2018 Duke Benefits

- Overview of Duke’s Benefits
- Summary Plan Descriptions
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This booklet contains summaries of the benefit plans, as of January 1, 2018, that apply to eligible Duke Employees, and is organized by subject and type of benefit.

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The term “Duke” is used throughout this booklet. “Duke” refers to the University, Duke University Health Systems, Inc., and any other entity which is or becomes controlled by Duke University and where, upon appropriate action by the Board of Trustees, the employees of that entity are included in the membership programs.

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.

You can get answers to benefits-related questions by calling the Human Resource Information Center (HRIC) at (919) 684-5600 or by visiting the HR web site at hr.duke.edu.
Duke Health Care Programs

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, vision services, prescription drugs, and mental health and substance abuse treatment.

You may enroll in one of four different health care plans to meet the needs of you and your family. When you enroll in a health care plan, you also receive pharmacy benefits and mental health and substance abuse benefits automatically.

Please read this Benefit Program Description, which serves as your Summary Plan Description (SPD), carefully. It is designed to answer questions about your health care plan. However, if you require additional information you should contact the administrator for your health care plan or the Human Resource Information Center (HRIC) at (919) 684 5600.

The term “Duke” is used throughout this document. For purposes of this Benefit Program Description, “Duke” refers to the University, Duke University Health System, Inc., and any other entity which is or becomes controlled by Duke University and where, upon appropriate action by the Board of Trustees, the employees of that entity are included in the membership of these programs.

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

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 is grandfathered 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 grandfather status continues for the course of this relationship only.
# Duke Health Care Programs

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Eligibility and Enrollment

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, 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,
- A 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 X 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 that is:

- The employee’s spouse (marriage certificate + proof of joint residency required)
- The employee’s Registered Same Sex Spousal Equivalent if registered with Duke HR prior to 1/1/2016.
- The employee’s child (“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.

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

- The parent must apply for the waiver on or 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 condition must exist on or prior to the 26th birthday;
- The parent must provide annual evidence of continued incapacity;
- 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 requires a birth certificate, marriage certificate, and proof of joint residency, or the first two pages of your tax return and proof of joint residency be submitted online within 30 days of the health plan effective date.
- 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 child you must be the legal guardian of the child.

Dependent Documentation
All employees covering dependents on the Duke Health Care Programs will be required to provide documentation to verify the eligibility of the dependents. A birth certificate, adoption papers, documentations of foster child, or legal guardianship papers must be submitted for children. Those covering step children must show the birth certificate with the name of the spouse, and proof of marriage and current joint ownership or 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/residence, such as a utility bill (not cell phone) or lease agreement with both names.

PLEASE NOTE: Legal guardianship if obtained outside of NC must be consistent with NC requirements, i.e. a permanent surrender of parental rights of the birth parents.

Collective Bargaining
Group health benefits are a subject of good faith bargaining between Duke and:
- Local 77 of the American Federation of State, County, and Municipal Employees,
- Local 465 of the International Union of Operating Engineers and
- Local 1328 Amalgamated Transit 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 Street
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 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
- 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 non-faculty employee regularly scheduled 30 or more hours per week).

Eligible Employees may change coverage from Duke Select, Duke Basic, Blue Care, or Duke Options during Open Enrollment periods designated by Duke. Subscribers enrolled in Duke Select, Duke Basic, or Blue Care also may change to Duke Options in the event that they or a covered dependent moves outside the service area for a period of three months or longer. Those changing to Duke Options for this reason must wait until Open Enrollment to change back to the previous plan if they return to the area.

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 employee’s portion of the month premium is not timely or consistently paid, or
- When his/her work schedule is reduced below 20-hours per week, the employee transfers to an ineligible position. The effective date will normally be the last day of the month after the work schedule 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 the 26th birthday.

Step Children
Step children who have not been adopted by the employee will lose eligibility in the event of divorce from 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 his/her 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 his or her 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 if 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 his/her legal guardian if he/she is 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 employees’ 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 Section, Termination of Coverage and COBRA Continuation Coverage.

Retirement Continuation
To continue to receive the health insurance plan in retirement, you must meet the following criteria:

- At the time you must be enrolled under the health plan as the subscriber.
- To receive a Duke contribution, you must be receiving one at the time of retirement.

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.

Eligibility Requirements for Duke University (Company Code 10 in SAP)
You must meet the Rule of 75, which became effective July 1, 1990. It requires your age plus years of continuous service with Duke at retirement must be equal to or greater than 75. Thus, an employee or faculty member must have at least ten years of continuous service to retire at 65 and continue Duke health coverage.
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 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
- 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.
- 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 grandfathered under the Rule of 75 eligibility provision.

All other employees employed by DUHS prior to July, 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 after age 45—DUHS will pay a portion of the premium
  OR
- Met the Rule of 75—Retiree pays 100% of the premium.

PLEASE NOTE: If a faculty or staff member meet 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.* Re-enrollment in the health or dental plan must occur within 60 days of the termination of your other employer sponsored coverage, or with the death of the Duke retiree (for a spouse who was covered on the date of retirement). Proof of continuous coverage through another employer plan 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.

*Coverage under another plan available to the individual as a retiree of another employer, through a spouse’s active or retiree plan or from service with the military does not count as an employee under another employer sponsored plan.

Medicare

The Federal Government provides medical benefits for people age 65 and older through Medicare Part A and Part B. Part A coverage includes payment for inpatient hospital expenses and Part B helps to pay for physician’s services, outpatient hospital care and other medical services not covered by Part A. Both Part A and Part B are subject to deductibles and co-insurance. Health benefits include, and are not in addition to, Medicare benefits. Contact the Social Security Administration for Medicare enrollment information.

Medicare Entitlement While Actively at Work

Members (and their spouse) 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 the 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. 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 Spouse

The Duke Health Plan will continue to 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 mandatory as Medicare becomes your primary coverage. 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
1-866-318-DUKE
www.umr.com

Retirees Age 65
Enrollment in Medicare Part A and Part B is mandatory for retirees or their spouses age 65 or older. 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 Human Resources Information Center at 919-684-5600.

Disabled
If you or your spouse are disabled, under age 65, and have been entitled to Social Security disability benefits for 24 months, you are eligible for Medicare coverage. You must 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 above.

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 30 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 became 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 Disabled section.

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 co-payments 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 not 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 pursuant to this Section I.B1 of this Part One permanently loses 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 (or his/her legal guardian if he/she is 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. Extended coverage for disabled dependents terminates with the death or remarriage of the spouse or age 26, whichever comes first.

Continuation of Coverage
For more information concerning COBRA continuation rights, please consult the section, 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 at the Human Resources Information Center (HRIC). 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 request 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, he reasons for upholding the disputed determination; c) reference to the Plan provisions on which the Plan Administrator based on his or her decision made by the Plan Administrator, in whole or in part, to the Staff Fringe Benefits Committee.

Time Table for Eligibility Review Decisions
Generally, the eligibility review decisions are made with 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 180 days.

Health Program and Duke Long Term Disability Plan
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 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, there is no reinstatement.
- There must not be a break in coverage under the disabled individual’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 date coverage ended to 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 prior to coverage under Duke Plus.
- When a family member is removed from coverage, they may not re-enroll.
- Once eligible for Medicare, the individual must notify Benefits and immediately enroll in Medicare A and B. Those who do not enroll in Medicare 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 is 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 Medicare becomes primary for them or a family member.
- 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 wage 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 it effective for coverage the first of the month after the date of employment or eligibility.

Different contributions rates are applied for the different coverage categories. A copy of the current contribution schedules for the four health care plans is available from the HRIC or on the web at www.hr.duke.edu/benefits. Your contributions are paid on a before-tax basis where permitted under Federal and State law. Postdoctoral scholars 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 coverage or a birth, marriage, adoption, or placement for adoption. See HIPAA Special Enrollment section for more information.

Grandfathered Status
The Duke Health Plans are a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Duke Human Resources at 919-684-5600. You may also contact Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Lifetime Limits
The lifetime limit on the dollar value of benefits under Duke Health Plans no longer applies.

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 new-born 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
- Prostheses and physical complications of all stages of the mastectomy including lymphedemas.

The benefits described above are subject to the same co-payment or co-insurance 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 or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan. Once it is determined that your 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 current as of April 16, 2010. You should contact your State for further information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
//dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHIP+) Health First Colorado
https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center:
FLORIDA – Medicaid
http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid Healthy Indiana Plan for low-income adults 19-64
http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid
http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

KANSAS – Medicaid
http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
http://dhhs.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
http://www.maine.gov/dhhs/ofi/publicassistance/inde x.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
http://www.mass.gov/eohhs/gov/departments/m asshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
http://mn.gov/dhs/people-weserve/seniors/health-care/health-careprograms/programs-and-services/medicalassistance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.html
Phone: 573-751-2005

MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
https://dwss.nv.gov/Medicaid
Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075
To see if any more States have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, you can contact either the U.S. Department of Labor Employee Benefits Security Administration at www.dol.gov/ebsa (1-866-444-3272) or the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services at www.cms.hhs.gov (1-877-267-2323, ext. 61565).

Qualified Medical Child Support Orders
A copy of the procedure can be obtained without charge from the Plan Administrator. Contact the Plan Administrator:

Health Care Plan Administrator
Duke Benefits
705 Broad Street
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 right 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 covered dependent recovers any amount of money from the third person or organization.

The plan’s right 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 Options

Duke Select, Duke Basic, and Blue Care HMO

You can choose among four 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, or
- Duke Options PPO (Preferred Provider Organization).

Duke offers three HMOs: Duke Select and Duke Basic (administered by Aetna), and Blue Care (administered by Blue Cross Blue Shield 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 co-pay—for most services when you visit a network provider. Routine, preventive services such as annual physicals, OB/GYN exams, immunizations, and well-baby visits are covered under these plans.

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 or urgent care provider. Routine, preventative services such as annual physicals, OB/GYN exams, immunizations, and well-baby visits are covered under these plans.

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 a 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.

* Please note: If your spouse has an HSA, you are not eligible for this sum as a pre-tax benefit.

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 or Blue Care service area should purchase additional health insurance coverage for non-emergent care services. 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, and emergency care elsewhere.

See also the Business Travel Assistance section of Summary Plan Description for additional information about coverage when traveling on Duke business.

Duke Options PPO

Duke offers you Duke Options PPO (administered by Blue Cross Blue Shield of NC). The plan also 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 travels often or lives elsewhere, you may want to consider this plan. 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, preventative services such as annual physicals, OB/GYN exams, immunizations, and well baby visits are covered with network providers under this plan.

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,” “Duke Options, Member Guide,” and “Blue Care, Member Guide.” A copy of the member document is available on the Duke HR web site (hr.duke.edu).
How to File a Claim

Medical Claims and Claims Review Procedures for the Plan
The medical claims and claims review procedures for Duke Select, Duke Basic, Duke Options, and Blue Care are described in the member schedule of benefits. Please see the Pharmacy and Mental Health Appeals Review in this portion of the Summary Plan Description for information related to pharmacy and mental/behavioral health 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.

However, Blue Cross Blue Shield of NC has been designated by the plan to hear and decide all appeals for medical claims under Blue Care and Duke options.

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:

- Information about COBRA continuation coverage, and
- Administration and other general information about this plan
Pharmacy Benefits

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, Duke Options, and Blue Care 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, Duke Options, and Blue Care 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 that injectable fertility drugs are not reimbursed according to the standard pharmacy benefit copayment. They are covered by Duke Select and Duke Options at 50% for those employees or their spouse with at least two years of service with Duke and only if treatment is received at Duke Fertility.

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 South, Duke Cancer Center, Duke Plaza Pharmacy, Student Health, or Duke Children’s Hospital—if you’re taking 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, Acredo. Specialty drugs which are needed immediately may be purchased at any retail pharmacy.

With the home delivery pharmacy:
Employees may purchase three months of maintenance drugs at the standard co-pay. 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 www.expressscripts.com or phone in your order toll-free to (800) 717-6575,
- Telephone consultations with a registered pharmacist are available around the clock by calling (800) 717 6575, and
- You can use e EasyRxSM to make ordering new or refill prescriptions simple. Just follow the steps on the next page.

Easy RxSM-the simple way to use the home delivery pharmacy.
1. Ordering new prescriptions
Ask your doctor to prescribe your medicine for a 90-
day supply plus refills, if appropriate. Mail your
prescription, required co-pay, and order form in the
envelope provided. Or ask your doctor to call (888)
EASYRX1 (888-327-9791) for instructions on how
to fax the prescription. Your doctor may also e-
prescribe, and you can call in your credit card
number. You will need to give your doctor your ID
number. 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, get a
paper prescription and mail in when desired.

2. Refilling your medication
A few simple precautions will help ensure you don’t
run out of your prescription. Remember to reorder
on or after the refill date indicated on the refill slip
or on your medication container. Or reorder when
you have fewer than 14 days of medication left.

Refills online: Log on to the web site at
www.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: Call (800) 4REFILL (800 473-
3455) to use the automated refill system. 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 co-pay to:
Express Scripts Rx Services
P.O. Box 650322
Dallas, TX 75265-9946

3. Delivery of Medication
Prescription orders receive prompt attention and,
after processing, are usually sent by U.S. mail or UPS
in about a 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.

4. Paying for your Medication
You may pay by check, money order WageWorks
Debit Card, VISA, Mastercard, Discover/NOVUS,
American Express, or Diners Club. If you prefer to
pay for all orders by credit card, you may join the
automated payment plan by calling (800) 948-8779.

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.
What Drugs Are 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)

What Drugs Are Not Covered?

- Compounded drugs
- Anorexiants (drugs for weight reduction) including Lonamin®, Pondimin®, Redux®, Meridia®, Xenical®, Qsymia
- 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® (for 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 the Duke Division of Reproductive Endocrinology when covered under Duke Options or Duke Select, and receiving services from 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 provider for himself/herself or his/her immediate family

In addition, the drugs on the following page have been excluded from coverage. This list is current as of August 2017. Changes may have occurred since this date. Please check the website, http://www.bcps.org/offices/benefits/pdf/Express-Scripts-Formulary_Pocket.pdf
The excluded medications shown below are not covered on the Duke pharmacy benefit. In most cases, if you fill a prescription for one of these drugs, you will pay the full retail price.

**Take action to avoid paying full price.** If you’re currently using one of the excluded medications, please ask your doctor to consider writing you a new prescription for one of the following preferred alternatives. Additional covered alternatives may be available. Costs for covered alternatives may vary. Log on to express-scripts.com/covered to compare drug prices. Check your benefit materials for the specific drugs covered and the copayments for your plan. For specific questions about your coverage, please call the number on your member ID card. Express Scripts manages your prescription plan for your employer, plan sponsor, health plan, or benefit fund. These changes do not apply to Medicare plans.

