and plan funding. Benefit programs covered by the Employee Retirement Income Security Act of 1974 (ERISA) are also noted. If you wish to request additional information about Duke's ERISA benefit plans from the Department of Labor, you should refer to the Plan Name and Plan Number (Duke University Welfare and Fringe Benefits: Plan Number 524.)

Duke University Welfare and Fringe Benefits: Plan Number 524

Duke Health Care Programs

Name of Benefit Program	Program Type	Program Funding	ERISA Coverage
Duke Select HMO Medical Program	Welfare Benefit	Unfunded / general assets; employer and employee paid	Yes
Duke Basic HMO Medical Program	Welfare Benefit	Unfunded / general assets; employer and employee paid	Yes
Blue Care HMO Medical Program	Welfare Benefit	Unfunded / general assets; employer and employee paid	Yes
Duke Options PPO Medical Program	Welfare Benefit	Unfunded / general assets; employer and employee paid	Yes
Duke USA PPO Medical Program	Welfare Benefit	Unfunded / general assets; employer and employee paid	Yes
Express Scripts Pharmaceutical Program	Welfare Benefit	Unfunded / general assets; employer and employee paid	Yes
Cigna Medical Benefits Abroad (MBA)	Welfare Benefit	Insured; employer paid	Yes
Duke Dental Program	Welfare Benefit	Insured; employer paid	Yes
Duke Vision Program	Welfare Benefit	Insured; employer paid	Yes

Cafeteria and Premium Conversion Programs

Name of Benefit Program	Program Type	Program Funding	ERISA Coverage
Cafeteria and Premium Conversion Program	Fringe Benefits IRC § 129	Unfunded / general assets; employee paid with pre-tax contributions	Yes
Health Care Reimbursement Account Program	Welfare Benefit	Unfunded / general assets; employer and employee paid with pre-tax contributions	Yes
Dependent Care Reimbursement Account Program	Fringe Benefits IRC § 129	Unfunded / general assets; employee paid with pre-tax contributions	No

Life Insurance Programs

Name of Benefit Program	Program Type	Program Funding	ERISA Coverage
Basic Life Insurance Program	Welfare Benefit	Insured; employer paid	Yes
Survivor Benefit Program	Welfare Benefit	Unfunded / general assets; employer paid	Yes
Business Travel and Accident Insurance Program	Welfare Benefit	Insured; employer paid	Yes
Insurance Certificate Program	Welfare Benefit	Unfunded / general assets; employer paid	Yes
Supplemental Life Insurance Program	Welfare Benefit	Insured; employee paid	Yes
Personal Accident Insurance Program	Welfare Benefit	Insured; employee paid	Yes
Post-Retirement Group Term Life Insurance Program	Welfare Benefit	Insured; employee paid with pre-tax contributions	Yes
Housestaff Life Insurance Plan	Welfare Benefit	Insured; employer paid	Yes

Disability Programs

Name of Benefit Program	Program Type	Program Funding	ERISA Coverage
Duke Disability Program	Welfare Benefit	Unfunded / general assets; employer paid	Yes
Long Term Disability Income Enhancer Program	Welfare Benefit	Insured; employee paid	Yes
Voluntary Short Term Disability Program	Welfare Benefit	Insured; employee paid	Yes
Voluntary Long Term Disability Program	Welfare Benefit	Insured; employee paid	Yes
Long Term Disability Program for Housestaff Members of Duke University Medical Center	Welfare Benefit	Insured; employer paid	Yes

Long Term Care

Name of Benefit Program	Program Type	Program Funding	ERISA Coverage
Long Term Care Insurance Program	Welfare Benefit	Insured; employee paid	Yes

Severance Pay Program

Name of Benefit Program	Program Type	Program Funding	ERISA Coverage
Severance Pay Program	Welfare Benefit	Unfunded / general assets; employer paid	Yes

Educational Programs

Name of Benefit Program	Program Type	Program Funding	ERISA Coverage
Employee Tuition Assistance Program	Fringe Benefits IRC § 117(d) and 127	Unfunded / general assets; employer paid	No
Children's Tuition Grant Program	Fringe Benefits IRC § 117(d)	Unfunded / general assets; employer paid	No

Pension and Retirement Plans

Name of Benefit Program	Program Type	Program Funding	ERISA Coverage
Duke University Faculty and Staff Retirement Plan	403(b) defined contribution plan	Funded; employer and employee paid with voluntary contributions	Yes, Plan No. 001
Employees' Retirement Plan of Duke University	401(a) defined benefit plan	Funded; employer paid	Yes, Plan No. 002
Duke University Commissioned Police Officers Supplemental Retirement Plan	403(b) defined contribution plan	Funded; employer paid	Yes, Plan No. 004

Plan Year

The Plan Year for the Employees' Retirement Plan of Duke University is July 1 to June 30. The plan year for all other benefit plans offered by Duke is January 1 to December 31.

Plan Funding

Benefit plans are funded by contributions from Duke and, in certain cases, by contributions from employees (as shown in the preceding charts).

Employee contributions for the Welfare and Fringe Benefits Plans are unfunded and are considered part of the general assets of Duke University. Premiums are transferred to the insurance carriers and benefits may be paid from the general assets of Duke as applicable. In the case of the Employees' Retirement Plan of Duke University, Duke pays the full cost of all pension benefits by making contributions as actuarially determined to a trust. In the case of the Faculty and Staff Retirement Plan, employee contributions are transferred to the applicable plan record keeper.

Plan Administrator for the Welfare and Fringe Benefits Plans

The Associate Vice President for Total Rewards is the Plan Administrator for the Welfare and Fringe Benefits Plans.

The Plan Administrator has the exclusive responsibility and complete discretionary authority to control the operation and administration of Duke's benefit plans, with all powers necessary to enable it to carry out such responsibility properly.

These powers include but are not limited to, the discretionary power and authority to construe the terms of Duke's benefit plans, to determine all questions relating to eligibility to participate in a benefit plan or program, to determine status and eligibility for benefits and to resolve all interpretive, equitable, and other questions that arise in the operation and administration of Duke's benefit plans. Any determinations made by the Plan Administrator, or its designee, shall be final and binding.

The Plan Administrator, acting through Benefits, is responsible for the day-to-day operations of the benefit plans. The Plan Administrator, acting through its Staff Fringe Benefits Committee, or the appeal process delegated to the applicable claim's administrator as described in the Summary Plan Descriptions (e.g. Blue Cross/Blue Shield of NC or Lincoln Financial Group) has the final authority for determining claims for benefits and is responsible for reviewing appeals. The Plan Administrator, however, has the power to delegate day-to-day administration of Duke's benefit plans to Benefits Processors and may also delegate claims review as well as appeals responsibility to an insurer or a third-party administrator. The address and telephone number of the Plan Administrator is:

**Duke University
705 Broad St.
Box 90502
Durham, NC 27708-0502
919-684-5600**

Plan Administrator for the Duke Retirement Plans

The Plan Administrator for the Duke University Faculty and Staff Retirement Plan, Employees' Retirement Plan of Duke University and the Duke University Commissioned Police Officers Supplemental Retirement Plan is set forth in the applicable Summary Plan Description (SPD).