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Excluded Medications</th>
<th>Preferred Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomic &amp; Central Nervous System</td>
<td>Sumavel Dosepro</td>
<td>sumatriptan injection</td>
</tr>
<tr>
<td>Anti-Migraine Therapy</td>
<td>Emflaza</td>
<td>Prednisone solution, prednisone tablets</td>
</tr>
<tr>
<td></td>
<td>Exondys 51</td>
<td>No alternatives recommended</td>
</tr>
<tr>
<td>Duchenne Muscular Dystrophy DMD Agents</td>
<td>Opana ER, Oxycodone ER</td>
<td>hydromorphone ER, morphine sulfate ER, oxymorphone ER, Hysingla ER, Nucynta ER, Oxycontin</td>
</tr>
<tr>
<td>Long-Acting Opioid Oral Analgesics</td>
<td>Buprenorphine Patches, Butrans</td>
<td>fentanyl patches, hydromorphone ER, morphine sulfate ER, oxymorphone ER, Hysingla ER, Nucynta ER, Oxycontin</td>
</tr>
<tr>
<td>Narcotic Analgesics</td>
<td>Evzio</td>
<td>naxolone syringe, Narcan Nasal Spray</td>
</tr>
<tr>
<td>Transmucosal Fentanyl Analgesics</td>
<td>Abstral, Fentora, Lazanda</td>
<td>fentanyl citrate lozenges</td>
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<tr>
<td>Dermatological</td>
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<tr>
<td>Oral Agents for Rosacea</td>
<td>doxycycline 40 mg. capsules</td>
<td>Oracea</td>
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<tr>
<td>Topical Acne/Antibiotic Combinations</td>
<td>Aktipak, Veltin</td>
<td>cindamycin/benzoyl peroxide, clindamycin tretinoin, erythromycin/bezoyl peroxide, Acanya, Onexion</td>
</tr>
<tr>
<td>Topical Agents for Actinic Keratosis</td>
<td>Fluorouracil 0.5% cream, Zyclara</td>
<td>diclofenac 3% gel, fluorouracil 2% solution, fluorouracil 5% cream, imiquimod 5% cream, Caraex, Picato</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug Class</td>
<td>Excluded Medications</td>
<td>Preferred Alternatives</td>
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<tr>
<td>Blood Glucose Meters &amp; Test Strips</td>
<td>Abbott (Freestyle Precision), Bayer (Breeze Contour), National Medical (Advocate), Omnis Health (Embrace, Victory), Roche (Accu-Chek), Trividia (TRUEtest, TRUEtrack), Unistrip</td>
<td>LifeScan (OneTouch)</td>
</tr>
<tr>
<td>Dipeptidyl Peptidase-4 Inhibitors &amp; Combinations</td>
<td>alogliptin, Nesina Onglyza, alogliptin/metformin, Kazano, Kombiglyze XR</td>
<td>Januvia, Tradjenta, Janumet, Janument XR, Jentadueto, Jentadueto XR</td>
</tr>
<tr>
<td>Metformin Extended Release Products</td>
<td>Glumetza, Fortamet and their metformin ER generics</td>
<td>Metformin ER (generic for Glucophage XR)</td>
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<tr>
<td>Glucagon-like Peptptide-1 Agonists</td>
<td>Adlyxin, Tanzeum, Victoza</td>
<td>Bydureon, Byetta, Trulicity</td>
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<tr>
<td>Insulins</td>
<td>Novolin</td>
<td>Humulin</td>
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<tr>
<td></td>
<td>Apidra, Novolog</td>
<td>Humalog</td>
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<tr>
<td>Ear/Nose</td>
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<tr>
<td>Nasal Steroids</td>
<td>Beconase AQ, Omnaris, Zetonna</td>
<td>Budesonide, Flunisolide, Fluticasone, Mometasone, Qnasl</td>
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<tr>
<td>Otic Fluoroquinolone Antibiotics</td>
<td>Cetraxal</td>
<td>Ciprofloxacin ear solution, Ofloxacin ear solution, Ciprodex, Otovel</td>
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<tr>
<td>Endocrine (Other)</td>
<td></td>
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<tr>
<td>Estrogen and Estrogen Modifiers for Vaginal Symptoms</td>
<td>Fermring</td>
<td>Estradiol patches, Estradiol tablets, Vuvafem, Estrace cream, Estring, Permarin cream, Premarin tablets,</td>
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<tr>
<td>Growth Hormones</td>
<td>Nutropin AQ, Nuspin, Omnitrope, Saizen, SaizenPrep, Zomacton</td>
<td>Genotropin, Humatrope, Norditropin</td>
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<tr>
<td>Somostatin Analogs</td>
<td>Sandostatin LAR Depot, Signifor LAR</td>
<td>Somuatuline Depot</td>
</tr>
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<td>Topical Estrogen Gels</td>
<td>Estrogel</td>
<td>Divigel</td>
</tr>
<tr>
<td>Topical Testosterone Products</td>
<td>Fortesta, Natesto, Testim, Testosterone Gel, Vogelxo</td>
<td>AndroGel 1.62%</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
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</tr>
<tr>
<td>Inflammatory Bowel Agents</td>
<td>Asacol HD, Delzicol, Dipentum, Mesalamine 800g delayed release</td>
<td>Balsalazide disodium, Mesalamine 1.2mg delayed release, Sulfasalazine, Apriso, Pentasa</td>
</tr>
<tr>
<td>Irritable Bowel Syndrome and Chronic Constipation Agents</td>
<td>Trulance</td>
<td>Amitiza, Linzess</td>
</tr>
<tr>
<td>Drug Class</td>
<td>Excluded Medications</td>
<td>Preferred Alternatives</td>
</tr>
<tr>
<td>----------------------------------------------</td>
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<td>----------------------------------------------------</td>
</tr>
<tr>
<td>Pancreatic Enzymes</td>
<td>Pancreaze, Pertzye, Ultresa</td>
<td>Creon, Zenpep</td>
</tr>
<tr>
<td>Erythropoiesis-</td>
<td>Aranesp, Epogen, Mircera</td>
<td>Procrit</td>
</tr>
<tr>
<td>Stimulating Agents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Granulocyte Colony</td>
<td>Neupogen</td>
<td>Granix, Zarxio</td>
</tr>
<tr>
<td>Stimulating Factors</td>
<td></td>
<td></td>
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<tr>
<td>Hematopoiesis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td>Daklinza, Olysio, Sovaldi, Zepatier</td>
<td>Epclusa, Harvoni, Mavyret, Technivie, Viekira Pak, Viekira XR, Vosevi</td>
</tr>
<tr>
<td>Musculoskeletal &amp;</td>
<td></td>
<td></td>
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<tr>
<td>Rheumatology</td>
<td></td>
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</tr>
<tr>
<td>Gout Therapy</td>
<td>Colchicine</td>
<td>Colcrys, Mitigare</td>
</tr>
<tr>
<td>Osteoporosis Therapy</td>
<td>Forteo</td>
<td>Tymlos</td>
</tr>
<tr>
<td>Obstetrical &amp; Gynecological</td>
<td></td>
<td></td>
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<tr>
<td>Gonadotropin-Releasing</td>
<td>Ganirelix Acetate</td>
<td>Cetrotide</td>
</tr>
<tr>
<td>Hormone (GnRH) Antagonists (for infertility)</td>
<td></td>
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<tr>
<td>Ovulatory Stimulants</td>
<td>Bravelle, Follistim AQ</td>
<td>Gonal-f, Gonal-f RFF, Gonal-f RFF Redirect</td>
</tr>
<tr>
<td>(Follitropins)</td>
<td></td>
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<tr>
<td>Vaginal Progesterones</td>
<td>Endometrin</td>
<td>Crinone 8% Gel</td>
</tr>
<tr>
<td>Ophthalmic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-glaucoma Drugs (Beta-Adrenergic Blockers)</td>
<td>Istalol, Timoptic Ocudose</td>
<td>betaxolol drops, levobunolol drops, timolol drops, Alphagan P 0.1%, Combigan</td>
</tr>
<tr>
<td>Anti-glaucoma Drugs (Ophthalmic Prostaglandins)</td>
<td>Zipotan</td>
<td>bimatoprost drops, latanoprost drops, Lumigan, Travatan Z</td>
</tr>
<tr>
<td>Ophthalmic Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)</td>
<td>Acuvail, Nevanac</td>
<td>bromfenac drops, diclofenac drops, ketorolac drops, Ilevro, Prolensa</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyaluronic Acid Derivatives</td>
<td>Gel-One, Gelsyn-3, Genvisc 850, Hylagan, Hymovis, Supartz, Supartz FX, Synvisc,</td>
<td>Euflexxa, Monovisc, Orthovisc</td>
</tr>
</tbody>
</table>


### Drug Class Excluded Medications Preferred Alternatives

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Excluded Medications</th>
<th>Preferred Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renal Disease</td>
<td>Synvisc-One</td>
<td>Fosrenol, Renagel, sevelamer carbonate, Phoslyra, Renvela tablets, Velphoro</td>
</tr>
<tr>
<td>Phosphate Binders</td>
<td>Auvi-Q, Epinephrine Auto-Injector (by A-S Medication, Impax, and Lineage)</td>
<td>ArmonAir RespiClick, Arnuity Elipta, Asmanex HFA/Twisthaler, Flovent Diskus/HFA, Pulmicort, Flexhaler QVAR</td>
</tr>
<tr>
<td>Pulmonary Anti-Inflammatory Inhalers</td>
<td>Alvesco</td>
<td>Levalbuterol HFA, Proventil HFA, Xopenex HFA, ProAir HFA, RespiClick, Ventolin HFA</td>
</tr>
</tbody>
</table>

### Indication Based Management

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Non-preferred Medications</th>
<th>Preferred Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inflammatory Conditions*</td>
<td>All other Brand Name medications for Inflammatory Conditions* are Non-preferred. Approval may be granted following a coverage review. A trial of one or more Preferred medications is required prior to initiating therapy with a Non-preferred medication. Formulary exception may be granted for patients already established on therapy with a Non-preferred medication.</td>
<td>Actemra, Cosentyx, Enbrel, Humira, Otezla, Remicade, Simponi 100mg, (for ulcerative colitis only), Stelara SC, Xeljanz, Xeljanz XR</td>
</tr>
</tbody>
</table>

### Retail Network Pharmacy Program

**For your immediate prescription drug needs.**

If you use a participating retail network pharmacy:
- Simply present your prescription drug ID card and prescription(s) at the pharmacy. The system will confirm your eligibility for benefits, and you will be told the copay/deductible you are required to pay.
- You do not have to file a claim form for prescriptions filled at a participating retail network pharmacy.

**Finding a participating retail network pharmacy:**
To find the participating retail network pharmacies nearest you, visit the web site at [www.express-scripts.com](http://www.express-scripts.com) and use the interactive pharmacy locator. Or, 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.
- You will usually be reimbursed within 21 days of submitting your claim form. You will be reimbursed the discounted amount that would have been charged by a participating pharmacy, less the required co-pay.

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 www.express-scripts.com or call Member Services at (800) 717-6575 to use the automated ordering system.

Other Important Features

Your program is designed to provide the care and service you expect, whether it’s keeping a record of your medication history, providing toll-free access to a registered pharmacist, or keeping you in touch with any changes to your program.

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 plans benefit programs. Express Scripts has a strong commitment to your privacy. Those are established effective administrative and technical safeguards 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 Services mail service pharmacies, the pharmacists use the health and prescription information you provide 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: 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. The 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 like drug interactions and possible side effects with every new prescription through the mail. By visiting www.express-scripts.com, you also can access other health-related information. Click on one of the links under “Health & Wellness” to browse health and wellness brochures, to get safety tips and answers to the most commonly-asked medication questions, or to just keep up with timely health issues. Written information cannot replace the expertise and advice of health care practitioners who have direct contact with a patient. All Express Scripts health information is designed to educate you and help you communicate more effectively with your doctor.

Health Management

Based on your prescription and health information, you may be invited to participate in one or more health management programs, provided as a service to you by your employer or health care provider. 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 our pharmacists.

Generic Drugs

The brand name of a drug is the product name under which the drug is advertised and sold, and many brand-name medications have become well known through advertising. Generic medications are sold under often unfamiliar names, yet they must have the same active ingredients and are subject to the same rigid 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 please ask your doctor to prescribe generic drugs whenever appropriate.

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. If a generic drug is available but you receive the brand-name drug, you will pay the generic co-pay plus the difference between the costs of the two drugs, unless you utilize the mail service, which requires non-formulary co-pay for brand drugs when a generic is available.

The Natural 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.

Visit our web site at www.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. Ask your doctor if you have any questions about a change in prescription. Only the medication authorized by your doctor can be dispensed.

Managed Rx Coverage/Prior Authorization
Your prescription drug program provides coverage for some drugs 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, 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 “step up” to pay for more expensive alternatives. 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.

Express Scripts, a national pharmacy benefit manager, provides pharmacy benefits for all four medical plans. Co-pays 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.

Co-pay & 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 co-pay structure. The $100 deductible applies to short-term drugs purchased at the Duke on-site pharmacies. The deductible is waived only for long-term drugs. There is no deductible for generic drugs (except for Duke Basic).

The retail co-pay structure for short-term medications and controlled substances is listed below:

- Generic – $15 or cost of the drug if less than $15 (no deductible)
- 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 on-site Duke Pharmacies (Duke Clinic, Duke Cancer Center, Duke Children’s Health Center, Student Health, and Duke Plaza Pharmacy). Reasons to consider using the mail order pharmacy or participating on-site Duke Pharmacies include reduced co-pays and a waiving of the $100 deductible for brand and non-formulary maintenance drugs. (See chart on page 28 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.

*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 on-site Duke Pharmacies after the third purchase of a long-term medication.

Co-pay Structure for Express Scripts Mail Order Pharmacy or Participating On-Site 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 on-site Duke Pharmacies. 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 co-payment.

The Express Scripts Appeal Process

Express Scripts provides clinical coverage review services for members of the Duke Health Plans. 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 1-800-753-2851. Alternatively, the prescriber may submit a completed coverage review form by fax to 1-877-329-3760. Forms can be obtained online at www.express-scripts.com/services/physicians/. 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 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 situation is urgent, the expedited review must be requested by the provider by phone at 1-800-753-2851.

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
- 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: 1-800-935-6103, Fax: 1-877-852-4070.

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.

Contacts
Express Scripts
www.express-scripts.com
Member Services at (800) 717-6575
(TTY 800-759-1089).

www.express-scripts.com
Member Services at (800) 717-6575
(TTY 800-759-1089).

24 hours a day, seven days a week.
Visit the web site 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 Rx Selections™ Formulary, or find a participating retail pharmacy near you.
# Pharmacy Benefits Comparison Chart

<table>
<thead>
<tr>
<th></th>
<th>At a Participating Retail Pharmacy</th>
<th>Through the Express Scripts Mail Order Pharmacy or Participating On Site Duke Pharmacies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Up to a 34-day supply</strong></td>
<td><strong>90-day supply</strong></td>
</tr>
<tr>
<td></td>
<td><strong>First three purchases of any medication</strong></td>
<td><strong>After the third purchase of a long term medication</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Anytime</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Generic</strong></td>
<td>$15</td>
<td>$25</td>
</tr>
<tr>
<td>(No deductible except for participants covered by Duke Basic)</td>
<td>(or cost of drug if less)</td>
<td>(or cost of drug if less)</td>
</tr>
<tr>
<td></td>
<td>$50</td>
<td>$130</td>
</tr>
<tr>
<td><strong>Brand</strong></td>
<td>$70</td>
<td>$180</td>
</tr>
<tr>
<td>($100 per person retail deductible applies. No deductible for 90 day supply through mail order or Duke pharmacies, except for Duke Basic participants)*</td>
<td>$50(^{\dagger}) min. $70, max. $165</td>
<td>$100(^{\dagger}) min. $85, max. $180</td>
</tr>
<tr>
<td><strong>Non-formulary</strong></td>
<td>$70</td>
<td>$180</td>
</tr>
<tr>
<td>($100 per person retail deductible applies. No deductible for 90-day supply through mail order or Duke Pharmacies, except for Duke Basic participants.)*</td>
<td>$50(^{\dagger}) min. $85, max. $180</td>
<td>$100(^{\dagger}) min. $85, max. $180</td>
</tr>
</tbody>
</table>

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

\(^{\dagger}\)The co-payment (50\% of the total cost of the medication) will also be subject to the following minimum and maximum co-payments. 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 $200 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.
Pharmacy Benefits

Q. Why should I use the home delivery pharmacy?
A. When you use the home delivery pharmacy for your long-term medications, you save money because you can purchase up to a 90-day supply for a lower co-pay than you would pay if you purchased three 30-day supplies at your retail pharmacy. In addition to the cost savings, you enjoy the convenience of home delivery.

Q. How soon will I receive my home delivery prescription?
A. Orders are usually processed and mailed within 48 hours of receipt. Please allow 7-11 days from the day you mailed your prescription for delivery. To check the status of your refill orders, visit www.express-scripts.com or call Member Services at (800) 717-6575 and use the automated system. You’ll need to provide your member ID number and the 12-digit prescription number found on the refill slip or on the medication container.

Q. I sent in a prescription to the home delivery pharmacy for a 30-day supply with 11 refills and I was charged the 90-day co-pay. Why is this the case?
A. The home delivery pharmacy only charges three different co-pays — so review your prescription prior to sending it in and make sure it is for a 90-day supply with three refills. Express Scripts must dispense the quantity listed on the prescription.

Q. How do I order additional home delivery order forms or claim forms?
A. Order online at www.express-scripts.com or call Member Services at (800) 717-6575 to use the automated system. We mail your requested materials to you right away.

Q. What if I send the wrong co-pay amount?
A. If there is a balance due, an invoice will be included with your prescription order. If you overpaid, your account will be credited.

Q. My child is diabetic and on insulin. How that is kept safe in the mail?
A. Refrigerated medications are placed in special insulated packages with gel packs designed to maintain the correct temperature. The packaging is designed to keep these prescriptions within the proper temperature range throughout the day of delivery. For medications that require a higher degree of special handling, Express Scripts may also call you to arrange a convenient delivery time.

Q. How do I find a participating retail network pharmacy?
A. Visit www.express-scripts.com or call Member Services toll-free at (800) 717-6575. You will be asked for your member ID number and the area in which you want to find a pharmacy.

Q. Does Express Scripts sell my individually identifiable information to people outside Express Scripts?
A. Express Scripts does not sell individually identifiable information or lists of their members and their covered dependents to outside companies.

Q. Do I have to participate in the health management programs?
A. Your participation in the health management programs is completely voluntary. You can choose not to participate, or you can discontinue participation at any time.

Q. Will I get an identification card?
A. Yes. Duke employees and retirees with individual coverage will receive one card. Employees and retirees with family coverage will receive two identification cards. If you need additional cards, you can order them online at www.express-scripts.com or by calling Member Services at (800) 717-6575.

Q. Who do I call if I have questions?
A. If you have questions about your eligibility or your dependents’ eligibility for this plan, you can call Duke University’s Human Resource Information Center (HRIC) at (919) 684-5600 or send an e-mail to benefits@duke.edu.
If you have questions about specific drugs, claims you have filed, co-pays, the Rx Selections™ Formulary, or home delivery orders, call Express Scripts at (800) 717-6575 (TTY 800-759-1089).

Q. My child is on a controlled substance maintenance medication. What will I need to do?
A. All controlled substances must be filled at a retail pharmacy. The annual $100 deductible and just the regular co-pay will apply.

Special Services

We continually strive to meet people’s special needs;

- You can call a registered pharmacist at any time for consultations at the Member Services telephone number,
- Visually impaired members can request that their mail service prescriptions include labels in braille by calling Member Services, and
- This brochure will be made available in alternative formats, such as braille, large print, or audio cassette, upon request. For information call (800) 717-6575.
Mental Health and Substance Abuse Benefits

Duke Select, Duke Basic, Duke Options, and Blue Care are self-insured plans providing the mental health and substance abuse benefits coverage described in this document to certain eligible employees of Duke University and Duke University Health System and their eligible dependents.

Your mental health and substance abuse benefits for Duke Select, Duke Basic, Duke Options, and Blue Care are administered through Cigna Behavioral Health.

This document describes the benefits available including limitations and exclusions, as well as the rules, conditions, and payment requirements a plan member must satisfy in order to use his or her benefits.

Amendment and Termination of the Plan
Duke Select, Duke Basic, Duke Options, and Blue Care are welfare benefit plans. Duke expects to continue the plans indefinitely, but reserves the right to terminate the plans or to change terms and benefits of the plans at any time in the future. Duke has the right to cancel your coverage.
### Mental Health and Substance Abuse Comparison Chart

<table>
<thead>
<tr>
<th></th>
<th>Duke Select (HMO)</th>
<th>Duke Basic (HMO)</th>
<th>Duke Options (Blue Cross Blue Shield PPO)</th>
<th>Blue Care (Blue Cross Blue Shield HMO)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Cigna Behavioral Health</td>
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<tr>
<td>In-Network</td>
<td>▪ Covered in full after $20 co-pay per visit for individual/family therapy ($25 for Duke Basic)</td>
<td>▪ After $650 annual deductible, plan pays 70% of allowable charge</td>
<td>▪ Limit of 20 visits per calendar year for Duke Select, Duke Basic, Blue Care</td>
<td>▪ Precertification required for psychological testing, electroshock therapy, hypnosis</td>
</tr>
<tr>
<td></td>
<td>▪ Precertification required for psychological testing, electroshock therapy, hypnosis</td>
<td>▪ Limit of 20 visits per calendar year for Duke Select, Duke Basic, Blue Care</td>
<td>▪ Precertification required for psychological testing, electroshock therapy, hypnosis</td>
<td>▪ Limit of 20 visits per calendar year for Duke Select, Duke Basic, and Blue Care</td>
</tr>
<tr>
<td></td>
<td>▪ Must be pre-certified prior to admission</td>
<td>▪ Must be pre-certified prior to admission</td>
<td>▪ Must be pre-certified prior to admission</td>
<td>▪ For Duke Options, the out-of-network deductible and co-insurance maximum will be consolidated with medical claims</td>
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<tr>
<td>Inpatient</td>
<td>▪ Co-pay of $600 per admission</td>
<td>▪ After $900 per admission co-pay and deductible, plan pays 70% of allowable charge</td>
<td>▪ Limit of 20 days per calendar year for Duke Select, Duke Basic, and Blue Care</td>
<td>▪ For Duke Options, the out-of-network deductible and co-insurance maximum will be consolidated with medical claims</td>
</tr>
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</table>

$600 per admission co-pay for Duke Facility; $700 for all other in-network admissions.
Cigna Behavioral Health Benefits

In-Network Benefits

Before Treatment Takes Place
To access in-network benefits, you can call Cigna Behavioral Health for network provider referrals before receiving any type of psychiatric or substance abuse treatment. Network referrals also can be obtained from Duke’s Personal Assistance Service (PAS) at (919) 416-1727.

If you face a life-threatening situation, call your local emergency number or go to a hospital emergency room. Then call Cigna Behavioral Health within 48 hours or on the next business day. The hospital usually will make this call for you.
1. Before beginning treatment, call Cigna Behavioral Health at (888) 253-8552 to locate an appropriate provider.
2. Use a Cigna Behavioral Health authorized provider or you may obtain a referral from PAS.
3. Before beginning inpatient or outpatient treatment that requires a precertification such as psychological testing, electroshock therapy, biofeedback, and hypnosis call Cigna Behavioral Health at (888) 253-8552.
4. Cigna Behavioral Health network providers may charge you only the amount of your co-pay and are required to submit the claims for you.

In-Network Substance Abuse Treatment
The plan approves a substance abuse rehabilitation and recovery program which:
• Is a Cigna Behavioral Health-approved substance abuse program with physician supervision;
• Involves individual and group therapy, as well as attendance at meetings of organizations specializing in the therapeutic treatment of alcohol or substance abuse/dependency. The patient must attend these meetings as prescribed in the patient’s aftercare treatment plan;
• Is provided by a Cigna Behavioral Health-approved facility or provider.

The following types of substance abuse treatment are not covered and benefits won’t be paid:
• Substance abuse detoxification treatments that are not followed by a completed clinically appropriate and Cigna Behavioral Health approved program of therapy directed toward rehabilitation; and
• Maintenance care, which provides an environment without access to alcohol or drugs but does not include a rehabilitation component.

Out-of-Network Benefits

Before Treatment Takes Place
To access out-of-network benefits, you can schedule a visit with any eligible provider for any type of psychiatric or substance abuse treatment. (See the section for eligible Behavioral Health provider information on page 34.) Referrals also can be obtained from Duke’s Personal Assistance Service (PAS).

If you face a life-threatening situation, call your local emergency number or go to a hospital emergency room. Then call Cigna Behavioral Health within 48 hours or on the next business day. The hospital will usually make this call for you.
1. Before beginning inpatient treatment or outpatient services requiring precertification, call Cigna Behavioral Health at (888) 253-8552.
2. Use any eligible provider, or you may obtain a referral from PAS.

For Your Information
For Duke Select, Duke Basic, Duke Options, and Blue Care, behavioral health benefits are administered by Cigna Behavioral Health. The same behavioral health benefits are available whether you are enrolled in the Duke Select, Duke Basic, or Blue Care health care plans. Duke Options has no limits on out-of-network care. When you need any type of behavioral health care — inpatient or out-patient — you can call a Cigna Behavioral Health clinical care manager at (888) 253-8552, 24 hours a day, seven days a week. Your clinical care manager will provide assessment, referral, and precertification services. All treatment must be provided by a mental health provider, licensed at the highest level available in North Carolina, and who has malpractice insurance, or at accredited treatment facilities. You also may obtain treatment from licensed mental health providers outside of the Cigna Behavioral Health network. Please see the section on out-of-network benefits for details.

3. Submit your claim to Cigna Behavioral Health. For members of Duke Select/Basic, claims for all services for which you are required to pay must be submitted within 180 days from the date services were rendered. Claim submissions beyond the 180
days will not be considered. Members of Blue Care or Duke Options have 18 months to submit claims.

Send claims forms to:

Cigna Behavioral Health
Attn: Claim Service
P.O. Box 188022
Chattanooga, TN 37422

Claims questions should be directed to:

(888) 253-8552
www.cignabehavioral.com
ID: Duke
PIN: employee

Out-of-Network Benefit Limits — Duke Select, Duke Basic, Blue Care

Each covered person’s benefits for inpatient and outpatient psychiatric and/or substance abuse treatment combined are limited to:

• Inpatient out-of-network treatment programs for psychiatric and/or substance abuse treatment limited to 20 days per calendar year; and
• Outpatient out-of-network treatment limited to 20 visits per year, including visits for psycho-logical testing.

Out-of-Network Benefits — Duke Options

Out-of-network inpatient and residential care must be pre-certified by Cigna.

Out-of-Network Substance Abuse Treatment

The plan approves substance abuse treatment which:

• Is provided by a licensed and accredited facility or provider; and
• Involves individual and group therapy, as well as attendance at meetings of organizations specializing in the therapeutic treatment of alcohol or substance abuse/dependency. The patient must attend these meetings as prescribed in the patient’s aftercare treatment plan.

The following types of substance abuse treatment are not covered and benefits will not be paid:

• Substance abuse detoxification treatments that are not followed by a completed clinically appropriate and Cigna Behavioral Health-approved program of therapy directed toward rehabilitation; and
• Maintenance care, which provides an environment without access to alcohol or drugs but does not include a rehabilitation component.

For questions about your mental health and substance abuse benefit plan or in-network provider list, contact Cigna Behavioral Health through either of the following:

• call: (888) 253-8552, or
• Log on to: hr.duke.edu/benefits/medical/mental/index.php to download claim forms.

Remember, you must use a Cigna Behavioral Health-approved provider to receive in-network benefits.

Medical/Behavioral Health Care Overlap

There are some instances where medical and behavioral health disorders may overlap. For instance, a suicide is attempted and the patient is admitted to a medical hospital, medically stabilized, and then transferred to a psychiatric unit. In this example, the Health Care Claims Administrator will process all claims incurred prior to the patient’s transfer to the psychiatrist unit, and Cigna Behavioral Health will process all claims incurred after the transfer.

Behavioral Health Providers

Under this plan, eligible providers of behavioral health services are defined as:

• Licensed psychiatrists;
• Licensed Doctor of Psychology (PhD, PsyD, EdD);
• Licensed neuropsychologists;
• Licensed master’s level clinical social workers;
• Licensed and certified advanced practice psychiatric nurse;
• Licensed master’s level professional counselors, which include pastoral counselors, licensed professional counselors, and marriage and family therapists recognized in the state of North Carolina; and
• Certified MD or DO Addictionologists.

Alternatives to Inpatient Care

Treatment alternatives to inpatient care for mental health and substance abuse are often available on an intensive outpatient basis or in partial hospitalization day or evening programs. Cigna Behavioral Health will make treatment recommendations after reviewing each patient’s clinical needs; all care must be pre-certified and authorized by Cigna Behavioral Health to qualify for benefits.
Claims and Appeals Procedures for Cigna Behavioral Health

Claims for Benefits and Deadlines for Filing a Claim. All claims must be filed within six months (180 days) of the date incurred for those enrolled in Duke Select and Duke Basic. Blue Care and Duke Options members have 18 months. There are no claim forms to complete when you receive services from in-network providers. Claim forms only are required when services are provided by out-of-network providers. On those occasions when you do need to file a claim, the proper claim form should be filed with Cigna Behavioral Health. Please call Cigna Behavioral Health at (888) 253-8552 with questions or to request a claim form, or download a form from www.cignabehavioral.com.

Claims for Mental Health Benefits. You or the provider must file the claim directly with Cigna Behavioral Health by submitting a claim on the specified claim form. All claims must be filed within six months (180 days) of the date incurred for those enrolled in Duke Select or Duke Basic. Blue Care and Duke Options members have 18 months. Payment by the plan will be made directly to you when you have filed for out-of-network benefits or to the provider when the provider has filed for in-network benefits. If the claim is denied in whole or in part, you may submit a written request within 180 days of the denial date for review along with any supporting documentation to:

Cigna Behavioral Health
P.O. Box 46270
Eden Prairie, MN 55344

Clinical Appeals Process
The CBH appeals process follows the standards of the American Accreditation HealthCare Commission (AAHCC—formerly URAC) and National Committee on Quality Assurance (NCQA). Our philosophy is that an appeals review is essentially a clinical discussion between peers. During the process, we strive to maximize the impartiality of our appeals reviewer. We have detailed each step of our appeals process:

1

First Step
Call Cigna Behavioral Health using the phone number on your ID card or benefit brochure, and speak to a representative if you have a complaint or question about the following:

- Denial of mental health or substance abuse treatment claims
- Denial of mental health or substance abuse services
- Quality of care with CBH participating providers

Whenever you take a step in the appeal process outlined here, Cigna Behavioral Health will send you a letter containing instructions for the next step. Be sure to retain this letter for your reference.

Response Timeframe:
Varies according to level of appeal. See the following steps.

2

Peer-to-Peer Review
If you or your provider are not satisfied with the results of the Clinical Review Process—the process that determines treatment based on a combination of your provider’s recommendation and Cigna’s care guidelines—either of you may contact the Care Manager (an employee of Cigna holding a degree in psychology, human services or a related field who acts as a consultant for your provider). He or she will organize a peer-to-peer review, in which your case will be discussed between your provider and another clinician who has the same licensure.

If this does not resolve your concern, Cigna Behavioral Health will, when appropriate, contact you or your provider, offering an expedited 1st level appeal by phone. If an expedited appeal is not appropriate, a standard 1st level appeal will be offered.

You or your provider can request a standard 1st level appeal within no more than 365 days of your verbal request.

Response Timeframe:
- Inpatient peer-to-peer reviews will be scheduled within 24 hours.
- Outpatient peer-to-peer reviews will be scheduled within 5 business days.

3

1st Level Appeal
In this process, another clinician holding the same licensure as your provider will independently review your case. If his or her determination for treatment is not satisfactory to you, Cigna Behavioral Health will communicate by phone and in writing with you or
your provider (whoever has requested the appeal), providing instructions for initiating a 2nd level appeal. You are responsible for the release of your medical records for this process to take place.

At the end of each level of appeal, a written notification of the final outcome and resolution, including the clinical explanation for treatment, will be sent to you, your provider, or facility.

**Response Timeframe:**
- Standard appeals will be completed within 15 calendar days if you are still in treatment, and 30 days if you have ended treatment.
- Expedited appeals will be completed within 24 hours of the receipt of the request.

## 4

### 2nd Level Appeal

Cigna Behavioral Health’s Formal Appeals Committee reviews all 2nd level appeals at your written request only. The Committee reviews for medical necessity and coverage under your benefit plan. This committee is comprised of medical management, risk management, account management, claims/customer service and your appeals advocate—a Cigna employee who assures that you have access to all your legal rights of appeal. At this level of appeal, you and your provider have the right to participate by phone in the review process.

If you are not satisfied with the decision reached by the Formal Appeals Committee, you may be eligible for a final level appeal as outlined in the response letter you will receive.

**Response Timeframe:**
- Hearings occur within 30 days of the 2nd level appeal request.
- Standard appeals will be completed within 15 calendar days if you are in treatment or waiting for admission to treatment, and 30 days if you have finished treatment.
- Expedited appeals will be completed within 24 hours of the receipt of the appeal.

---

### For Cigna Behavioral Health Voluntary Appeals

#### 1. Filing the Appeal

Appeals to the Staff Fringe Benefits Committee (the Committee) must be submitted in writing to Duke, addressed to the attention of the Committee, within 60 days of receiving notice of the 2nd level appeal decision you wish to further appeal or, if you did not receive notice of the decision within the applicable time-frame, within 60 days of the date on which the applicable time-frame elapsed. Such appeals should specifically identify the decision being appealed, and those aspects of the decision that are being disputed.

Write the Committee at the following address:

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


The Committee will review the decision and issues identified in your written appeal. During this review process, you will have an opportunity to review certain documents, as required by the Employee Retirement Income Security Act of 1974 (ERISA), and to submit your written comments and any additional written information or materials in support of your appeal.

If the 2nd level appeal was denied by Cigna Behavioral Health based on a medical, the committee will consult with a health professional with appropriate training and experience in the pertinent field of medicine, and who is not a professional consulted during the prior determinations, or a subordinate of such professional.

The Committee shall provide you its decision in writing. If your appeal is denied in whole or in part, the Committee’s written decision shall set forth specific reasons written in a manner that is reasonably understandable, and shall cite the plan provisions on which the decision is based. The decision on appeal by the Committee shall be final and conclusive.

PLEASE NOTE: Neither you nor your representative has the right to be present during the consideration of any appeal from the initial denial.
3. Time Table for Committee’s Decisions.