Please refer to these documents as the Plan Administrator varies among the retirement benefit plans. The SPD can be found at hr.duke.edu/spd.

Benefit Processing

Certain administrative services with regard to the processing of applications for benefits and the payment of benefits are provided under a contract. Please contact the appropriate Benefits Processor about benefit application issues:

Benefits Processors Contact Information

Health Insurance Plans

- **Duke Select HMO Medical Program**
- **Duke Basic HMO Medical Program**

Aetna
P.O. Box 981106
El Paso, TX 79998
800-385-3636
aetna.com

- **Blue Care HMO Medical Program**
- **Duke Options PPO Medical Program**
- **Duke USA PPO Medical Program**

Blue Cross Blue Shield of North Carolina
Claims Department
P.O. Box 35
Durham, NC 27702-0035
877-224-3305
bcbsnc.com/members

Duke Plus Retiree Medical Program

UMR Inc.
PO Box 8052
Wausau, WI 54402
866-318-3853
umr.com

Prescription Drug Benefits

Express Scripts Rx Services
P.O. Box 650322
Dallas, TX 75265-9946
800-717-6575
express-scripts.com

COBRA

HealthEquity
Claims Administrator
P.O. Box 223684
Dallas, TX 75222-3684
800-526-2720
wageworks.com

Dental Program

Ameritas
Group Dental Claims
P.O. Box 82520
Lincoln, NE 68501-2520
800-487-5553
explore.ameritas.com/duke/

Vision Program

UnitedHealthcare Vision
P.O. Box 30978
Salt Lake City, Utah 84130
800-638-3120
myuhcvision.com

Cafeteria and Premium Conversion Program

Duke University
705 Broad St.
Box 90502
Durham, NC 27708-0502
919-684-5600

Reimbursement Account Programs

HealthEquity
Claims Administrator
P.O. Box 14053
Lexington, KY, 40512
877-924-3967
wageworks.com

Medical Benefits Abroad Program

Cigna Health & Life Insurance Company
P.O. Box 1511
Wilmington, DE 19850
Outside USA: 800-243-1348
Inside USA: 302-797-3535
cignaglobal.com

Life Insurance

Basic Life Insurance Program

Lincoln Financial Group
Group Life Claims
P.O. Box 7212
London, KY 40742-7212
888-787-2129

Supplemental Life Insurance Program

Mercer Voluntary Benefits

P.O. Box 9122

Des Moines, IA 50306-9905

800-552-9670

Customer Service: 800-552-9670 (8:00 a.m. to 6:00 p.m. EST / EDT, Mon. – Fri.)

Universal Life Insurance Programs

Holroyd Agency

2508 Hinton St.

Raleigh, NC 27612

919-819-0456

North Carolina Mutual Life Insurance Company

411 West Chapel Hill Street

Durham, NC 27701

800-793-0223

ncmutuallife.com

Post-Retirement Group Term Life Insurance Program

Holroyd Agency

2508 Hinton St.

Raleigh, NC 27612

919-819-0456

Long Term Care Program

The Prudential Insurance Company of America

751 Broad St.

Newark, NJ 07102-3777

800-732-0416

prudential.com

Survivor Benefit Program

HRIC

Duke University

705 Broad St.

Box 90502

Durham, NC 27708-0502

919-684-5600

hr.duke.edu/policies/benefits/survivors-benefits

Insurance Certificate Program

HRIC

Duke University

705 Broad St.

Box 90502

Durham, NC 27708-0502

919-684-5600

Housestaff Life Insurance Program

Principal Financial Group
Des Moines, IA 50392-0002
800-986-3343
principal.com

Personal Accident and Travel Insurance

Business Travel and Accident Insurance Program

Chubb Accident & Health / International SOS (formerly ACE USA Accident & Health)
1 Beaver Valley Road
P.O. Box 15417
Wilmington, DE 19850
800-336-0627
chubb.com/us-en/business-insurance/accident-health

Personal Accident Insurance Program

Mutual of Omaha
Special Risks Claims
P.O. Box 31156
Omaha, NE 68131-0156
844-579-5586
mutualofomaha.com

Disability Insurance

Duke Disability Program

The Lincoln Financial Group
100 Liberty Way, Suite 100
Dover, NH 03820-4695
800-291-0112

Voluntary Short Term and Long Term Disability

For Claims:

Hartford Life and Accident
One Hartford Plaza
Hartford, CT 06115
888-277-4767
thehartford.com

For Enrollment and Billing:

MGIS Companies
111 S. Main St., Ste 400
Salt Lake City, UT 84111-2176
800-969-6447

Housestaff Disability Program

The Guardian Life Insurance Company of America
100 Hudson Yards
New York, NY 10001
212-598-8000
guardianlife.com

Long Term Disability Income Enhancer

Massachusetts Mutual Life Insurance Company Plan Administrator
Duke Benefits
705 Broad St.
Box 90502
Durham, NC 27708

Retirement Plans**Employees' Retirement Plan of Duke University**

Associate Director, Benefits
Duke University
705 Broad St.
Box 90502
Durham, NC 27708-0502
919-684-5600
hr.duke.edu/benefits/retirement/about-dukes-plans

403(b) and 457(b) Investment Plans

Fidelity
7011 Fayetteville Rd., Suite 110
Durham, NC 27713

fidelity.com/duke

National Phone: 800-343-0860

Traditional Annuity Account

TIAA
5425 Page Rd., Suite 220
Durham, NC 27703
Local Phone: 919-687-5200 or 866-904-7804
National Phone: 800-842-2776
tiaa.org/duke

Frozen Accounts / Previous Recordkeepers

Corebridge Financial (AIG / VALIC)

3211 Shannon Road

Suite 600 (6th floor)

Durham, NC 27707

919-401-3252

Fax: 919-401-3224

Thomas.Overcash@aig.com

National Phone: 800-448-2542

aig.com/retirementservices

Tuition Assistance

Employee Tuition Assistance Program

Benefits Program Coordinator

Duke University

705 Broad St.

Box 90502

Durham, NC 27708-0502

919-684-5600

hr.duke.edu/benefits/educational

Children's Tuition Grant Program

Benefits Program Coordinator

Duke University

705 Broad St.

Box 90502

Durham, NC 27708-0502

919-684-5600

hr.duke.edu/benefits/educational

Severance Pay Program

HRIC

Duke University

705 Broad St.

Box 90502

Durham, NC 27708-0502

919-684-5600

hr.duke.edu/benefits/enrollment/life-events/leaving-duke/severance-overview

Claims Review and Appeals Procedures

If your application for benefits is denied by a Benefits Processor and you (or your beneficiary, if applicable) believe that you are being denied any rights or benefits under a benefit plan or benefit program, you may request a review or appeal a denial. To ensure that disputes are settled fairly, claims review and appeals procedures have been established for each benefit program offered under the Duke University Welfare and Fringe Benefits Plan, the Employees' Retirement Plan of Duke University, the Duke University Faculty and Staff Retirement Plan, and the Duke University Commissioned Police Officer Supplemental Retirement Plan. Please refer to the claims review and appeals procedures set forth in the Benefit Program Descriptions / Summary Plan Descriptions for each benefit program as the procedures vary among the benefit plans and programs.