Generally, the Committee will reach its decision within 45 days following receipt of an appeal, but in some cases special circumstances may exist which necessitate extending the time for the appeal 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 in most cases will be made within 45 additional days—that is within a total of 90 days.

Limited Right to Representation

Any action required or permitted to be taken by you regarding the claims process, requests for review of eligibility determinations, or appeals to the Committee 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.

Authority of Committee and Plan Administrator

Both the Committee and the Plan Administrator have the duty and discretionary authority to interpret and construe the provisions of the plan, subject to the terms of the plan and the procedures described on the previous page. Interpretations and determinations made by the Committee and the Plan Administrator will be applied consistently to all members similarly situated (with due regard for individual differences in circumstances) and will be binding and conclusive upon each member and any other interested person. Such interpretations and determinations made by the Committee or the Plan Administrator will be overruled only by a court of law if the Committee or the Plan Administrator, as the case may be, is found to have acted arbitrarily and capriciously in interpreting and construing the provisions of the plan.
Services That Are Not Covered

The following services are not covered under the mental health benefit:

- Accommodations, services, supplies, or other items determined as neither clinically nor medically necessary;
- Administrative psychiatric services when these are the only services rendered;
- Bioenergetics therapy;
- Carbon dioxide therapy;
- Chart review;
- Confrontation therapy;
- Consultation with a mental health professional for adjudication of marital, child support, and custody cases;
- Crystal healing treatment;
- Cult deprogramming;
- Eating disorder and gambling programs based solely on the 12-step model;
- Educational evaluation and therapy;
- EST (Erhard) or similar motivational services;
- Environmental ecology treatment
- Examinations or treatment exclusively required as part of legal proceedings if not medically necessary;
- Expressive therapies (art, poetry, movement, psychodrama) as separately bill services;
- Guided imagery;
- Hemodialysis for schizophrenia;
- Hyperbaric or normobaric oxygen therapy;
- Internet therapy;
- L-Tryptophan and vitamins, except thiamine injections on admissions for alcoholism or with diagnosis of nutritional deficiency
- Marathon therapy;
- Megavitamin therapy;
- Narcotherapy with LSD;
- Orthomolecular therapy;
- Prescription paid through prescription drug benefits;
- Primal therapy;
- Private duty nursing;
- Private rooms (except when required for injection control);
- Rolfing;
- Sedative action electrostimulation therapy;
- Speech therapy;
- Sensitivity training;
- Sex therapy;
- Supervision of clinical treatment practitioners or team;
- Telephone therapy (does not include video visit with an In-Network provider)
- Training analysis (Tuition or Orthodox)
- Transcendental meditation;
- Treatment of sexual addiction, codependency; or any other behavior that does not have a DSM III-R diagnosis;
- Vocational assessment/school assessment;
- Wilderness Programs;
- Z therapy; or
- Any service or supply listed under general exclusions of the Health Care Programs as described in the schedule of benefits
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 Benefit 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.
Dental Benefits
Coverage provided and underwritten by Ameritas Life Insurance Corp.
Duke Dental Program

Coverage provided and underwritten by Ameritas Life Insurance Corp

The 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 basic benefit and payments are based on a fixed schedule of fees.

You can find a PPO network provider by calling Ameritas at 1-800-755-8844 or by visiting www.ameritasgroup.com/duke.

The term “Duke” is used throughout this document. For purposes of this Benefit Program description, “Duke” refers to the University, Duke University Health System, Inc., and any other entity which is or becomes controlled by Duke University and where, upon appropriate action by the Board of Trustees, the employees of that entity are included in the membership of this program.

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 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 is grandfathered 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 grandfather status continues for the course of this relationship only.
# Duke Dental Program

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# Group Dental for Duke Employees and Their Families

## Coverage and Limitations Comparison Chart

Below and on the following page is a comparison chart of the three Duke dental options – PPO Plan, Plan A and Plan B:

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<th>Service</th>
<th>Procedures</th>
<th>PPO Plan</th>
<th>Plan A</th>
<th>Plan B</th>
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| Type 1 (Preventive)¹ | 2 Exams per year  
2 Cleanings per year  
Space Maintainers  
X-Rays  
Fluoride treatment (for children under age 19) | MAC²  
No deductible | 100% of U&C² | Benefits based on the schedule for Plan B (sample schedule on page 52)  
No deductible |
| Type 2 (Basic)   | Extractions and fillings  
Full or partial denture repair  
Sealants  
Anesthesia (with surgical procedures) | Based on benefits payable levels  
No deductible | Based on benefits payable levels  
$100 lifetime deductible per person³ | Benefits based on the Schedule for Plan B (sample schedule on page 52)  
$50 calendar year deductible on Type 2 (basic) and Type 3 (major), procedures combined |
|                 | Benefit Payable Levels⁴  
Level 1 80% of MAC²  
Level 2 90% of MAC²  
Level 3 100% of MAC² | Benefit Payable Levels⁴  
Level 1 80% of U&C²  
Level 2 90% of U&C²  
Level 3 100% U&C² | N/A |

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.

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.
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<th>Procedures</th>
<th>PPO Plan</th>
<th>Plan A</th>
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| Type 3  | 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

$75 calendar year deductible per person\(^1\) | $50% of U&C\(^1\)
Benefits based on the Schedule for Plan B
(Sample schedule on page 52) |
| Type 4  | Periodontics
Endodontics | 65% of MAC\(^1\)
$50 calendar year deductible per person on Types 3 and 4 procedures combined

$75 calendar year deductible per person on Types 3 and Type 4 procedures combined\(^2\) | Provisions 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 | N/A | N/A | N/A | Three deductibles per family per year |
| Maximum Benefit | N/A | $1,250 per person per year\(^3\) Types 3 and 4 procedures combined | $1,000 per person per year\(^3\) Types 1,2,3 and 4 combined | $750 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
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 |

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, with less than $500 in claims payments, will have their annual maximum benefit increased by $250 beginning in 2006. This accumulation can continue until the annual maximum has increased. On PPO from $1,250 to $2,250, Plan A from $1,000 to $2,000, Plan B from $750 to $1,750.  

Please see pages 48–50 for claims payment examples and pages 53–54 for a list of ineligible expenses.
Eligibility and Enrollment

Eligibility
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, who is receiving wages for Social Security purposes,
- Regular employee or House Staff scheduled to work at least 20 hours per week,
- Postdoctoral scholar previously eligible for coverage.

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

- Your legal spouse,
- Your dependent children (includes natural children, stepchildren, adopted children, foster children, or children for whom you are legal guardian up to age 26, regardless of student or marital status. Dependent children does not include grandchildren, siblings, or other family members, or children of whom you have legal custody), 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 handicapped dependent 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.

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 plans options, there are several types of coverage in which you may enroll:

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

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.

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 Premium Conversion and Flexible Reimbursement Accounts Plan.

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 his/her 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 his or her 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 payable level (Level 1, Level 2, or Level 3). Please refer to the comparison charts on page 50 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, there is no deductible 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 his or her 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, the insurance company will not reimburse any additional services for the remainder of the calendar year. 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.

Ameritas Dental Rewards®: Dental plan members who file a claim for at least one covered procedure in a calendar year, with less than $500 in claims payments, will have their annual maximum benefit increased by $250 beginning in 2006. This accumulation can continue until the annual maximum has increased on the PPO Plan from $1,250 to $2,250; Plan A from $1,000 to $2,000; on Plan B, from $750 to $1,750.

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 on page 53. 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 and Plan A Incentive Program
The Duke Dental program offers a special “incentive program” to motivate you and your family 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 page 53 for 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)
There are no deductibles 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)
There are no deductibles 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 on page 54.

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 pro-rated 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 WageWorks if you want to use both the Health Care Reimbursement Account and the Dental Program to cover the orthodontia expenses for a dependent child. WageWorks 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.
Sample Comparison of PPO Option, Plan A and Plan B

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 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 PPO Option, his reimbursement from Ameritas would be calculated like this:

Dentist Normal Charge $1150.00
Amount Allowed under Plan $816.00 (Contracted amount)
Coinsurance Level 65%
Amount Paid by Plan $502.45
Amount Due Dentist $647.55

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

Dentist Normal Charge $1150.00
Amount Allowed under Plan $963.00 (Based on U&C)
Coinsurance Level 65%
Amount Paid by Plan $778.70
Amount Due Dentist $371.30

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

Dentist Normal Charge $1150.00
Amount Allowed under Plan B $160.00 (Set Dollar Reimbursement)
Coinsurance Level 65%
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 (select) 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 $773.00 (Contracted amount)
Coinsurance Level 65%
Amount Paid by Plan $402.45
Amount Due Dentist $1,097.55

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

Dentist Normal Charge $1,500.00
Amount Allowed under Plan $1,198.00 (Based on U&C)
Coinsurance Level 65%
Amount Paid by Plan $778.70
Amount Due Dentist $721.30

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

Dentist Normal Charge $1,500.00
Amount Allowed under Plan $263.25 (Based on U&C)
Coinsurance Level 65%
Amount Paid by Plan $263.25
Amount Due Dentist $1,236.75
Sample Procedure 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 & 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 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.

<table>
<thead>
<tr>
<th>Procedure Number</th>
<th>Procedure</th>
<th>Maximum Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation</td>
<td>$56.00</td>
</tr>
<tr>
<td>D1120</td>
<td>Prophylaxis – child (cleaning)</td>
<td>$68.00</td>
</tr>
<tr>
<td>D1110</td>
<td>Prophylaxis – adult (cleaning)</td>
<td>$97.00</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic film</td>
<td>$123.00</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings – two films</td>
<td>$49.00</td>
</tr>
<tr>
<td>D4910</td>
<td>Periodontal maintenance</td>
<td>$130.00</td>
</tr>
<tr>
<td>D2140</td>
<td>Amalgam – one surface, primary or permanent</td>
<td>$118.00</td>
</tr>
<tr>
<td>D2330</td>
<td>Resin-based composite – one surface, anterior</td>
<td>$140.00</td>
</tr>
<tr>
<td>D3320</td>
<td>Root canal, bicuspid (excluding final restoration)</td>
<td>$806.00</td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth or exposed root</td>
<td>$147.00</td>
</tr>
<tr>
<td>D7210</td>
<td>Surgical removal of erupted tooth</td>
<td>$255.00</td>
</tr>
<tr>
<td>D2751</td>
<td>Crown – porcelain fused to predominantly base metal</td>
<td>$863.00</td>
</tr>
<tr>
<td>D5214</td>
<td>Mandibular partial denture</td>
<td>$1,393.00</td>
</tr>
</tbody>
</table>
Sample Procedure List for PPO PLAN

<table>
<thead>
<tr>
<th>ADA</th>
<th>Procedure</th>
<th>MAB*</th>
</tr>
</thead>
<tbody>
<tr>
<td>D120</td>
<td>Periodic oral evaluation – established patient</td>
<td>$37.00</td>
</tr>
<tr>
<td>D272</td>
<td>Bitewings – two radiographic images</td>
<td>$37.00</td>
</tr>
<tr>
<td>D1110</td>
<td>Prophylaxis – adult</td>
<td>$72.00</td>
</tr>
<tr>
<td>D2140</td>
<td>Amalgam – one surface – primary or permanent</td>
<td>$99.00</td>
</tr>
<tr>
<td>D2330</td>
<td>Resin–based composite – one surface, anterior</td>
<td>$112.00</td>
</tr>
<tr>
<td>D2750</td>
<td>Crown – porcelain with gold</td>
<td>$792.00</td>
</tr>
<tr>
<td>D2752</td>
<td>Crown – porcelain with semiprecious metal</td>
<td>$816.00</td>
</tr>
<tr>
<td>D2792</td>
<td>Crown – semiprecious metal – full cast</td>
<td>$831.00</td>
</tr>
<tr>
<td>D3330</td>
<td>Endodontic therapy, molar</td>
<td>$884.00</td>
</tr>
<tr>
<td>D4341</td>
<td>Periodontal scaling and root planning – 4 or more tth</td>
<td>$174.00</td>
</tr>
<tr>
<td>D6240</td>
<td>Pontic – porcelain fused to high noble metal</td>
<td>$805.00</td>
</tr>
<tr>
<td>D6242</td>
<td>Pontic – porcelain fused to noble metal</td>
<td>$719.00</td>
</tr>
<tr>
<td>D6750</td>
<td>Crown – porcelain fused to high noble metal</td>
<td>$832.00</td>
</tr>
<tr>
<td>D6752</td>
<td>Crown – porcelain fused to noble metal</td>
<td>$744.00</td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth or exposed root</td>
<td>$109.00</td>
</tr>
</tbody>
</table>

*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, 2013 and may be subject to change.

Sample Schedule 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" on page 53 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**

<table>
<thead>
<tr>
<th>Proc. no.</th>
<th>Procedure</th>
<th>Maximum Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation</td>
<td>$18.18</td>
</tr>
<tr>
<td>D1120</td>
<td>Prophylaxis – child</td>
<td>$30.30</td>
</tr>
<tr>
<td>D1110</td>
<td>Prophylaxis – adult</td>
<td>$42.42</td>
</tr>
<tr>
<td></td>
<td>(age 14 and over)</td>
<td></td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic film</td>
<td>$54.54</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings – two films</td>
<td>$18.18</td>
</tr>
</tbody>
</table>
TYPE 2 (BASIC) PROCEDURES

<table>
<thead>
<tr>
<th>Proc. no.</th>
<th>Procedure</th>
<th>Maximum Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4910</td>
<td>Periodontal maintenance</td>
<td>$62.40</td>
</tr>
<tr>
<td>D2140</td>
<td>Amalgam – one surface, primary or permanent</td>
<td>$23.40</td>
</tr>
<tr>
<td>D2330</td>
<td>Resin-based composite – one surface, anterior</td>
<td>$25.35</td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth or exposed root (elevation and/or forceps removal)</td>
<td>$23.40</td>
</tr>
<tr>
<td>D7210</td>
<td>Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth</td>
<td>$35.10</td>
</tr>
<tr>
<td>D3320</td>
<td>Root canal, bicuspid (excluding final restoration)</td>
<td>$195.00</td>
</tr>
</tbody>
</table>

TYPE 3 (MAJOR) PROCEDURES

<table>
<thead>
<tr>
<th>Proc. no.</th>
<th>Procedure</th>
<th>Maximum Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2751</td>
<td>Crown – porcelain fused to predominantly base metal</td>
<td>$160.00</td>
</tr>
<tr>
<td>D5214</td>
<td>Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
<td>$224.00</td>
</tr>
</tbody>
</table>

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 if 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. Sub-gingival curettage or root planning 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 of, 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.

**Continuation of Benefits**

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 your Human Resource Information Center (HRIC), Ameritas, or the Duke web site (hr.duke.edu).

2. Take the claim form with you to the dentist performing your service.

3. You complete Parts 1 and 3 of the claim form. Part 1 is information about you and your employer. Part 3 allows you to have benefits paid directly to your dentist.

4. Your dentist completes Parts 2 and 4. Part 2 identifies the services that were performed. Part 4 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 we 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 may decide your claim based on the information we have 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 our 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 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,
- A description of any additional information needed to support your claim,
- Information concerning your right to a review of their 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. Our 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.

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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 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 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 change or terminate these benefits or your eligibility for benefits under the Duke Dental Program. The written plan documents for the Duke Dental Program are not employment contracts or any type of employment guarantee.
Vision Benefits

Coverage provided and underwritten by UnitedHealthcare Vision
Duke Vision Program
Coverage provided and underwritten by United HealthCare Vision

The coverage for the Duke Group Vision Insurance Program is provided and underwritten by United HealthCare 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 United HealthCare 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 www.MyUHCvision.com or call 1-800-638-3120.

The term “Duke” is used throughout this document. For purposes of this Benefit Program description, “Duke” refers to the University, Duke University Health System, Inc., and any other entity which is or becomes controlled by Duke University and where, upon, appropriate action by the Board of Trustees, the employees of that entity are included in the membership of this program.

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. This employee’s registered partner is grandfathered 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 grandfather status continues for the course of this relationship only.
# Duke Vision Program

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Eligibility and Enrollment

Eligibility
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, who is receiving wages for Social Security purposes,
• Regular employee or House Staff scheduled to work at least 20 hours per week,
• Postdoctoral scholar previously eligible for coverage.

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 children (includes natural children, stepchildren, adopted children, foster children, or children for whom you are legal guardian up to age 26, regardless of student or marital status. Dependent children does not include grandchildren, siblings, or other family members, or children of whom you have legal custody), 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 the 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.

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

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 his/her 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 his or her 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, United HealthCare 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

Vision Care Plan Chart

In-network, covered-in-full benefits (after applicable co-pay) 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.

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<th>Benefits</th>
<th>Network Benefits</th>
<th>Out of Network Reimbursement</th>
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<tr>
<td><strong>Vision Exam (once every 12 months)</strong></td>
<td>$30 co-pay</td>
<td>Up to $40</td>
</tr>
<tr>
<td><strong>Materials Co-pay</strong></td>
<td>$20 co-pay</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Frames (once every 24 months)</strong></td>
<td>Covered in full; $50 wholesale frame allowance (approximate retail value of $120-$150); receive wholesale price and $50 credit towards wholesale price</td>
<td>Up to $45</td>
</tr>
<tr>
<td><strong>Retail Chain Provider</strong></td>
<td>Covered in full; $130 retail frame allowance</td>
<td></td>
</tr>
<tr>
<td><strong>Eyeglass Lenses per pair (once every 12 months)</strong></td>
<td>Covered-in-full</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Single Vision</td>
<td>Covered-in-full</td>
<td>Up to $60</td>
</tr>
<tr>
<td>Bifocal</td>
<td>Covered-in-full</td>
<td>Up to $80</td>
</tr>
<tr>
<td>Trifocal</td>
<td>Covered-in-full</td>
<td>Up to $80</td>
</tr>
<tr>
<td>Lenticular</td>
<td>Covered-in-full</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Lens Options</strong></td>
<td><strong>Standard</strong> (including but not limited to scratch-resistant coating, basic progressive lenses, polycarbonate lenses, tints, UV coating, anti-reflective coating, photo chromatic, and Transitions®)</td>
<td>Covered-in-full</td>
</tr>
<tr>
<td></td>
<td><strong>Non-standard</strong> (including but not limited to high index, high density)</td>
<td>May be available at discount</td>
</tr>
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</table>

1 Materials co-pay 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.

2 Receive a $50 wholesale frame allowance at a private practice provider or a $130 retail frame allowance at a retail chain provider (a corporately-owned provider that uses their own lab and materials).

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 United HealthCare Vision confirming how much of a reimbursement you can expect to receive before you purchase such contacts.

4 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).
5 Usage during prior periods of employment during the same calendar year count towards the 12-month/24-month period.

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<tr>
<td><strong>Contact Lenses</strong>3 – in lieu of eyeglasses (once every 12 months)5</td>
<td>Covered-in-full after co-pay (up to 6 boxes)3 including evaluation, fitting, and up to two follow-up visits</td>
<td>Up to $150</td>
</tr>
<tr>
<td><strong>Elective</strong></td>
<td>Up to $150 allowance towards the fitting/evaluation fees and lenses purchase (materials co-pay does not apply)</td>
<td>Up to $150</td>
</tr>
<tr>
<td>Covered-in-full lenses (including but not limited to Acuvue by Johnson &amp; Johnson, Optima by Bausch &amp; Lomb)</td>
<td>Covered-in-full after applicable co-pay</td>
<td>Up to $210</td>
</tr>
<tr>
<td>All other elective lenses (including but not limited to toric, gas permeable, and bifocal contact lenses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medically Necessary</strong>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medically Necessary</td>
<td></td>
<td></td>
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1 Materials co-pay 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.

2 Receive a $50 wholesale frame allowance at a private practice provider or a $130 retail frame allowance at a retail chain provider (a corporately-owned provider that uses their own lab and materials).

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 United HealthCare Vision confirming how much of a reimbursement you can expect to receive before you purchase such contacts.

4 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).

5 Usage during prior periods of employment during the same calendar year count towards the 12-month/24-month benefit period.
Accessing and Using Your Benefits
United HealthCare 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 www.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 on the previous page.

Step 2: Find a Conveniently Located Provider
You may locate a United HealthCare Vision network provider by logging on to www.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 on the next page. Additionally, you may contact United HealthCare Vision customer service at (800) 638-3120.

Step 3: Schedule Your Appointment
Always identify yourself as a United HealthCare Vision participant when making an appointment with a United HealthCare Vision provider. This will assist your provider in obtaining a claim authorization number before your visit. Provide the primary insured’s Duke Unique ID (a seven 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, 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 United HealthCare 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 co-pay. United HealthCare Vision will reimburse you for your health plan’s vision examination co-pay if you visit a provider outside of United HealthCare Vision’s network. Details about submitting an out-of-network claim are located on the next page.

The Duke Eye Center does not participate in the United HealthCare Vision network. An exam is covered under all of the Duke Health Plans, and the co-pay cost filed with United HealthCare Vision.

Step 5: Your Eyewear
If prescription eyewear is necessary, your United HealthCare Vision provider will assist with your selection and order your prescription. Your United HealthCare 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 (a seven 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:

United HealthCare 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:

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

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 United HealthCare Vision’s appeals process are ERISA compliant, and follow the Department of Labor laws regarding ERISA appeal and grievance information. United HealthCare 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:

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Duke Benefits
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Authority of the Committee and the Plan Administrator

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Reimbursement Account Programs
Duke Reimbursement Account Programs

To help you pay for your health care and dependent care expenses, Duke offers their 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 don’t pay taxes on the amount you contribute, our 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 WageWorks, 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 document. For purposes of this Benefit Program Description, “Duke” refers to the University, Duke University Health System, Inc., and any other entity which is or becomes controlled by Duke University and where, upon appropriate action by the Board of Trustees, the employees of that entity are included in the membership of this program.
## Duke Reimbursement Account Programs

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**Note:** The page numbers are placeholders and should be replaced with actual page numbers from the document.
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, who is receiving wages for Social Security purposes,
- You are a regular employee or House Staff 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
- Your spouse is not enrolled in a Health Savings Account (HSA).

Employees on an approved Worker’s 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 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, 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.

New Hires
You may enroll in one or both of the 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 on the next page. However, at the next Open Enrollment, you will be able to elect to contribute to one or both accounts effective the next plan year.

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.

Open Enrollment
You can enroll in one or both of the 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 Resource Information Center (HRIC) at (919) 684-5600 of that event within 30 days.

Qualifying events include:

- Your marriage, divorce, annulment, or legal separation;
- 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 or turns age 26;
- Your (or your spouse’s or dependent’s) change in health coverage eligibility due to a relocation of residence or work place;
- 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.

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 benefits-ineligible 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 WageWorks 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 lay off 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 the 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.

**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.

**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.

**The “Use It or Lose It” Rule**
The U.S. Department of the Treasury and Internal Revenue Service recently modified the longstanding “use it or lose it” rule that required any remaining balance at the end of the plan year to be forfeited. With the new rule, up to $500 of your unused WageWorks Health Care Reimbursement Account balance can be carried over into the next plan year. However, any amount above $500 remaining in your account after December 31, will be forfeited unless claims are submitted by April 15 of the new plan year for eligible expenses incurred January 1–December 31. You must be an Active employee in a benefits-eligible work status on December 31 in order to be eligible for the carryover provision.

Claims for expenses incurred during the new plan year and processed before the carryover transfer date (approximately 10 days after April 15) 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 10 days after April 15) 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. Review your dependent care bills carefully from the previous year before deciding how much to contribute to a reimbursement account. Then estimate your expenses for the remainder of the calendar year.

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 WageWorks 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 it, at that point, is an issue that may need to be resolved between you and the Internal Revenue Service, independent of the plan.

**How Do I Decide How Much to Contribute?**
This is a very common question. 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. Additionally, since up to $500 of your unused Health Care Reimbursement Account remaining balance can be carried over into the next plan year, it 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 $2,600 and the maximum annual contribution for Dependent Care Reimbursement Accounts is $5,000.

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’re just starting out with an account.

If you have questions, want account updates, need to check on the status of claims, or need forms, simply call WageWorks, the claims administrator for the reimbursement accounts, at (877) 924-3967. WageWorks’ customer service representatives are available Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern time. You may also call WageWorks’ 24-hour automated voice response system at (877) 924-3967. Access to your personal online account is available at any time by logging on at hr.duke.edu/benefits/medical/reimbursement/account.php.

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**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.
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. Expenses for same-sex spousal equivalents are not eligible for reimbursement as spouses, unless married, but may be eligible if the same-sex spousal equivalent meets the definition of a qualifying relative (i.e., claimed as a dependent on the employee’s taxes). See the “qualifying relative” definition on this page or refer to Internal Revenue Code Section 152. Eligible health care expenses include medically necessary medical, dental, vision, prescription drug expenses, and some over-the-counter drugs which are used to treat specific medical conditions.

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 his/her 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 non-custodial 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 with 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 Service (IRS) 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.
## Health Care Reimbursement Account: Eligible Expenses

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

<table>
<thead>
<tr>
<th>Acupuncture</th>
<th>Drug addiction treatment</th>
<th>Psychotherapy for approved medical care (by approved provider)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholism treatment</td>
<td>Eye surgery (e.g., LASIK and radical keratotomy)</td>
<td>Smoking cessation program fees and prescription drugs</td>
</tr>
<tr>
<td>Ambulance fee</td>
<td>Guide Dogs (dog, training, care)</td>
<td>Surgery</td>
</tr>
<tr>
<td>Animal trained to aid deaf person</td>
<td>Hearing aids/exams</td>
<td>Telephone for the hearing impaired</td>
</tr>
<tr>
<td>Artificial limbs</td>
<td>Hospital services</td>
<td>Therapy (medical)</td>
</tr>
<tr>
<td>Braille books and magazines (difference in cost only)</td>
<td>Infertility treatments</td>
<td>Transplants</td>
</tr>
<tr>
<td>Car controls for the disabled</td>
<td>Lab fees</td>
<td>Tuition at special schools for the disabled (select circumstances only)</td>
</tr>
<tr>
<td>Chiropractors’ fees</td>
<td>Lamaze classes for expectant mothers</td>
<td>Varicose vein removal surgery</td>
</tr>
<tr>
<td>Christian Science practitioner fees</td>
<td>Mileage (requires receipt from physician and distance traveled)</td>
<td>Vitamins (prescribed)</td>
</tr>
<tr>
<td>Contact lenses and cleaning solutions</td>
<td>Nursing Services (wages and taxes)</td>
<td>Weight-loss programs at physician’s discretion to treat existing disease</td>
</tr>
<tr>
<td>Co-pays, deductibles, and co-insurance not covered by insurance</td>
<td>Optometrist fees</td>
<td>Wheelchairs</td>
</tr>
<tr>
<td>Dental fees (for non-cosmetic purposes)</td>
<td>Orthodontia expenses</td>
<td>X-rays</td>
</tr>
<tr>
<td>Doctor’s fees</td>
<td>Prescription drugs and medications*</td>
<td></td>
</tr>
</tbody>
</table>

Please note: Insurance premiums are not eligible expenses under a reimbursement account plan.

*Reimbursement for over-the-counter drugs and medications is not allowed unless the drugs and medications are prescribed by a physician.

### Over-the-Counter Drugs and Medicines

In addition to the Health Care Expenses noted on the previous page, some 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 it is 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.

Effective Jan. 1, 2011, you are required to have a doctor’s prescription to be reimbursed for over-the-counter (OTC) drugs and medicines. OTC drugs and medicines include, but aren’t limited to: cough, cold and flu medicines, stomach remedies, antibiotics, pain relievers, digestive aids, and allergy and sinus medicine and sleep aids. As a general rule, any OTC drug or medicine that you take orally or topically will require a prescription and the prescription date must be on or before the purchase date of the OTC item.
To use the WageWorks card for OTC drugs and medications, a prescription will need to be presented along with the medicine to a pharmacist. The pharmacist will then dispense and process the purchase. The health care card system will not accept a charge for an OTC drug or medicine unless a prescription number has been assigned.

Please see the list below for OTC items that will and will not require a doctor’s prescription effective Jan. 1, 2011:

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

### FSA Eligible Medical Items That DO NOT REQUIRE A Doctor’s Prescription

<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Bandages and related items (over-the-counter)</td>
<td></td>
</tr>
<tr>
<td>Birth control (over-the-counter)</td>
<td></td>
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<tr>
<td>Blood pressure monitors</td>
<td></td>
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<tr>
<td>Cholesterol test kits and supplies</td>
<td></td>
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<tr>
<td>Condoms</td>
<td></td>
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<tr>
<td>Contact lenses, cleaning solutions, etc.</td>
<td></td>
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<tr>
<td>Crutches, canes, walkers or like equipment (purchase or rental)</td>
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<tr>
<td>Dentures, bridges, etc.</td>
<td></td>
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<tr>
<td>Diabetic monitors, test kits, strips and supplies</td>
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<tr>
<td>Eye related equipment/materials</td>
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<tr>
<td>Eyeglasses (over-the-counter)</td>
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<tr>
<td>Fertility monitors (over-the-counter)</td>
<td></td>
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<tr>
<td>First aid kits (over-the-counter)</td>
<td></td>
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<tr>
<td>Hearing aids and batteries</td>
<td></td>
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<tr>
<td>Incontinence supplies</td>
<td></td>
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<tr>
<td>Insulin, testing materials and supplies</td>
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<tr>
<td>Magnetic Therapy (over-the-counter)</td>
<td></td>
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<tr>
<td>Medical equipment (for treatment of medical condition) &amp; repair</td>
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<tr>
<td>Medical monitoring and testing devices</td>
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<tr>
<td>Medical supplies (for treatment of a medical condition)</td>
<td></td>
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<tr>
<td>Monitors &amp; test kits (over-the-counter)</td>
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<tr>
<td>Occlusal guards to prevent teeth grinding</td>
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<tr>
<td>Orthotics</td>
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<tr>
<td>Orthopedic and surgical supports</td>
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<tr>
<td>Over-the-counter bandages and related items</td>
<td></td>
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<tr>
<td>Ovulation monitor (over-the-counter)</td>
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<tr>
<td>Pregnancy tests (over-the-counter)</td>
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<tr>
<td>Reading glasses (over the counter)</td>
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<tr>
<td>Teeth grinding prevention devices</td>
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<tr>
<td>Urological products</td>
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<tr>
<td>Walking aids (canes, walkers, crutches and related supplies)</td>
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<tr>
<td>Wheelchair and repairs</td>
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<tr>
<td>Wound care (over-the-counter)</td>
<td></td>
</tr>
</tbody>
</table>

### FSA Eligible Medical Items THAT NOW REQUIRE A DOCTOR’S PRESCRIPTION

<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne treatments</td>
<td></td>
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<tr>
<td>Allergy &amp; sinus medicine and products</td>
<td></td>
</tr>
<tr>
<td>Antacids</td>
<td></td>
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<tr>
<td>Antibiotic ointment</td>
<td></td>
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<tr>
<td>Aspirin or other pain relievers</td>
<td></td>
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<tr>
<td>Asthma medicines or treatments</td>
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Health Care Reimbursement Account: Ineligible Expenses

In the box below are some examples of expenses that are not eligible for reimbursement under a Health Care Reimbursement Account. If you want to check whether or not a particular expense is eligible for reimbursement, refer to WageWorks’ web site www.wageworks.com/employee/health-care/expenses/fsa.htm. This is not meant to be an all-inclusive list.

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*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 $2,650 for plan years starting on or after January 1, 2018. The maximum you can deposit to your Health Care Reimbursement Account during the plan year January 1 – December 31 is $2,650. If your spouse is enrolled in a Health Care Reimbursement Account, each of you is eligible to deposit $2,650 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’ll 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 adviser.

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.

Note 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/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.
Dependent Care Reimbursement Account

Eligible Dependents

Per the IRS rules effective 1/1/2005.

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

- Your qualifying child* – under the age of 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 www.wageworks.com/forms/dcdependents.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

- 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, he/she must regularly spend at least 8 hours a day in your home and not file a joint tax return with his/her spouse for the calendar year.
- Will provide no more than 50% of his/her 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).

- 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 his/her 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:

- The 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.
- The care is provided when the dependent meets the definition of a qualifying child or relative (per the IRS, based on a tax year).
- The 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 is able to provide you with his/her Social Security or Tax ID number. You will need this to request a 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 non-custodial 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 with 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).

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 http://www.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 age 13 and over, and
• Nursery school and kindergarten tuition.
What is incapable of self-care?
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 rules also affect the amount you may deposit:

- If your spouse is a full-time student or is disabled (meaning your spouse is unable to take care of him 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 $120,000 in 2015), your dependent care election may need to be adjusted based on the results of federal required non-discrimination tests. If you’re 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 to see that you don’t exceed any specific lower limitations that may apply to your family situation. In addition, you’re also responsible to see that your participation in all similar programs (such as a program through your spouse’s employer) meets all the requirements.
Example:
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 wasn’t working. Expenses incurred outside of the workweek cannot be claimed as eligible dependent care expenses.