Agent for Service of Legal Process for Welfare and Fringe Benefits Plans

Please direct any legal papers and summonses regarding Duke's Welfare and Fringe Benefits Plans to:

Duke University
Associate Vice President for Total Rewards
705 Broad St., Box 90502
Durham, NC 27708-0502
919-684-5600

Assignment of Benefits

The Duke Benefit Plans do not give you a right to any benefit or interest in the plans or programs except as specifically provided herein. In some cases, the plans or programs permit you to have benefit payments sent directly to your provider. However, you may not assign your rights, benefits, or any other interest in the plans or programs to a provider or any other individual or entity.

No Guarantee of Tax Consequences

Neither Duke nor the Plan Administrator makes any commitment or guarantee that any amounts paid to you or for your benefit under the benefit plans shall be excludable from your gross income for federal or state tax purposes, or that any other federal or state tax treatment shall apply or be available. It shall be your obligation to determine whether each payment under a benefit plan is excludable from your gross income for federal and state income tax purposes, and to notify Duke if you have reason to believe that any of the payment is not so excludable.

Plan Amendment or Termination

Duke intends to continue these plans and programs indefinitely. However, Duke reserves the right, in its sole discretion under circumstances that it deems advisable (including, but not limited to, a need to address legal changes, cost, or plan design considerations), to terminate or amend any benefit plan or underlying benefit program (including an amendment to reduce benefits or eliminate benefits or changes to the premium or contribution rates) for all participants or for a specific class of participants, including current or former employees, at any time and for any reason, without notice. Current participation in a benefit plan does not vest in any participant (including current and former employees) any rights to any particular benefit coverage in the future. In the event of termination or amendment or elimination of benefits, the rights and obligations of participants prior to the date of such event shall remain in effect, and changes shall be prospective, except to the extent that Duke or applicable law provides otherwise.

Controlling Effect of Plan Documents, Governance, and Interpretation

The Plan document for the Duke University Welfare and Fringe Benefits Plan consists of the Duke University Welfare and Fringe Benefits Plan document, the Benefit Program Descriptions contained in this booklet, any Member Guides to the extent provided to employees, and any insurance contracts through which benefits are provided. To the extent there is conflict between a Benefit Program Description and an insurance contract or member guide, the insurance contract or member guide in effect shall govern. If you would like to review the Plan document, need more information, or have any questions, please contact Duke Benefits at **919-684-5600**.

The Plan document for the Duke University Faculty and Staff Retirement Plan, the Employees' Retirement Plan of Duke University and the Duke University Commissioned Police Officers Supplemental Retirement Plan are separate legal documents and govern the Plans' operation and administration. To the extent there is conflict between the Summary Plan Description and the actual terms and conditions as described in the Plan document, the applicable Plan document will govern. If you would like to review the Plan document, need more information, or have any questions, please contact Duke Benefits at **919-684-5600**.

All legal questions pertaining to the plans and their benefit programs shall be determined in accordance with the provisions of the Internal Revenue Code, the laws of the State of North Carolina (to the extent not pre-empted), and to the extent required, the provisions of ERISA.

The provisions of the plans and programs shall in all cases be interpreted in a manner that is consistent with (i) the respective plans constituting a single "employee welfare benefit plan" or a "retirement plan" within the meaning of ERISA, and (ii) the exclusion from gross income of benefits provided hereunder in accordance with Internal Revenue Code Sections including 79, 105(b), 106, 117(d), 127, 125, 129, 403(b), and 132(f), as applicable.

Your Rights Under ERISA

Under certain benefit plans and programs, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). (See the "General Information About Your Benefits" chapter, section entitled "Plan Names, Numbers, Type, and Funding" for the plans and benefit programs covered by ERISA.) ERISA provides that all participants of plans subject to ERISA are entitled to the following:

Receive Information about Your Plan and Benefits

- You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the plans, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plans with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plans, including insurance contracts and collective bargaining agreements, and copies of the latest annual reports (Form 5500 Series) and updated Summary Plan Descriptions. The Plan Administrator may make a reasonable charge for the copies.
- You may receive a summary of a Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report if an annual financial report is required to be filed with the U.S. Department of Labor.

- You may obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work in order to have a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Health Care Program, Dental Program, Vision Program, and, under certain circumstances, the Health Care Reimbursement Account Program, as a result of a qualifying event. For additional information, please review the section entitled “Your Rights under COBRA” as well as the Benefit Program Descriptions on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties on the people who are responsible for the operation of the plans. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the internal plan appeals procedure. In addition, if you disagree with a Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court. If it should happen that plan fiduciaries misuse a Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory. You can also contact the Department of Labor’s Division of Technical Assistance and Inquiries by writing to:

**Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210**

You also may obtain certain publications about your rights under ERISA by calling the publications hotline of the Employee Benefits Security Administration at **866-444-3272**.

Your Rights Under USERRA (Medical, Dental, and Vision Coverage)

Duke's leave policies comply with the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA). USERRA is intended to allow eligible employees who are on uniformed service for more than 31 days to continue coverage for themselves and their covered dependents. You must apply for military leave of absence to be eligible to elect continued coverage under USERRA. Uniformed service refers to the performance of duty on a voluntary or involuntary basis, including:

- Active duty;
- Inactive duty for training;
- Full-time National Guard duty;
- Commissioned corps of the Public Health Service duty; and
- Any other category of person designated by the President of the United States in time of war or emergency.

You also are eligible to elect continued coverage under USERRA for a period during which you are absent from work for the purpose of an examination to determine your fitness to perform any such duty in the Armed Forces, the Army National Guard, and the Air National Guard.

Once you know that you will be in uniformed service for more than 31 days, you must apply for a military leave of absence. You will be provided with information on your right to elect continued coverage under USERRA at that time.

Continued coverage becomes effective on the date your military leave of absence begins. Under USERRA, you can be required to pay for the full cost of your coverage, plus a two percent administrative fee. However, you should contact the HRIC at **919-684-5600** at the time of your leave to see if Duke is offering a more favorable option.

Coverage Following Reemployment

If you have continued coverage under USERRA, you and your covered dependents are eligible to receive coverage under the Plan as if you were a regular employee, provided you return to work before your re-employment rights expire. Generally, upon release from active duty, you must return to work:

- At the beginning of the first full regularly scheduled work period of the first day following your release, or the beginning of the following day if time is needed for the safe return from the place of service if your period of active duty was less than 31 days;
- Within 14 days of your release, if your period of active duty was 32 days but less than 181 days; or
- Within 90 days of your release, if your period of active duty was 181 days or more.

Upon re-employment, you and your covered family members will not be required to complete any waiting period.