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.

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 will 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 can’t 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 credits” is more beneficial to you. Before making a decision, you may want to consult your tax advisor.

These guidelines are based on information available about current tax laws and rates. You’ll 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 can’t 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’s 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 adviser.
How to File for Benefits

All participants can view information pertaining to the reimbursement accounts at hr.duke.edu/benefits/medical/reimbursement/index.php. Forms and instructions for filing claims are included on this web site. Additional forms are available at hr.duke.edu/forms/index.php or 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 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 non-profit 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 actually performed or received.

In order 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.

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:

Claims Administrator
P.O. Box 14053
Lexington, KY 40512

Or fax to: (877) 353-9236

Eligible expenses are processed every day 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/medical/reimbursement/account.php to receive reimbursements directly into your checking account.

Grace Period

You have a grace period — 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 reimbursement accounts. Although you have until April 15 to submit your claims, only expenses from the previous calendar year — Jan. 1 through Dec. 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.

You can carry over up to $500 of unused funds into the next plan year for the Health Care Reimbursement Account only.
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 WageWorks in writing within 180 days of the date you receive notice of the denial. First level appeals should be mailed to WageWorks at the following address:

WageWorks Claims Appeal Board
P.O. Box 991
Mequon, WI 53092-0991

You will be able to examine all the materials related to your claim, such as the plan’s official documents. WageWorks 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. Request 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.
Life and Accident Insurance Benefits
Duke Life Insurance Programs

Duke Provided Plans

Basic Life Insurance—The Basic Life Insurance program provides financial protection for your loved ones in the event of your death. A $10,000 benefit is provided to your survivors in the event of your death. An additional $10,000 benefit is provided if the death is due to an accident. A partial benefit is available for the loss of a limb or sight. This benefit is provided by Duke for eligible employees.

Survivor Benefit—The Survivor Benefit provides your spouse or estate with an additional sum in the event of your death. This benefit is provided by Duke for eligible employees.

Business Travel and Accident Insurance—For eligible employees, this insurance provides benefits in the event of your death or if you suffer a covered loss as the result of a business-travel related accident. The plan also pays benefits for related medical expenses.

Insurance Certificate Plan—This plan provides a death benefit to the beneficiaries of employees covered under the plan on or before December 1, 1974, and who meet other eligibility criteria.

Additional Coverage Options

Supplemental Life Insurance—You can elect to purchase Supplemental Life Insurance for additional coverage for yourself, your spouse, and dependent children.

Personal Accident Insurance—Personal Accident Insurance pays a benefit in the event of your death, dismemberment, or disability, with one year of an injury suffered from an on-or-off-the-job accident.

Post-Retirement Group Term Life Insurance—The Post Retirement Group Term Life Insurance Plan is a voluntary, employee-paid life insurance plan that provides life insurance after your retirement. This plan is not available for new employees.

Other Optional Programs

Universal Life Insurance—You also have the opportunity to enroll for individual Universal Life Insurance, which provides basic death benefits with a unique cash value accumulation fund. The Universal Life Insurance Program is not covered under the Employee Retirement Income Security Act of 1974 (ERISA).

The term “Duke” is used throughout this document. For purposes of this Benefit Program description, “Duke” refers to the University, Duke University Health System, Inc., and any other entity which is or becomes controlled by Duke University and where, upon appropriate action by the Board of Trustees, the employees of that entity are included in the membership of this program.

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 is grandfathered 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 grandfather status continues for the
# Duke Life Insurance Programs

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Which Type of Insurance is Right for Me?

To help you with your life insurance choices, below are brief explanations of two primary types of life insurance.

1. Term Life Insurance Example: Duke's Supplemental Term Life Insurance

Term life insurance provides protection for a specified period of time, typically from one to 30 years. Since term life insurance offers coverage for a fixed period of time, it is typically less expensive than permanent life insurance coverage. However, when the policy renews, the premiums will increase based on the age of the policyholder. One feature that is often available with term life insurance is the periodic increase in coverage amount. For instance, Duke's Supplemental Term Life Insurance gradually increases your coverage amount over the life of the policy as your salary increases. The premiums will increase with the increase in coverage. This type of policy may be appropriate if you believe your insurance needs will grow in coming years (for instance, if you anticipate obtaining a larger mortgage or expanding your family).

2. Permanent Life Insurance Examples: Universal, Whole Life, and Variable Life Insurance

Permanent life insurance is designed to provide life-long protection as long as you continue to pay premiums. The premiums are based on your age at the time of purchase and generally remain level and do not increase as you age. Therefore, the younger you are when you buy the policy, the lower the premium you will pay for the life of the policy.

Because premiums remain level, permanent insurance can be more expensive than term insurance. However, permanent insurance accumulates cash value. With most permanent life insurance policies, the policyholder can surrender the policy and claim the policy’s cash value. Additionally, most policies allow the policyholder to borrow against or use the cash value to pay premiums while the policy is in force.
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

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

- Supplemental Life Insurance,
- Personal Accident Insurance, and Universal Life 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 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, 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, Personal Accident Insurance, and Universal Life 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.

Beneficiary Designation
Your beneficiary designation is kept on file. You can review, add or change your beneficiary at any time and complete a beneficiary designation form online at hr.duke.edu/forms/basic life.php, which is a secure website that requires your NetID and password. You also have the option to complete and return a paper beneficiary change 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.
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 and classified as a full-time member of the faculty, 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 (paid or unpaid).

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 (with the exception of 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.

House Staff 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, 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.

Benefit Coverage
Coverage is automatically provided at $10,000, with an additional 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 9 months after the date of the accident.
What is a Loss?

**Loss of life**, a hand permanently severed at or above the wrist but below the elbow, a foot permanently severed at or above the ankle but below the knee, an arm permanently severed at or above the elbow, a leg permanently severed at or above the knee, or sight in one eye.

**Loss of sight** means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.

**Loss of thumb and index finger of same hand** means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.

**Loss of speech** means the entire and irrecoverable loss of speech that continues for 6 consecutive months following the accidental injury.

**Loss of hearing** means the entire and irrecoverable loss of hearing in both ears that continues for 6 consecutive months following the accidental injury.

**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** means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 30 days of the accidental injury and continue for 7 consecutive days.

<table>
<thead>
<tr>
<th><strong>Loss</strong></th>
<th><strong>Benefit Paid</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Life</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of a hand permanently severed at or above the wrist but below the elbow</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of a foot permanently severed at or above the ankle but below the knee</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of an arm permanently severed at or above the elbow</td>
<td>75%</td>
</tr>
<tr>
<td>Loss of a leg permanently severed at or above the knee</td>
<td>75%</td>
</tr>
<tr>
<td>Loss of sight in one eye</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of any combination of hand, foot, or sight of one eye, as defined in the Certificate</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of the thumb and index finger of same hand</td>
<td>25%</td>
</tr>
<tr>
<td>Loss of speech and loss of hearing</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of speech or loss of hearing</td>
<td>50%</td>
</tr>
<tr>
<td>Paralysis of both arms and both legs</td>
<td>100%</td>
</tr>
<tr>
<td>Paralysis of both legs</td>
<td>50%</td>
</tr>
<tr>
<td>Paralysis of the arm and leg on either side of the body</td>
<td>50%</td>
</tr>
<tr>
<td>Paralysis of one arm or leg</td>
<td>25%</td>
</tr>
<tr>
<td>Brain Damage</td>
<td>100%</td>
</tr>
<tr>
<td>Coma</td>
<td>1% monthly beginning on the 7th day of the Coma for the duration of the Coma to a maximum of 60 months.</td>
</tr>
</tbody>
</table>
**Air Bag Benefit**

If an Air Bag is deployed for the covered person during the accident and the covered person dies as a result of the accident while driving or riding in a passenger car and wearing a properly fastened seat belt, MetLife 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. 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.

**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 otherwise privately arranged transportation, taxis, or limousines.

**Human Immunodeficiency Virus (HIV) Benefit**

The HIV Benefit provides an additional benefit if the employee sustains an accidental injury in the performance of his/her 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, MetLife 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. 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.

**Exclusions and Limitations**

MetLife will not pay benefits under this section for any loss caused or contributed to by:

1. Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
2. Infection, other than infection occurring in an external accidental wound;
3. Suicide or attempted suicide*;
   *Exclusion pertains only to the AD&D portion of the benefit; beneficiary maintains entitlement to the $10,000 Basic Life benefit
4. Intentionally self-inflicted injury;
5. Service in the armed forces of any country or international authority, except the United States National Guard;
6. Any incident related to:
   - Travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
• parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;
• Travel in an aircraft or device used:
  • For testing or experimental purposes;
  • By or for any military authority; or
  • For travel or designed for travel beyond the earth’s atmosphere;

7. Committing or attempting to commit a felony;

8. The voluntary intake or use by any means of:
  • Any drug, medication or sedative, unless it is:
    • Taken or used as prescribed by a Physician, or
    • An “over the counter” drug, medication or sedative taken as directed;
  • Alcohol in combination with any drug, medication, or sedative; or
  • Poison, gas, or fumes; or

9. War, whether declared or undeclared; or act of war, insurrection, rebellion or riot.

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 the MetLife broker by phone within 31 days after coverage ends, at (919) 605-0488.

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, Metropolitan Life Insurance Company, and provide proof of the loss. Claims for accidental death or dismemberment benefits must be made to the underwriter within 20 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:

Metropolitan Life Insurance
Group Life Claims
PO Box 3016
Utica, NY 13504-3016

Or

Metropolitan Life Insurance
Group Life Claims
5950 Airport Rd
Oriskany, NY 13424 (overnight)
800-638-6420

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 90 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 under-writer 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

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 approved for benefits under Duke’s Long Term Disability plan (while still satisfying the waiting period) or Duke’s Workers’ Compensation program.

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 (with the exception of 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.

House Staff 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 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, 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 service you accrue, up to a maximum of six months of pay. 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.

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. 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.

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 in order 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

- 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 aero-medical specialists operates 24 hours a day, 365 days a year from SOS Alarm Centers around the world.

Your SOS membership, provided by Duke, is an 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 handy. 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 find answers to Frequently Asked Questions.

While you are abroad, you should always attempt to activate 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 ISOS. 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 on-line 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 on-site personnel, policies and procedures. Should you have any questions about International SOS, please contact the Corporate Risk Management department.

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 University-related programs or business.

Program Benefits

Medical Services
(For evacuation and travel; fees may apply.)

- 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

Frequently Asked Questions

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 on-site 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 Inter-national 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 web site.

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 web site when using the web site)
   • The telephone number from which you are calling (in case you are disconnected)
   • Your relationship to the 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 and financial and voltage/plug information.

Q. Do I need to activate my membership?
A. No, your membership is already active. Simply carry the card in your wallet 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 on-line account with SOS into which you can save medical, family and emergency information. Unless you input your information into an 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 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 the card another card from the Inter-national SOS web site.

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, on-site 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, and 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.

24-Hour Access
Insured employees, students and their eligible dependents will be able to reach the Europ Assistance coordination center, by calling toll-free or by facsimile 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:
1-800-243-6124

The following is a brief 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 get a better understanding of the covered person’s condition. If appropriate, Europ Assistance will monitor the covered person’s condition and will remain in communication with his or her 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.

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.
• **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 on-site 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, Europ Assistance will provide funds for emergency payments to cover on-site 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, 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.

• **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 by for 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 his or her 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 arrangement for one family member or one friend designated by the covered person from his or her 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; 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 air-lines, 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 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 a 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.

House Staff, 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) natural 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
1. On business for the Policyholder; and
2. In the course of the Policyholder’s Business; or
3. 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:
1. On business for the Policyholder; and
2. 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:
1. The date a Covered Person returns to his or her home;
2. The date a Covered Person returns to his or her place of work; or
3. The date a Covered Person makes a Personal Deviation.

“Personal Deviation” means:
1. An activity that is not reasonably related to the Policyholder’s business; and
2. 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) eye glass 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:

1. The Covered Person is on the Policyholder’s premises when the Covered Accident occurs;
2. 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:

1. The Covered Person is riding in, or getting on or off of, a covered aircraft; or
2. As a result of a Covered Person being struck by a covered aircraft.
3. away from the Policyholder’s premises in the Covered Person’s city of permanent assignment;
4. On business for the Policyholder; and
5. 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:

1. The date a Covered Person returns to his or her home;
2. The date a Covered Person returns to his or her place of work; or
3. The date a Covered Person makes a Personal Deviation.

"Personal Deviation" means:

1. An activity that is not reasonably related to the Policyholder’s business; and
2. 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

1. On business for the Policyholder; and
2. In the course of the Policyholder’s business; or
3. 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:

1. The date a Covered Person returns to his or her home;
2. The date a Covered Person returns to his or her place of work; or
3. The date a Covered Person makes a Personal Deviation.

"Personal Deviation" means:

1. An activity that is not reasonably related to the Policyholder’s business; and
2. 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:

1. he or she is in a vehicle that disappears, sinks, or is stranded or wrecked on a trip covered by this Policy; and
2. 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:

a) He or she is riding as a passenger only, and not as a pilot or member of the crew; and
b) The aircraft has a valid certificate of airworthiness; and
c) The aircraft is flown by a pilot with a valid license; and
d) the aircraft is not being used for: (i) 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).
e) 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:
1. Intentionally self-inflicted Injury.
2. Suicide or attempted suicide.
3. War or any act of war, whether declared or not.
4. Service in the military, naval or air service of any country.
5. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or viral infection or medical or surgical treatment there-of, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food.
6. 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).
7. 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:

Covered Activity Principal Sum
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

Dependants:
Covered Activity Principal Sum
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
Covered Loss Benefit Amount
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 Principal Sum 100% of the
Loss of Use of Three Limbs Principal Sum 75% of the
Paraplegia 75% of the Principal Sum
Loss of Use of Two Limbs Principal Sum 67% of the
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**

<table>
<thead>
<tr>
<th>Benefit Maximum:</th>
<th>$5,000</th>
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</thead>
<tbody>
<tr>
<td>Maximum Benefit Period:</td>
<td>365 days from the date of the Covered Accident</td>
</tr>
<tr>
<td>Deductible:</td>
<td>$0</td>
</tr>
</tbody>
</table>

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:

1. For Usual and Customary Charges incurred after the Deductible has been met;
2. For those Medically Necessary Covered Expenses that the Covered Person receives; and
3. 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 day’s 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 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. It 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:

1. The applicable Benefit Waiting Period shown in the Schedule of Benefits for this benefit is satisfied; and

2. 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:

1. if employed, cannot do any work for which he or she is, or may become, qualified by reason of education, experience or training; and

2. 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 his or her 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.

7 Ways to Reach Cigna Medical Abroad

**Website**
www.CignaEnvoy.com

**Toll-free telephone number**
+1.800.243.1348

**Direct (collect calls accepted):**
+1.302.797.3535

**Toll-free facsimile number**
+1.800.243.6998

**Direct facsimile number**
+1.302.797.3150

**Mail Delivery**
Cigna
P.O. Box 15111
Wilmington, DE 19850-5111 U.S.A.

**Courier Delivery**
Cigna
300 Bellevue Parkway
Wilmington, DE

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 come up, 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/abroad/certificate.pdf

**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. That means less money out of your pocket. 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 doesn’t need to have a previous agreement with us to request a Guarantee of Payment. All you have to 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 they will not accept a guarantee of payment, you can still receive care. After your visit, simply 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.

And 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. The result? You get the right care, even quicker.

**Other Resources Available**

Your MBA plan gives you access to one central online resource that is tailored exclusively for your needs. It’s Cigna Envoy for international business travelers located at www.CignaEnvoy.com. You can access information on some 200 countries before you even leave for your trip. You can easily research:

- Currency and exchange rates
- Immunization requirements
- Security alerts
- Voltage requirements
- Country weather and time
- Disease prevention tips

**To access Cigna Envoy:**

- Select Int’l Business traveler from the drop-down box in the “Choose your website” section
- Click Go
- Log in by inserting the username: 05449BMBAband password: Cigna1

**Frequently Asked Questions:**

**Q. How much do I have to pay for Medical Benefits Abroad?**

A. There is no cost and no enrollment process for the 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 Duke 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.

You must not have terminated employment for any reason prior to age 65 or have died while employed by Duke to participate. House Staff 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.
The Supplemental Life Insurance Plan

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

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

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

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 plan 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 19 or age 26 if a full-time student,
- You reach age 95,
- The plan terminates, or
- If you have been covered under this plan for less than 2 years and your employment ends, your coverage ends on your last day worked.