When USERRA Coverage Ends

Your continued coverage under USERRA ends on the earliest of the following dates:

- The last day of the 24-month period beginning on the effective date of your military leave of absence;
- The date you fail to make a required USERRA premium payment; or
- The date your re-employment rights expire.

You may also be eligible for continued coverage under COBRA. For more information, refer to the section "Your Rights under COBRA." Please note that USERRA and COBRA Eligibility run concurrently.

Your Rights Under HIPAA

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). This Act is designed to make it easier for you and your family members to have continued medical coverage when changing from one employer to another.

Non-Discrimination Rules

Under HIPAA, group health plans cannot exclude you from enrolling based on health factors. This means that a health plan cannot require evidence of insurability (proof of good health) as a condition of enrollment and cannot exclude individuals who cannot pass a physical exam (including late enrollees).

Special Enrollment Opportunities

If you decline coverage for yourself or your eligible family members because of other employer-based group health insurance coverage, you may enroll yourself or your dependents in Duke's medical Plan during open enrollment or if you request enrollment within 30 days of when your other coverage ends.

The special enrollment right is available if the other coverage ends:

- Due to loss of eligibility;
- Because an employer's contribution for the other coverage stops; or
- In the case of COBRA coverage, because the maximum COBRA period has expired.

In addition, if you have previously declined coverage and you have a new dependent as a result of marriage, birth, adoption, or placement for adoption (a qualified change in family status), you may enroll yourself and your dependents, provided you request enrollment within 30 days of the family status change.

Your Rights Under FMLA

The Family and Medical Leave Act of 1993 (FMLA) allows eligible employees to take up to 12 weeks of unpaid leave time (or up to 26 weeks of military care giver leave) for the following family or medical reasons:

- Care of your child after birth, or placement for adoption or foster care;
- Care of your spouse, son, daughter, or parent who has a serious health condition; or
- Your own serious health condition, which causes you to be unable to perform your job.

To be eligible for FMLA leave, you must be a part- or full-time employee who has:

- Been employed by Duke for at least one year (12 continuous months); and
- Worked at least 1,250 hours in the previous 12 months.

Continued Coverage During FMLA Leave

During your FMLA leave, you are entitled to the following benefits:

- Duke must maintain your group health plan coverage on the same conditions as coverage would be provided if you had been continuously employed during the entire period of your leave;
- The same group health plan benefits provided to you prior to your leave must be maintained during your leave;
- You are entitled to new or changed group health plan benefits on the same basis as if you were not on leave;
- You must be given notice of any opportunity to change coverage; and
- If you do not retain your coverage during your leave, you are entitled to be reinstated when you return from leave, without any requirements to requalify such as any waiting periods, physical examinations, or pre-existing condition exclusions.

If you have questions regarding your eligibility for coverage under other benefit plans during an FMLA leave, please contact the HRIC at **919-684-5600**.

Paying for Continued Coverage

During your FMLA leave, you must continue to pay any contribution toward the cost of your coverage that you were paying prior to your leave. If while on leave, premiums are raised or lowered, you will be required to pay the new premium rates.

Duke has the right to recover premiums it pays for the cost of your coverage during an unpaid FMLA leave unless you fail to return to work at the end of your FMLA leave due to:

- A serious health condition that would entitle you to leave under FMLA; or
- Other circumstances beyond your control, including:
 - Your spouse being unexpectedly transferred to a job location more than 75 miles from your work site;
 - Your need to care for a relative or individual other than an immediate family member having a serious health condition; or
 - Your being laid off from work while on FMLA leave.

Please see the Duke Reimbursement Account Programs (section titled “Changing Your Benefit Election”) for details on continuing participation in your reimbursement accounts during FMLA.

Duke may request medical certification to verify your own or your family member's serious health condition. If you do not provide such certification within 30 days of the request, Duke may recover premiums it paid during any unpaid portion of your leave. The amount Duke can recover is limited to only the company's share of

allowable premiums as would be calculated under COBRA, less the two percent administrative fee. Duke can recover its share of these premiums through deductions from any sums due to you, or initiate legal action against you. Duke cannot recover premiums it pays for the cost of your group coverage during a paid FMLA leave.

When Coverage May End

Duke’s obligation to provide continued coverage ends upon the earliest of the following:

- You inform Duke of your intent not to return to work from FMLA leave;
- You fail to return from FMLA leave and terminate your employment; or
- You exhaust your FMLA leave entitlement.

If one of these events occurs, you would become eligible for continued coverage under COBRA.

Your Rights Under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you have the right to continue your coverage under the Health Care Program, Dental Program, Vision Program and, under certain circumstances, you may have the right to continue coverage under the Health Care Reimbursement Account Program when you and/or your eligible dependents lose coverage for one of the reasons (known as “qualifying events”) shown in the following chart. The chart also shows when and for how long you and your dependents can continue coverage under COBRA for the various qualifying events.

Duration of COBRA Coverage

If coverage is lost because of any of the qualifying events . . .	You can continue coverage for yourself up to . . .	Each eligible dependent can continue coverage for up to . . .
Your employment with Duke terminates (for reasons other than gross misconduct)	18 months* from the date of the qualifying event for the Health, Dental, and Vision Programs, and through the end of the plan year for the Health Care Reimbursement Account Program	18 months* from the date of the qualifying event
Your scheduled work hours are reduced to less than 20 hours per week	18 months* from the date of the qualifying event for the Health, Dental, and Vision Programs, and through the end of the plan year for the Health Care Reimbursement Account Program	18 months* from the date of the qualifying event
You die	Not applicable	36 months from the date of the qualifying event
Your dependent is no longer eligible for coverage (for example, your Medicare entitlement results in loss of coverage for your dependents, you and your spouse divorce, or your dependent child reaches age 26)	Not applicable	36 months from the date of the qualifying event

*If you or your dependents are disabled when coverage ends due to a qualifying event or at any time during the first 60 days of continuation of coverage, you and your dependents may continue coverage for up to 29 months (that is, 11 months beyond the usual 18-month period). To continue coverage for 29 months, you must notify the Plan Administrator

of the disability before the end of the initial 18-month continuation period and within 60 days following the date you are determined to be disabled under Social Security. If you or your dependents are no longer considered disabled under Social Security, you must notify the Plan Administrator within 31 days of the determination.

Applying for COBRA

You or your dependents can elect to continue coverage any time within the first 60 days of the qualifying event or the date coverage ends. Employees who reduce their work schedule to less than 20 hours / week or terminate employment will be notified by letter from HealthEquity, Duke's COBRA administrator. You and your dependents will be sent information about the application process and the cost to continue coverage. If you do not choose continuation coverage within the first 60 days after coverage ends or within 60 days from the date you are notified of your COBRA rights, your eligibility for COBRA will end.

If, as an active employee, one of your covered dependents becomes ineligible through loss of student status, age, or divorce, you must notify the Human Resources Information Center at **919-684-5600** within 60 days of the date of the loss of eligibility in order to be eligible for COBRA benefits. Your dependent will be sent information from HealthEquity, an affirmative election must be made, and premiums paid retroactive to the termination date.