Qualified Issue

What is Qualified Issue?
Qualified issue for insurance coverage means that you must satisfactorily answer two questions:

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

Benefit Coverage
You can select coverage amounts of one to eight times your annual pay, up to $100,000 for your spouse and $10,000 for each dependent child. Employee coverage is required in order for a dependent to participate. Employees must have active coverage in effect at the time of issuance of spouse coverage. If the employee cancels his/her 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 would equal $60,000 [$17,100 x 3 = $51,300, rounded up to $60,000].

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

Coverage is guaranteed for up to two times annual pay to a maximum of $500,000 if you meet the eligibility requirements, are actively at work, and request coverage within 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 must not have been previously denied coverage, must not have been hospitalized during the past 90 days, and must be able to perform normal activities on the date you elect coverage. Coverage is guaranteed within 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 step-child) who is under age 19 (or under age 26 if a full-time student), but not less than 14 days old, and who is dependent on you for support. Additional underwriting requirements require that the child must not have been hospitalized during the past 90 days and must be able to perform normal activities on the day you sign the application. You may enroll your newborn child within 45 days of birth.

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

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

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

**Additional Plan Member Benefit**
As a Supplemental Life insurance plan member, you are eligible for Will Preparation and Estate Resolution Services, which include will preparation, updating of wills, and fully covers attorney fees for probating your estate when using a participating plan attorney. These services also provide advice and consultation to beneficiaries. For more details, go to hr.duke.edu/benefits/finance/life/supplemental/will_planning.pdf.

**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 plan coordinator, if you have had coverage for at least two years and the group plan is still in effect. You may keep this coverage until you reach age 95.

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. This option is not available for a mentally or physically disabled child. Coverage for a mentally or physically disabled child may be continued at the $10,000 level as a rider to an adult certificate.

The child may request conversion to an individual certificate by notifying 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 determines whether the claim is allowed. If a claim is denied in whole or in part, the underwriter will notify you and explain its procedure for reviewing a denied claim.

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

**Appeals of Eligibility, Right to Participate, and Other Claims Not Directly Related to Benefit Payments**
With respect to all other eligibility claims or issues, including the right to participate under the plan, claims and proof of claims must be filed in writing with the Plan Administrator in accordance with the
procedures and guidelines established from time to time by the Staff Fringe Benefits Committee. Send your claim to:

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

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

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

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

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

If you are dissatisfied with the Staff Fringe Benefits Committee’s decision after you have pursued these steps, you have the right to file a lawsuit in state or federal court. You may not file a lawsuit before 90 days have passed after you file your claim or later than three years after the loss due to death occurred. The Duke Life Insurance Program 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.
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 House Staff member 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 Human Resource Information Center at (919) 684-5600 or on the Internet at hr.duke.edu. You may enroll anytime 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 Benefit’s 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 (26th 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.

What is total disability?
Total disability means that period during which you receive medical treatment and are unable to engage in any gainful work or service which you are reasonably qualified by education, training, or experience. If injuries result in your total disability which begins within 365 days from the date of the accident and continues for 12 consecutive months and if it can be then shown with documented medical evidence such total disability will be permanent, then the principal sum will be paid. The disability benefit applies only to employees and only for accidents that occur before the employee’s 70th birthday.

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 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 $0.18 per month for each $10,000 of coverage you elect. The premium for family coverage is $0.30 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, due to a covered injury, suffer loss of life, 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 shown below.

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.

If 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. Children are considered eligible dependents until age 19 or age 26 if a full-time student and unmarried. 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:

<table>
<thead>
<tr>
<th>Age</th>
<th>Percentage of Principal Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to Age 69</td>
<td>100%</td>
</tr>
<tr>
<td>70 to 74</td>
<td>82.5%</td>
</tr>
<tr>
<td>75 to 79</td>
<td>57.5%</td>
</tr>
<tr>
<td>80 to 84</td>
<td>37.5%</td>
</tr>
<tr>
<td>85 and Over</td>
<td>20%</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Benefit Paid</th>
<th>Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>100%</td>
</tr>
<tr>
<td>Both hands or both feet</td>
<td>100%</td>
</tr>
<tr>
<td>Sight in both eyes</td>
<td>100%</td>
</tr>
<tr>
<td>Sight of one eye</td>
<td>50%</td>
</tr>
<tr>
<td>Speech</td>
<td>50%</td>
</tr>
<tr>
<td>Hearing in both ears</td>
<td>50%</td>
</tr>
<tr>
<td>One hand or one foot</td>
<td>50%</td>
</tr>
<tr>
<td>Thumb and index finger of same hand</td>
<td>25%</td>
</tr>
</tbody>
</table>

**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.
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.

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 such 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.

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.

When you or a covered dependent receives 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 next following the date the dependent child graduated from the 12th grade.

Surviving Spouse/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:

(a) Any licensed U.S. civil aircraft or its foreign equivalent:
   (1) Operated by a person holding a valid and enforce pilot certificate (other than a student certificate) of a rating authorizing him or her to operate it;
   (2) Where the primary purpose of the flight is transporting passengers or passengers and cargo;

(b) Any transport-type, multi-engined fixed-wing aircraft operated by:
   (1) The Military Airlift Command (MAC) of the United States;
   (2) The Department of National Defense (Canada);
   (3) The Royal Air Force Air Transport Command of Great Britain; or

(c) Any aircraft of the United States Department of Defense, other than a single-engine jet:
   (1) Operated by a pilot with proper authorization;
   (2) 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 threat while sane or insane;
- 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;
• 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 Chris Yager at Mutual of Omaha at (402) 351-3349.

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 Human Resource Information Center 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
   (800) 524-2324
   www.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 its procedure for reviewing a denied claim.

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

Appeals of Eligibility, Right to Participate, and Other Claims Not Directly Related to Benefit Payments
With respect to all other eligibility claims or issues, including the right to participate under the plan, claims and proof of claims must be filed in writing with the Plan Administrator in accordance with the procedures and guidelines established from time to time by the Staff Fringe Benefits Committee. Send your claim to:
   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 your Human Resources representative.
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.

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 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. House Staff 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 Worker’s 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:
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.

**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 have passed after you file your claim or later than three years after the loss due to death or dismemberment 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.

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 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) is one of Duke’s benefits that provides the flexibility to choose from a broad range of benefit options for the coverage that best fits your life and your budget.

This information is provided here 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, 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 MetLife Auto & Home® at a special rate through Mercer Voluntary Benefits’ Auto and Home Insurance Benefit.

The insurance provided through Mercer Voluntary Benefits is available as part of your Duke benefits program and provides several advantages:

- Special program rates that are often lower than individual rates**
- Convenient payroll deduction of your premiums
- Special discounts including a payroll deduction, multi-policy and tenure discount***

Overall, this program offers high-quality insurance at competitive rates. Since homeowners and renters insurance is based on several factors including the state you live in, the type of construction of your home, and many other factors, this insurance may not give you the lowest premium.

**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 get 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.

Although the most convenient way to pay your homeowner’s insurance premium is via payroll deduction, you also can elect to pay by check, or add it to your mortgage or escrow payment.

**How the Plans Work**

You don't have to wait until your current policy expires to switch. Call toll-free 1-800-552-9670 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 MetLife Auto & Home®. The real advantage to you is:
You can call one toll-free number to receive competitive quotes and compare premiums from two of the most respected auto and home insurance carriers.

You could save based on individual circumstances:
- By paying your premiums through payroll deduction,
- Protecting both your auto and your home through this program
- Your years of employment with Duke

If you would like to purchase a policy, the customer service representative can take your information and issue coverage.

Coverage is available to meet all your personal insurance needs. Coverage includes: auto, home, boat, landlord’s rental dwelling, motorcycle, recreational vehicles, all-terrain vehicles, campers, travel trailers, personal property and articles, and personal excess liability (“Umbrella”).

The property to be insured must be in the United States.

Getting a Quote

Getting a free, no-obligation quote is easy. You can:

- Call the Mercer service center (1-800-552-9670) to work with an insurance counselor over the phone.
- Complete the online quote process (www.personal-plans.com/duke). 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 are still eligible for group rates.

MetLife Auto & Home

When you retire, terminate, or go on a leave of absence from Duke, you can continue your MetLife Auto & Home 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:

MetLife Auto and Home
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 at 1-800-552-9670 to speak to a claims representative. Always call as soon as possible, regardless of who is at fault. Find out whether you’re 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 MetLife Auto & Home, 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.

Discounts
**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 for all employees.

Plan Administrator
Mercer Voluntary Benefits
12421 Meredith Drive
Urbandale, IA 50398

Call Center Phone: (800) 552-9670
(8:00 a.m. to 6:00 p.m. EST/EDT, M-F)
Email: customer.service@mercer.com
The Individual Universal Life Insurance Plan*

You have the opportunity to purchase voluntary individual Universal Life Insurance coverage. Your coverage amount is based on your age. Coverage also is available for your family members. In addition, this coverage also includes the potential for cash accumulation through a cash value account. In general, a portion of your premium is used to pay expenses and the cost of the insurance, and the balance of the premium goes into a cash accumulation fund. The interest earned on this accumulation is tax-deferred and the premium does not increase with age.

This information is provided here 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.

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.

House Staff 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.

Enrolling for Coverage

You may sign up for coverage at any time by contacting either of the vendors authorized to provide this coverage. The vendors are:

- **Holroyd Agency**
  (919) 755-8684

- **North Carolina Mutual Life**
  (800) 635-4467

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 Begins

Your coverage becomes effective on the date you are both actively at work at Duke and meet the eligibility requirements (see the column to the left). 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 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.
<table>
<thead>
<tr>
<th><strong>Provider</strong></th>
<th><strong>Coverage Types</strong></th>
<th><strong>Interest Rate</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Holyrod Agency</td>
<td>Simplified Issue 3x salary up to $100,000</td>
<td>Minimum 3.0% Current 4.7%</td>
</tr>
<tr>
<td>North Carolina Mutual Life</td>
<td>Conditional Guaranteed Issue/Simplified Issue up $10,000 if you sign up when you are first eligible.</td>
<td>Minimum 4.5%</td>
</tr>
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<td></td>
<td>Conditional Guaranteed Issue/Simplified Issue age 18-39: $63,000-$100,000 age 40-59: $17,000-$59,000 age 60-45: $12,000-$16,000 Family Coverage Available</td>
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**What is simplified issue?**

Simplified issue for the insurance coverage through the Holroyd Agency requires two questions be satisfactorily answered: 1) Has the proposed insured ever been diagnosed and/or treated by a member of the medical profession for positive HIV (Human Immunodeficiency Virus) or AIDS (Acquired Immune Deficiency Syndrome)?; and 2) In the last 90 days, has proposed insured sought or received care or treatment (including taking any daily or ongoing prescribed medication), on an inpatient or outpatient basis, in any hospital, doctor’s office or medical care facility for any condition (excluding pregnancy, birth control, colds/flu, allergies, high blood pressure, elevated cholesterol, heartburn/reflux, back trouble, chiropractic care, wellness exams, or diagnostic testing with normal results)?

Pertaining to North Carolina Mutual Life Insurance Company, conditional guaranteed issue/simplified issue means in order to obtain coverage, you must answer a limited number of medical questions including disclosing if you have been diagnosed or treated by a licensed physician for any illness or injury in the past year; have been hospitalized within the past six months; have been diagnosed, treated, or prescribed medication for AIDS or ARC (AIDS-related complex); or received a confirmed positive result on an FDA-approved HIV test prior to enrollment in the individual Universal Life Insurance Plan.
Long Term Care Insurance Program
Effective July 1, 2013, Duke no longer offers a Group Long Term Care Insurance plan. 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.

Duke Long Term Care Insurance Program

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.

Duke’s Long Term Care Program is provided under a group insurance policy which is underwritten by The Prudential Insurance Company of America (Prudential).

The term “Duke” is used throughout this document. For purposes of this Benefit Program Description, “Duke” refers to the University of Duke, Duke University Health Systems, Inc., and any other entity which is or becomes controlled by Duke University and where, upon appropriate action by the Board of Trustees, the employees of that entity are included in the membership of this program.
**Duke Long Term Care Insurance Program**

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Existing Policyholders

Effective July 1, 2013, 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: 1-800-732-0416, 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 cancels the coverage,
- You die,
- You or the family member ceases 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 are able to 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 age 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. Premiums 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 you get older, become ill, or file claims under the plan.

**No Cancellation for Any Reason**

As long as you keep paying your premiums and you haven’t 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**

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 the Long Term Care Insurance Shopper's Guide (pdf).

National Clearinghouse for Long Term Care Information the U.S. Department of Health and Human Services developed this website to provide 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 consumer’s learn more about the state’s Partnership program for long term care insurance.

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 home 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.
How 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 or 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.

Benefit Coverage

You may select different levels of coverage under the plan, based on three variables:

- The daily nursing home benefit (which determines the home and community-based care benefit),
- The lifetime maximum benefit, and
- The inflation protection options
- Voluntary increase (standard)
- Automatic increase (additional premium required).
## Sample Plan Options

<table>
<thead>
<tr>
<th></th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Daily Benefit Maximum (DBM)</strong></td>
<td>$100</td>
<td>$150</td>
<td>$200</td>
</tr>
<tr>
<td>Nursing Home Care, Hospice Facility Care, Assisted Living Facility Benefit:</td>
<td>100% of DBM</td>
<td>100% of DBM</td>
<td>100% of DBM</td>
</tr>
<tr>
<td>The maximum amount of coverage your plan could provide each day.</td>
<td><strong>Home &amp; Community-Based Care and Adult Day Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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).</td>
<td>75% of DBM</td>
<td>75% of DBM</td>
<td>75% of DBM</td>
</tr>
<tr>
<td><strong>Lifetime Maximum Benefit:</strong></td>
<td>3 Years*</td>
<td>3 Years*</td>
<td>3 Years*</td>
</tr>
<tr>
<td>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.</td>
<td>$109,500</td>
<td>$164,250</td>
<td>$219,000</td>
</tr>
<tr>
<td>10 Years*</td>
<td>10 Years*</td>
<td>10 Years*</td>
<td></td>
</tr>
<tr>
<td>$365,000</td>
<td>$547,500</td>
<td>$730,000</td>
<td></td>
</tr>
</tbody>
</table>

*You may choose a daily benefit amount between $100– $350 and a lifetime maximum of 3, 5, 10 years, or an unlimited lifetime maximum. For additional options visit [www.prudential.com/gltc](http://www.prudential.com/gltc) (Group Name: dukeltc; Password: enrollment) or call (800) 732-0416.
All of the options in the table on the preceding page 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.

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**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.
- **Transferring** — moving into or out of a bed, chair, or wheelchair.
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.

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.

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.

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 his or her home. You must satisfy the Benefit Waiting/Elimination Period before benefits are payable.

Inflation Protection
So that your plan coverage can 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) our 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 or governmental plan under which the patient is or could be covered. This (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 1-800-732-0416. 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’s,” “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.

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.
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 adviser for additional information.

Claims for the Long Term Care Insurance Program should be sent to the insurer at the address listed on the claim form.

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 Long Term Care Insurance Program. Duke reserves the right to change or terminate these benefits or your eligibility for benefits under the Duke Long Term Care Insurance Program. The written plan documents for the Duke Long Term Care Insurance Program are not employment contracts or any type of employment guarantee.
Disability Benefits
Duke Disability Program
The Duke University Disability Program provides you with income if you are 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 document. For purposes of this Benefit Program description, “Duke” refers to the University, Duke University Health System, Inc., and any other entity which is or becomes controlled by Duke University and where, upon appropriate action by the Board of Trustees, the employees of that entity are included in the membership of this program.

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 is grandfathered 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 grandfather status continues for the course of this relationship only.
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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 purposes, you are eligible to participate in the Duke Disability Program as of the first day of the month after the completion of three years of full-time continuous service with Duke.

You also are eligible to participate in the plan as of the first day of the month after your hire date, without the three-year waiting period if you have had group long term disability coverage (which would have provided benefits for a minimum of five years) through your former employer within 90 days of starting your eligible position at Duke. You must provide proper documentation to Duke Benefits within 90 days of 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/disabilitywavier.

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,
- Employees covered for other monthly disability income coverage provided by Duke,
- Private Diagnostic Clinic faculty, or
- House Staff Officers.

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 and must be 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 a 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
- The first of the month after satisfying the Duke LTD 3 year waiver requirement.

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 a 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, 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 would 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.

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,
- Be covered on the date the benefit waiting period begins,
- Notify Duke Benefits in writing within 180 days of you becoming disabled or while on Duke Workers’ Compensation leave and receiving wage replacement.
- 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 waiting period, you can receive pay and benefits through your vacation, sick, Paid Time Off (PTO) benefit, or donated hours through the Kiel Memorial Vacation/PTO Donation Program.