Once COBRA continuation coverage begins, you or your dependents must notify HealthEquity within 60 days of any additional qualifying event such as death, divorce, legal separation, Medicare eligibility, or if a child loses dependent status under the Plan. If you do not notify HealthEquity within the 60-day period, your dependent will not be eligible for continued COBRA benefits. These events may allow your dependents' coverage to continue for a longer period, but in no event for longer than 36 months. You also must notify HealthEquity of any change of address. In addition, if a child is born or adopted by you during a continuation period, you can obtain coverage for that child. You must notify HealthEquity within 31 days of the date of birth or adoption if the new child is to be covered.

Paying for COBRA

As permitted by COBRA, you pay 100% of the applicable premium, plus an additional 2% to cover administrative fees. If you are eligible to extend coverage for the additional 11 months granted to disabled qualified beneficiaries, you pay 150% of the applicable premium for this period.

If you or your dependents wish to continue coverage under COBRA, you must make the initial premium payment within 45 days of the date you elect to continue coverage. Coverage will not be reinstated until all retroactive payment is made. You must continue to pay the cost of coverage on time or your coverage will automatically end.

The premium for continuation coverage may be changed from time to time, as permitted by COBRA.

When COBRA Ends

COBRA continuation coverage generally ends when the maximum benefit period expires; however, it also ends on the earlier of the following dates:

- The date you (or your dependents) fail to pay the required premium within 31 days of the due date;
- The date you (or your dependents) become covered under another health care plan;
- The date you (or your dependents) become entitled to Medicare benefits; or
- The date Duke terminates the Plan for all participants.

Notice of Privacy Practices

Duke Health Care Program

Effective Date: April 14, 2003

Revised: July 1, 2023

Assistance with this information is available upon request. Please contact the Human Resources Information Center at **919-684-5600** for additional details.

Asistencia con esta información está disponible por petición. Por favor comuníquese con el Centro de Información de Recursos Humano al **919-684-5600** para detalles adicionales.

This Notice describes how medical information about you may be used and disclosed and how you may obtain access to this information. Please review it carefully.

Use and Disclosure of Health Information

The provisions of the Duke University Health Plan (“the Health Plan”) are designed to protect the privacy of health information that it creates or receives about you that can identify you, called “protected health information.” Protected health information includes information about your past, present or future health, the provision of health care to you, or your past, present, or future payment for the provision of health care. The Health Plan has established policies to protect the privacy of your protected health information. The Health Plan consists of Duke Select, Duke Basic, Blue Care, Duke Options, Duke USA, and Duke Plus medical benefits programs; Express Scripts pharmaceutical benefits program; the Health Care Reimbursement Account program; the Personal Assistance Service (PAS) program; and the Employee Assistance Plans.

The Health Plan’s privacy practices concerning your protected health information are as follows:

- The Health Plan will safeguard the privacy of protected health information that it has created or received.
- The Health Plan will explain how, when and why it may use and/or disclose your protected health information.
- The Health Plan will only use and/or disclose your protected health information as described in this notice.

The following categories describe different ways that the Health Plan may use and disclose health information. For each category of uses or disclosure we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways the Health Plan is permitted to use and disclose information will fall within at least one of the categories.

To make or obtain payment — The Health Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Health Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To conduct health care operations — The Health Plan may use or disclose health information for its own operations to facilitate the administration of the Health Plan and as necessary to provide coverage and services to all of the Health Plan's participants. We are not allowed to use genetic information to decide

whether we will give you coverage and the price of that coverage. Health Care Operations includes such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination and utilization review.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development, including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of the Health Plan, including customer service and resolution of internal grievances.

For treatment alternatives — The Health Plan may use or disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For distribution of health-related benefits and services — The Health Plan may use or disclose your health information to provide information on health-related benefits and services that may be of interest to you.

For disclosure to the Plan Sponsor. The Health Plan may disclose your health information to the Plan Sponsor for Plan administration functions performed by the Plan Sponsor on behalf of the Health Plan. In addition, the Health Plan may provide health information to the Plan Sponsor so that the Plan Sponsor may solicit premium bids from health insurers or modify, amend or terminate the Plan. The Health Plan may also disclose to the Plan Sponsor information on whether you are participating in the Health Plan.

Special Situations

The Health Plan may use and/or disclose protected health information about you for a number of circumstances in which you do not have to consent, give authorization or otherwise have an opportunity to agree or object. Those circumstances include:

When legally required — The Health Plan will disclose your health information when it is required to do so by any federal, state or local law.

To conduct health oversight activities — The Health Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Health Plan, however, may not disclose your health

information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

Research — Under certain circumstances, the Health Plan may use and disclose your health information for research purposes. All research projects are subject to a special approval process. Before the Health Plan uses or discloses medical information for research, the project will have been approved through this research approval process. The Health Plan may use your health information in preparing to conduct a research project, for example, to look for Health Plan participants with specific needs, so long as the health information reviewed is not removed from the Health Plan.

In connection with judicial and administrative proceedings — As permitted or required by law, the Health Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal. It must be expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Health Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For law enforcement purposes — As permitted or required by state law, the Health Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Health Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

Lawsuits and disputes — If you are involved in a lawsuit or a dispute, we may disclose your health information in response to a court or administrative order. We may also disclose your health information in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

In the event of a serious threat to health or safety — The Health Plan may, consistent with applicable law, disclose your health information if the Health Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For specified government functions — In certain circumstances, federal regulations require the Health Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

To respond to organ and tissue donation requests — and work with a medical examiner or funeral director.

For workers' compensation — The Health Plan may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

Authorization To Use or Disclose Health Information

Other than as stated above, the Health Plan will not disclose your health information other than with your written permission. In addition, we will not use your PHI for marketing and fundraising purposes without your permission. We will not sell your PHI without your permission. If you authorize the Health Plan to use or disclose your health information, you may revoke that permission in writing at any time. If you revoke your permission, the Health Plan will no longer use or disclose your health information for the reasons covered by your written authorization. The Health Plan is unable to take back any disclosures it has already made with your permission.

North Carolina law — In the event that North Carolina law requires the Health Plan to give more protection to your health information than stated in this notice or as required by federal law, the Health Plan will give that additional protection to your health information.

Your Rights with Respect to Your Health Information

You have the following rights regarding your health information that the Health Plan maintains:

Right to request restrictions — You may request restrictions on certain uses and disclosures of your health information. For example, you have the right to request a limit on the Health Plan's disclosure of your health information to someone involved in the payment of your care. However, the Health Plan is not required to agree to your request. If you wish to make a request for restrictions, call **919-684-5600** for the appropriate request form.

Right to request alternative ways of communications — You have the right to request that the Health Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Health Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, call **919-684-5600** for the appropriate request form. The Health Plan will attempt to honor your reasonable requests for confidential communications. When appropriate, the Health Plan may condition the accommodation on providing the Health Plan with information regarding your alternative address or other method of contact.

Right to inspect and copy your health information — You have the right to inspect and copy your health information. To so inspect and copy your health information, please call **919-684-5600** for the appropriate request form. If you request a copy of your health information, the Health Plan may charge a fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to amend your health information. If you believe that your health information records are inaccurate or incomplete, you may request that the Health Plan amend the records. That request may be made as long as the information is maintained by the Health Plan. To request an amendment to your health information, call **919-684-5600** for the appropriate form. The Health Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Health Plan, if the health information you are requesting to amend is not part of the Health Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Health Plan determines the records containing your health information are accurate and complete.

Right to an accounting — You have the right to request a list of certain disclosures of your health information that the Health Plan is required to keep under the Privacy Rule, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law. To request an accounting of disclosure, call **919-684-5600** for the appropriate form. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Health Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Health Plan will inform you in advance of the fee, if applicable.

Right to a paper copy of this notice — You have a right to request and receive a paper copy of this notice at any time, even if you have received this notice previously or agreed to receive the notice electronically. You

may also obtain a copy of this notice at any time from our website at hr.duke.edu or by calling **919-684-5600** and requesting a paper copy.

Right to choose someone to act for you — If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will verify that the person has this authority and can act for you before we take any action.

Right to file a complaint if you feel your rights have been violated — You can complain if you feel we have violated your rights by contacting us using the information listed for the privacy official. In addition, you can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave., S.W., Washington, D.C. 20201; calling **877-696-6775**; or visiting hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Duties of the Health Plan

The Health Plan is required by law to maintain the privacy of your health information as set forth in this notice and to provide to you this notice of its duties and privacy practices. The Health Plan is required to abide by the terms of this notice, which may be amended from time to time. The Health Plan reserves the right to change the terms of this notice and to make the new notice provisions effective for all health information that it maintains. If the Health Plan changes its policies and procedures, the Health Plan will revise the notice and will provide a copy of the revised notice to you within 60 days of the change. You have the right to express complaints to the Health Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Health Plan should be made in writing to the Health Plan's Privacy Official. The Health Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person

If you have any questions regarding this notice, you believe your privacy rights have been violated, or you wish to file a complaint about the Health Plan's privacy practices, you may contact:

**Associate Director, Benefits
Privacy Official
Duke University
Benefits Administration
705 Broad St.
Durham, NC 27705**

Important Summary for Employees Transitioning to the Duke Health Integrated Practice (DHIP) on July 1, 2023

Effective July 1, 2023, a group of employees within the Private Diagnostic Clinic (PDC) transitioned to employment with the Duke Health Integrated Practice, Inc. (DHIP), an affiliate of Duke University Health System (DUHS). The employees that transitioned into DHIP on July 1, 2023 have the same eligibility for the Duke University Health and Welfare Plan as DUHS employees with the following clarifications and criteria:

- The DHIP employee's prior PDC continuous service date is included for purposes of:
 - Determining eligibility to participate in the Duke provided Long Term Disability program (i.e. towards the 3 years of full-time service);
 - Determining eligibility to participate in the Employee Tuition Assistance Program (i.e. 6 months of full-time service); and
 - Counting towards the 15 years of service after age 45 requirement to be eligible to participate in the Retiree Health or Dental program for DUHS employees.
- Unless the employee is directly transferring from another Duke entity (e.g., Duke University (DU) or DUHS) to DHIP, the employee's PDC continuous service date is excluded for purposes of:
 - Determining eligibility for all of the Plan's legacy provisions (e.g., eligibility for Duke's contribution towards retiree health or eligibility for the Children's Tuition Grant program);
 - The twenty-years of service threshold for a full-time employee to be able to reduce his/her work schedule to 20 hours and retain Duke's contribution towards the Health Plan premium;
 - Determining the amount of the Survivor Benefit under the Plan;
 - Determining the amount of the Severance Benefit under the Plan;
 - Enabling enrollment in the Plan's voluntary short term and/or voluntary long term disability coverage as a new hire;
 - Enrolling in the Plan's supplemental life program with new hire eligibility provisions; and
 - Eligibility to enroll in Duke's health, dental, vision, and reimbursement account programs as a new hire.

In the above cases, the employee's continuous service date is July 1, 2023.

Dental Program

Effective July 1, 2023, the employees that transitioned into DHIP on July 1, 2023 that were participating in the PDC Dental Plan as a PDC retiree were provided a one-time opportunity to enroll in the Duke Dental Plan and will not be considered a late entrant.

Supplemental Life Insurance Program

Effective July 1, 2023, these employees that transitioned into DHIP on July 1, 2023 and who were participating in the PDC Life Insurance Plan as a PDC retiree were provided a one-time opportunity to enroll in the age-banded, retiree premiums for Duke's Supplemental Life Insurance program at the amount of coverage he/she had through the PDC at the time of transition without needing to undergo medical underwriting by Duke's carrier, effective July 1, 2023.

Long Term Disability Program

Effective July 1, 2023, Duke's employer provided long term disability program is modified as follows:

- Employees holding a full time, active, Private Diagnostic Clinic faculty position and receiving compensation from Duke immediately prior to the transition are no longer excluded from eligibility to participate in the program.
- The definition of disability under the program for clinical faculty is as follows:
 - You are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury, and you have a 20% or more loss in your monthly earnings due to the same sickness or injury. The loss of professional or occupational license or certification does not, in itself, constitute disability. For physicians, "regular occupation" means your specialty or subspecialty in the practice of medicine, in which you are both board certified (or the equivalent certification from another country) and practiced immediately prior to the start of your disability.

Voluntary Short and Long Term Disability Programs

Effective July 1, 2023, Clinical Faculty interested in enrolling in voluntary short and/or long term disability coverage under the Plan are eligible to apply for coverage.

Children's Tuition Grant (CTG)

Prior to July 1, 2023, Duke University employees leased to the Private Diagnostic Clinic (PDC) were reflected in SAP in a payroll classification as eligible for the CTG program once other service criteria was met (for example, five years of consecutive full-time service). Generally, these employees retained that classification post June 30, 2023. However, this is not a "grandfathered" or "legacy" status that is vested. If the employee moves to a job outside of Duke University (Company Code 10) the eligibility for the benefit is not retained unless the employee has met the criteria described in the Transfers section of the Children's Tuition Grant program.

DUKE CAFETERIA AND PREMIUM CONVERSION PROGRAM

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DUKE CAFETERIA AND PREMIUM CONVERSION PROGRAM

Introduction

Eligible employees enrolling in Duke's Health, Dental, and Vision Programs, the Post-Retirement Group Term Life Insurance Program, and the Reimbursement Account Programs also become participants in the Cafeteria and Premium Conversion Program (the Program).

The Program permits you to pay the eligible portion of your premium cost for Health, Dental, Vision, and Post-Retirement Group Term Life on a pre-tax basis, and also allows you to contribute some of your pay on a pre-tax basis to pay for many of your medical, dental, vision, and dependent care bills under the Reimbursement Account Programs. Your premiums and contributions are taken out of your paycheck automatically each pay period. Because you do not pay taxes on these amounts, your federal and state income taxes may be reduced.

Some of your other Duke benefits, such as life insurance, are determined based on your base pay. These benefits will not be affected by your participation in the Program. They will continue to be determined based on your base pay. However, other benefits, such as your Social Security and Medicare wage base, may be affected if you decide to enroll.

Your Social Security benefits may be slightly reduced if you enroll in the Program. That is because account deposits lower the amount of your income from which Social Security taxes are withheld. The amount of the reduction will depend on the amount of your deposits and the length of time you participate between now and when you retire.

The term "Duke" is used throughout this booklet. "Duke" refers to the University, Duke University Health System, Inc. and any other corporation or entity that adopts the Plan with the duly authorized approval of the Board of Trustees. When used in this Plan document, "Employer" shall refer to all of the foregoing collectively except where the context requires that such term refer to the corporation or entity that actually employs an individual.

The benefit program provided is based on an employee's company code and job code as reflected in the HR benefits administration system (SAP). Duke employees holding more than one position classification receive the benefits associated with their primary position classification as reflected in SAP. For example, a housestaff member who also works within DHIP, receives benefits associated with their housestaff position classification.

Eligibility and Enrollment

If you are eligible to enroll in Duke's Health Program, Dental Program, Vision Program, Post-Retirement Group Term Life Insurance Program, or Reimbursement Account Programs, you also are eligible to participate in the Cafeteria and Premium Conversion Program (the Program).

Enrollment

Your enrollment in this Program is conditioned on your enrollment in Duke's Health Program, Dental Program, Vision Program, Post-Retirement Group Term Life Insurance Program, or Reimbursement Account Programs. To enroll in the Program, you must complete the enrollment forms for any of the programs listed above within 30 days after your date of employment or eligibility (these enrollment forms include salary-reduction agreements). If you do not enroll in these programs when you are first eligible, you must wait until the next annual open enrollment unless you are eligible for special enrollment or have a qualifying event (see "Qualifying Events" section). You have 30 days from a qualifying event to enroll.

Effective Date of Enrollment

New Participants

Your enrollment in the Program is effective as of the effective date of your enrollment in Duke's Health Program, Dental Program, Vision Program, Post-Retirement Group Term Life Insurance Program, or Reimbursement Account Programs, whichever is earliest. The corresponding portion of your salary-reduction agreement also is effective as of the effective date of your enrollment in such benefit programs. In most cases, this is the first day of the month following Duke's receipt of your enrollment forms. If you are a new employee, your enrollment and salary-reduction agreement may be effective as early as your first day of employment with Duke.

Open Enrollment

For subsequent plan years, your enrollment elections for the Health Program, Dental Program, Vision Program, and Post-Retirement Group Term Life Insurance Program, and corresponding portion of your salary-reduction agreement will remain in effect from plan year to plan year unless you change (or waive) your elections during the applicable open enrollment period. To continue your participation in the Reimbursement Account Programs, you must re-enroll every year.

Salary-Reduction Agreements

The amounts withheld under your salary-reduction agreement are applied towards your premium or enrollment costs for the benefit programs elected in your enrollment election. Premiums may be transferred to the insurance carriers or benefits may be paid from the general assets of Duke as applicable. Salary-reduction contributions toward a Health Care or Dependent Care Reimbursement Account are credited, as soon as reasonably practical after each payroll period, to a bookkeeping account maintained on your behalf. They are not placed in trust and are considered part of the general assets of Duke.

Irrevocability of Salary-Reduction Agreements

Your Health, Dental, Vision, Post-Retirement Group Term Life Insurance, and Reimbursement Account Program enrollment elections and corresponding portions of your salary-reduction agreement are irrevocable until the end of the plan year unless:

- You are entitled to special enrollment; or
- You have a qualifying event.

You may, however, change your enrollment election and corresponding portion of your salary-reduction agreement:

- Due to significant cost or coverage change to your health, dental, vision, post-retirement group term life insurance coverage, or Dependent Care Reimbursement Account (a change to a Health Care Reimbursement Account for this reason is not permitted under the Internal Revenue Code (IRC)); or
- Due to a leave of absence that qualifies for an enrollment change and corresponding salary-reduction agreement change.

If your enrollment election is changed, terminated, or suspended, the corresponding portion of your salary-reduction agreement is automatically changed, terminated, or suspended.

Special Enrollment

If you are entitled to special enrollment under the Health Insurance Portability and Accountability Act (HIPAA) due to a loss of health coverage or due to birth, adoption (or placement for adoption), or marriage, you may change your enrollment elections in the Health Care Program and you may increase your contributions to your Health Care Reimbursement Account provided that you submit a special enrollment election within 30 days of the event. A special enrollment election will be effective on the first day of the month following Duke's receipt of a completed special enrollment election or such other date as permitted under the applicable benefit program or member documents. For example, in the case of birth or adoption, a special enrollment election may be effective as of the date of such birth or adoption. In all cases, the portion of your salary-reduction agreement covering your special enrollment election(s) will be adjusted accordingly with a pre-tax deduction in the next appropriate deduction period following Duke's receipt of your special enrollment election. Further information regarding special enrollment under HIPAA may be found in your member documents.

Qualifying Events

You may change your enrollment elections and make corresponding changes to your salary-reduction agreement if you have a qualifying event, but only if the change is permitted by the terms and conditions of the applicable benefit program and your election change is on account of, and is consistent with, the qualifying event. In the case of each benefit program, an election change is "on account" of a qualifying event only if submitted to Duke within 30 days of the event and shall be permitted only if Duke determines, in its discretion, that the change in election and salary-reduction agreement is permitted under Section 125 of the IRC and applicable regulations. Any such determination shall be final and conclusive. Qualifying events include the following:

- A change in your marital status, including marriage, death of spouse, or divorce;
- A change in the number of your dependents, including birth, adoption, placement for adoption, or death of an eligible dependent;
- A change in the employment status, including termination or commencement of employment for a covered dependent, or a reduction or increase in hours of employment resulting in a loss or gain of eligibility for coverage (coverage must not be a student or individual policy);
- A change in coverage under another employer's plan, including a change made during the other employer's open enrollment period;
- A covered dependent satisfying or ceasing to satisfy the eligibility requirements of a benefit program due to age limits, or similar circumstances, including in the case of the Dependent Care

Reimbursement Account Program, loss of “eligible dependent” status upon a dependent attaining age 13;

- A change in the cost of enrollment due to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage for you, your spouse, or dependent;
- The entitlement or loss of eligibility for coverage under Medicare or Medicaid;
- A qualified medical child support order (QMCSO) that orders health coverage; and
- Change in residence of you, your spouse, or a dependent if enrolled in a health plan with geographic restrictions.

Several additional qualifying events are described more fully in the following pages. Additional information is also available in the Benefit Program Descriptions.

You may change your enrollment elections and corresponding adjustments will be made to your salary-reduction agreement upon a “significant cost or coverage change” event but only if the change is permitted by the terms and conditions of the applicable benefit program, and your election change is on account of, and is consistent with, the event. An election change is “on account” of an event described in this section only if submitted to Duke within 30 days of the event and shall be permitted only if Duke determines, in its discretion, that the change in election and salary-reduction agreement is permitted under Section 125 of the IRC and applicable regulations. Any such determination shall be final and conclusive.

Significant Change in Cost or Coverage Change

Significant Change in Cost

If your share of the premium cost significantly increases or decreases during the plan year (including a cost increase resulting from a change in your job classification), you may enroll in similar health, dental, or vision coverage to the extent available under the Health, Dental, or Vision Program and the corresponding portion of your salary-reduction agreement will be adjusted to reflect your share of the premium cost for the new coverage for the remainder of the plan year. If your share of the premium cost significantly increases and no similar coverage is available, you may terminate your health, dental, or vision coverage for the remainder of the plan year.

Significant Change in Coverage

If coverage is significantly curtailed during a plan year, you may enroll in similar health, dental, or vision coverage to the extent available under the Health, Dental, or Vision Program and the corresponding portion of your salary-reduction agreement will be adjusted to reflect your share of the premium cost for the new coverage for the remainder of the plan year. You may not waive medical, dental, or vision coverage unless the curtailment constitutes a “loss of coverage” as defined under Section 125 of the IRC and applicable regulations, and no similar coverage is available.

Addition or Improvement of Coverage

If a coverage is added or significantly improved during a plan year, you may enroll in such coverage (and terminate other coverage) to the extent permitted under the Health, Dental, or Vision Program and the corresponding portion of your salary-reduction agreement will be adjusted to reflect your share of the premium cost for the new coverage for the remainder of the plan year.

Impact on Reimbursement Accounts

The significant change in cost or coverage events permit you to change the level of your contributions to the Dependent Care Reimbursement Account but do not permit you to change the level of your contributions to the Health Care Reimbursement Account.

Change in Coverage Under Another Employer Plan

If a change is made to the cafeteria plan of your spouse's or former spouse's employer, your dependent's employer, or your employer (other than Duke), you may change your enrollment election for Duke Health, Dental and/or Vision Program coverage to the extent permitted under the Duke Health, Dental, and/or Vision Program. You also may change your enrollment election for Duke Health, Dental, and/or Vision Program coverage if the coverage period under another employer's plan is different from the coverage period under the Duke Health, Dental, and/or Vision Program. The corresponding portion of your salary-reduction agreement will be adjusted to reflect your share of the premium cost for the new coverage for the remainder of the plan year.

Leaves of Absence

Paid Leave of Absence

If you take a paid leave of absence, including paid leave under the Family and Medical Leave Act of 1993 (FMLA) or paid military leave, your enrollment elections and salary-reduction agreement shall continue during such leave of absence.

Unpaid Leave of Absence

If you take an unpaid FMLA or military leave, you may continue your enrollment elections during the unpaid leave (but not longer than 12 weeks in the case of FMLA leave or 24 months in the case of military leave); provided that you pay, on an after-tax basis, your premium or enrollment costs on the same schedule that your premium or enrollment costs would have been made if you were not on leave.

Contact the HRIC at **919-684-5600** to arrange payment of your premium prior to the start of your leave.

If you did not maintain your coverage during an unpaid leave of absence, you may re-enroll in your Health, Dental, Vision, Post-Retirement Group Term Life Insurance, or Reimbursement Account Programs upon return from the leave, provided that you sign another salary-reduction agreement within 30 days of the date you return to work, unless you are otherwise permitted to change your enrollment elections and salary-reduction agreement due to special enrollment or a qualifying event.

Authorized Leaves of Absence

An authorized leave of absence means any paid or unpaid personal leave from active employment duly authorized by Duke under Duke's standard personnel practices. An FMLA leave is any paid or unpaid personal leave from active employment duly authorized by Duke under the Family and Medical Leave Act of 1993. A military leave is any paid or unpaid personal leave from active employment duly authorized by Duke under the Uniformed Services Employment and Re-employment Rights Act of 1994.

Automatic Changes, Suspensions, or Terminations

Automatic Cost Increase or Decrease

If your share of the premium cost for your enrollment in the Health, Dental or Vision Program changes during the plan year and such change is not a “significant cost” change as described in the preceding pages, your salary-reduction agreement will automatically change accordingly.

Change to Ineligible Status

If you cease to be eligible to participate in a benefit program but do not terminate employment or take a leave of absence, the corresponding portion(s) of your salary-reduction agreement will be suspended and will be terminated at the end of the plan year if active participation is not reinstated earlier. Your enrollment or coverage under a benefit program, however, may continue to the extent permitted under the applicable benefit program. In such case, the cost of your continued enrollment (as determined under the applicable benefit program) must be paid by you on an after-tax basis. If you again become eligible to participate in a benefit program, you have 30 days after your date of eligibility to enroll and sign the corresponding salary-reduction agreement.

Termination of Employment

Your salary-reduction agreement will automatically terminate when you terminate employment with Duke. Your enrollment or coverage under a benefit program, however, may continue to the extent permitted under the applicable benefit program. In such case, the cost of your continued enrollment (as determined under the applicable benefit program) must be paid by you on an after-tax basis. If you are rehired by Duke as an eligible employee, you will need to re-enroll in the various benefit programs and sign the corresponding salary-reduction agreements.

Nondiscrimination

If you are a highly compensated employee (as defined in Section 414(q) of the IRC), Duke may suspend your enrollment election and the corresponding portion of your salary-reduction agreement during a plan year, prospectively reduce amounts paid under a salary-reduction agreement during a plan year, or otherwise limit your enrollment in a benefit program for a plan year to the extent and in such manner as Duke determines is necessary to satisfy the nondiscrimination requirements imposed by the IRC. Duke may also treat and report an otherwise nontaxable benefit as a taxable benefit to satisfy any nondiscrimination requirement or limitation on contributions or benefits imposed by the IRC to the extent it deems necessary under the circumstances.

Termination of Program

Your salary-reduction agreement will automatically terminate if Duke terminates the Program. Your enrollment or coverage under a benefit program, however, may continue to the extent permitted under the applicable benefit program.

Reinstatement of Salary-Reduction Agreements

If your enrollment elections and salary-reduction agreement is reinstated during a plan year (e.g., upon return from a leave of absence or upon rehire within 31 days), you may elect to either reduce your annual election amount or elect to reinstate your original annual reimbursement amount by making up any missing contributions.

If you reduce your annual election amount, you will not be eligible to seek reimbursement for expenses incurred while out on a leave of absence.

Requests for Information and Claims Procedures

The Cafeteria and Premium Conversion Program only concerns the payment of premium and enrollment costs for the benefit programs described in this document and has no effect on the benefits or claim payments made under each benefit program. Because your eligibility to participate in the Program is based on your eligibility to participate in the benefit programs offered hereunder, any questions regarding eligibility to participate in the Program are handled under the procedures established for the applicable benefit program. Refer to the applicable Benefit Program Descriptions for information regarding benefit processing and claims and appeals procedure. With respect to any other questions, contact:

**HRIC
Duke University
705 Broad St.
Box 90502
Durham, NC 27708-0502**