Exception: You may return to work for up to 30 days during the benefit waiting period without having to begin a new benefit waiting period. The days you work do not count toward meeting the benefit waiting period, and any part of a day worked will count as a full day for the benefit waiting period. If you return to work for more than 30 days before satisfying your benefit waiting period, you will have to begin a new benefit waiting period.

When Benefits Are Paid

Your Benefit Waiting Period Is:

<table>
<thead>
<tr>
<th></th>
<th>Duke University</th>
<th>Health System</th>
<th>All Other Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>90 calendar days</td>
<td>90 calendar days</td>
<td>120 calendar days</td>
</tr>
</tbody>
</table>

After completion of the benefit waiting period (see this page for additional information), 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.

Amount of Coverage

Total Disability

Total disability is defined as the following:

- 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 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.
Your monthly income benefit for total disability is equal to the lesser of 60% of your basic monthly earnings or $25,000, minus any other income, such as employment income, unemployment income, Workers’ Compensation, or Social Security payments.

Please note that your disability benefits are subject to federal and state taxes as taxable income.

Partial Disability
You are partially disabled when your indexed basic monthly earnings are reduced by more than 20% 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 earnings minus your current monthly earnings divided by your indexed basic monthly earnings times the benefit you would receive if you were totally disabled (before other income is subtracted) minus any other income.

Who is a doctor?
Doctor means a person who is:
1) 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;
2) licensed to practice in the jurisdiction where care is being given;
3) Practicing within the scope of that license; and
4) 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.

Basic Monthly Earnings
Basic monthly earnings are your base pay as of the day before your disability began. It does not include bonuses, commissions, shift pay or overtime pay.

Indexed Basic Monthly Earnings
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.
**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:

<table>
<thead>
<tr>
<th>Age at Disability</th>
<th>Maximum Benefit Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The end of the month following:</td>
</tr>
<tr>
<td>Less than age 61</td>
<td>to age 65</td>
</tr>
<tr>
<td>61 but less than 62</td>
<td>48 months</td>
</tr>
<tr>
<td>62 but less than 63</td>
<td>42 months</td>
</tr>
<tr>
<td>63 but less than 64</td>
<td>36 months</td>
</tr>
<tr>
<td>64 but less than 65</td>
<td>30 months</td>
</tr>
<tr>
<td>65 but less than 66</td>
<td>24 months</td>
</tr>
<tr>
<td>66 but less than 67</td>
<td>21 months</td>
</tr>
<tr>
<td>67 but less than 68</td>
<td>18 months</td>
</tr>
<tr>
<td>68 but less than 69</td>
<td>15 months</td>
</tr>
<tr>
<td>69 and over</td>
<td>12 months</td>
</tr>
</tbody>
</table>

**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,
- 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),
- 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,
- 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, 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.

Social Security Filing Requirements
We will require you to apply for disability benefits that may be available to you under the U.S. Social Security Act. The disability administrator is available to assist in your application for benefits. If we disagree 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. If denied again, you will be required to request a hearing. We will provide you 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 having requested you in writing to do so, we will estimate the amount of the Social Security disability benefit. We will include that amount as an “other income benefit” until we receive notice that your application was denied at the first level of appeal after the initial denial.

Paid Time Off and Duke Disability Benefits
Approved disability benefits may be supplemented with accrued paid time off (sick, vacation, 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 while on an approved long-term disability claim until their accrued sick or vacation is exhausted.
- Duke University Heath System employees can utilize accrued aid time off for weeks 13 – 25 of disability only. Beginning week 26 of disability, one is eligible for Duke’s LTD benefits and accrued paid time off may not supplement approved disability 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:
1. Fraud;
2. Any error made by the disability administrator in processing a claim; or
3. The covered person’s receipt of any Other Income benefits.

The disability administrator may recover an overpayment by, but not limited to, the following:
1. Requesting a lump sum payment of the overpaid amount;
2. Reducing any benefits payable under the policy;
3. Taking any appropriate collection activity available including legal action needed.

You will be notified by letter of the amount of overpayment by the disability administrator. You will have four weeks 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. See page 160 for more detail on “Other Income.”

Benefits that will be discontinued include, but are not limited to:
- Monthly income from the 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 his or her 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**

Employees eligible for the Duke contribution to the Faculty and Staff Retirement Plan will receive the contribution while on disability leave covered by the Duke Disability Plan. No employee contribution is required to receive the University contribution. Once approved for Long Term Disability, you become 100% vested in all Duke Contributions to the Faculty and Staff Retirement Plan.

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 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 terminated for non-payment, there is no reinstatement.
- There must not be a break in coverage under the disabled individual’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 date coverage ended to 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 regardless of a qualifying event;
• When a family member is removed from coverage, they may not re-enroll;
• Once eligible for Medicare, the individual must notify HR Benefits and immediately enroll in Medicare A and B. Those who do not enroll in Medicare 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.
• If the individual 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

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 equal to or be greater than 75 to continue Duke health insurance.

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
• For an employee who does not meet the Rule of 75, they 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 grandfathered 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

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.

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 whether you are sane or insane,
- 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 has designated Liberty Life Assurance Company of Boston (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.

All claims information must be submitted in English. You are responsible for any cost incurred in getting medical records translated. All claim benefits will be paid in U.S. dollars.

Claim Review Procedure

A claims kit with appropriate forms is available from the HRIC at 919-684-5600. Information is also available on the Duke web site, hr.duke.edu.

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 files, 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, docu-
ments, 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 runs out, call the Human Resource 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 his or her customary place of employment with the intent and ability of working the scheduled hours and doing the normal duties of his or her 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.

**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.


**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.

Total Disability, Totally Disabled (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

You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (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 plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan 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 plan, 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.
  - In addition to creating rights for plan participants, ERISA imposes duties on the people who are responsible for the operation of the plan. 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. 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. Or you can 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 Benefit Plan consists of the Duke Welfare and Fringe Benefit 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 Street
Box 90502
Durham, NC 27708-0502
(919) 684-5600

Plan Administrator
Duke University 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 Street
Box 90502
Durham, NC 27708-0502
(919) 684-5600

Named Fiduciary
Plan Administrator

Type of Benefit Plan Provided
Welfare and Fringe Benefit Plan. All benefits under the Plan are provided through employer paid, unfunded/ general assets.

Agent for Service of Legal Process
Director, Benefits
Duke University
705 Broad Street
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.

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This Benefit Program Description, which is part of the Duke University Welfare and Fringe Benefit 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.
Voluntary Disability Income Programs

Your Life Is Insured,  
But What About Your Income?  

If you are like most Americans, you have some form of life and health insurance, and probably insure other things you value, but what about your “income”? Who will pay the bills if you become disabled and cannot work? How will you preserve your lifestyle and your family’s security?  

Many people cannot keep up with monthly expenses if they miss more than a few paychecks. A disability could deplete your savings and affect your family’s future.  

Still, no one really expects to become disabled, especially for a period of months or even years. But the fact is, disability strikes one in four workers before age 65.* That is why Duke makes it possible for you to protect your income by offering an optional short term and long term disability program to supplement the disability benefits provided by Duke.  

The term “Duke” is used throughout this document. For purposes of this Benefit Program Description, “Duke” refers to the University, Duke University Health System, Inc., and any other entity which is or becomes controlled by Duke University and where, upon appropriate action by the Board of Trustees, the employees of that entity are included in the membership of these programs.  

* Source: 1987 Commissioner’s Group Disability Income Table, Society of Actuaries
# Voluntary Disability Income Programs

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Disability Coverages Provided By Duke University and Duke University Health System

As an employee 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 provides a group disability plan that replaces up to 60% of your base salary that begins after 120 calendar days.

As an employee of Duke University Health System you earn paid time off, 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 University Health System provides a group disability plan that begins after 90 calendar days.

See Duke Disability Program section beginning on page 154 for further details.
Additional Disability Coverage You Can Purchase

The voluntary 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.

Deciding Which Plans to Choose
Consider the importance of each plan:

Duke University or Medical Center Employees
Voluntary 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 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. This plan is one of the MOST IMPORTANT benefits you can purchase because it can help protect your financial future.

Voluntary Short Term Disability (STD)
Voluntary STD benefits begin after four weeks 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 sick leave during the four week waiting period.

Voluntary Long Term Disability (LTD)
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 16 weeks.

Duke University Health System Employees
Voluntary 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.

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. This plan is one of the MOST IMPORTANT benefits you can purchase because it 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.

Voluntary STD
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 LTD
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.

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, 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.
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 faculty, Private Diagnostic Clinic faculty, and house staff. 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 Private Diagnostic Clinic faculty and house staff. Full-time Clinical Associates and Consulting Associates are eligible for this program.

Duke University Health System Employees

- Voluntary STD — Active full-time employees in a benefit eligible classification, excluding faculty, Private Diagnostic Clinic faculty, and house staff. 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 faculty, Private Diagnostic Clinic faculty, and house staff. Full-time Clinical Associates and Consulting Associates are eligible for this program.

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 in your new hire packet or online at hr.duke.edu, and return it to our plan record keeping administrator:

The MGIS Companies
10 West Broadway, Suite 800
Salt Lake City, UT 84101-2100

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. 175
9:30 AM to 6:15 PM 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/benefits

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/disabilitybenefits/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.

All plans provide benefits for total disability. All plans may provide benefits even if you are partially disabled during the benefit waiting period and after.

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 weekly 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 LTD benefits will be reduced by the amount of other income benefits you receive while disabled, such as Social Security, sick leave, vacation pay, hours donated through the Kiel Memorial Vacation/PTO Donation Program, 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.

No Voluntary STD or LTD premium payments are due while you are receiving Voluntary STD or LTD benefits.

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-benefits/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:

Normal Retirement Age means the Social Security Normal Retirement Age as stated in the 1983 revision of the United States Social Security Act. It is determined by your date of birth as follows:

<table>
<thead>
<tr>
<th>Year of Birth</th>
<th>Normal Retirement Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1937 or before</td>
<td>65</td>
</tr>
<tr>
<td>1938</td>
<td>65 + 2 months</td>
</tr>
<tr>
<td>1939</td>
<td>65 + 4 months</td>
</tr>
<tr>
<td>1940</td>
<td>65 + 6 months</td>
</tr>
<tr>
<td>1941</td>
<td>65 + 8 months</td>
</tr>
<tr>
<td>1942</td>
<td>65 + 10 months</td>
</tr>
<tr>
<td>1943 through 1954</td>
<td>66</td>
</tr>
<tr>
<td>1955</td>
<td>66 + 2 months</td>
</tr>
<tr>
<td>1956</td>
<td>66 + 4 months</td>
</tr>
<tr>
<td>1957</td>
<td>66 + 6 months</td>
</tr>
<tr>
<td>1958</td>
<td>66 + 8 months</td>
</tr>
<tr>
<td>1959</td>
<td>66 + 10 months</td>
</tr>
<tr>
<td>1960 or after</td>
<td>67</td>
</tr>
</tbody>
</table>

As long as you remain totally disabled, Voluntary LTD benefit payments will continue according to the following 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

STD/LTD 12/2000 Printed in USA Copyright 2000
The Hartford, Hartford CT 06115

Underwritten by:
Hartford Life and Accident Insurance Company
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.

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 https://www.thehartfordatwork.com/thaw/. For claim processing, the Duke’s group number is 043211. For a voluntary long term disability claim, please file your 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 plan 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 Faculty and Staff Retirement Plan for Exempt Employees

Duke offers the Faculty and Staff Retirement Plan for eligible faculty and staff members. For exempt employees, the program is funded by both your and Duke’s contributions. You may make voluntary contributions through payroll deduction, and Duke will make a contribution if you are in an eligible category, are at least age 21 and have completed one year of service. You direct your own investments in this plan. Duke has designed a simplified investment tiered structure to help you with your investment selection.

The term “Duke” is used throughout this document. For purposes of this summary plan description, “Duke” refers to the University, Duke University Health System, Inc., and any other entity which is or becomes controlled by Duke University and where, upon appropriate action by the Board of Trustees, the employees of that entity are included in the membership of this plan.

This is a summary plan description of the Duke University Faculty and Staff Retirement Plan provisions for exempt employees. It highlights the main provisions of the plan but is subject to the terms of the legal documents, which may be modified from time to time. Where this description and the official documents vary, the official plan documents are the final authority. Duke reserves the right to change or terminate this benefit or your eligibility for benefits under the plan. This description of the Duke Faculty and Staff Retirement Plan is not an employment contract or any type of employment guarantee.
# Duke Faculty and Staff Retirement Plan for Exempt Employees

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Eligibility and Participation

Eligibility to Make Contributions
You are eligible to make contributions to the plan if you are a faculty member or staff member of Duke, including house staff, post-doctoral associates or postdoctoral scholars, or chaplains in Job Code 1671.

A faculty member or staff member does not include graduate or undergraduate student workers or otherwise exempt from FICA taxes; or non-resident aliens who do not have earned income from Duke that constitutes income from sources within the United States.

Eligibility to Receive Duke’s Contribution
You are eligible to receive Duke’s contribution if you are a faculty member or exempt staff member of Duke. However, you are not eligible to receive Duke’s contribution if you are classified as: non-exempt staff, house staff, a post-doctoral associate or post-doctoral scholar, or a chaplain in Job Code 1671.

If you are in an excluded position as of January 1, 2009, but received the Duke contribution in December 2008, you will be “grandfathered” and continue to receive the Duke contribution while in that excluded position.

Participation
You may participate in the plan upon employment and make your own voluntary contributions by completing and properly executing the investment carrier applications and the enrollment/retirement contribution form. Enrollment information is included in your new hire packet or you may log on to: hr.duke.edu/retirementmanager. Duke may make contributions on your behalf (subject to the exceptions outlined in the next section) in the month following the month you have completed one year of service and have attained age 21.

The investment carriers offered in the Faculty and Staff Retirement Plan are:
- Fidelity Investments (Fidelity)
- TIAA
- VALIC
- The Vanguard Group (Vanguard).

Exceptions to One Year Wait for the Duke Contribution
If you are a professor, associate professor, or such subsequent designation selected by Duke, you may participate and Duke’s contribution may commence on the first day of the month following your employment date, if age 21 or older at the time of employment.

If you are eligible for Duke’s Contribution, you may be eligible to waive the one year wait if you meet the following criteria:
- Your hire date with Duke is within 90 days of your date of termination with your immediate previous employer;
- You were receiving fully vested employer contributions or accruals under a Code Section 403(b), 401(k), or 401(a) retirement plan maintained by the prior organization; and
- Your immediate previous employer is an organization as described in Section 501(c)(3) of the Internal Revenue Code (the Code) (examples: churches, schools, colleges/universities, hospitals, medical research organizations, some publicly supported/ community organizations) or a state educational organization as described in the Code Section 403(b)(1)(A)(ii).

It is your responsibility to provide proof of participation with your previous employer’s plan. Additional information about the documentation required for the service waiver can be obtained at: hr.duke.edu/servicewaiver

If your service waiver is approved, your Duke contribution will start on the first day of the month following the month the HRIC receives acceptable information from your previous employer.

In the event you are not currently an eligible employee, you may participate if you become eligible, and Duke’s contribution may commence at that time if you have attained age 21 and met the service requirements.

PLEASE NOTE: The timing of your eligibility may result in contributions being made on your behalf in the month following your date of hire.
Your Voluntary Contributions
You may make elective (or “voluntary”) contributions from your salary on a pre-tax basis, Roth after-tax basis or a combination of both by means of a salary reduction agreement.

Pre-Tax Contributions
When you contribute to the plan on a pre-tax basis, you pay no current federal or state income tax on the salary directed into the plan. It is important to understand that you are not avoiding paying taxes on these contributions permanently; instead you are deferring the payment of taxes until the time you receive a distribution from the plan.

Roth After-Tax Contributions
When you contribute on a Roth after-tax basis, you pay current federal or state income tax on the salary directed into the plan; however, you can make tax-free withdrawals of your contributions—and any earnings—provided that you are at least 59½ and made your first Roth after-tax contribution at least five years earlier.

Contribution Limitations
Your combined voluntary contributions which include pre-tax and Roth contributions are limited by Internal Revenue Service (IRS) rules. Your contribution limit for each plan year (January 1 to December 31) can be viewed on the Duke Retirement Manager website. Duke Retirement Manager is a secure website where you can enroll, make changes to your contributions and view information about your retirement plan. Please see instructions for accessing the site at: hr.duke.edu/retirementmanager.

In addition, the limits contained in Sections 403(b) or 415 of the Code may limit your voluntary contributions. If you have questions about your contribution limits, contact the Human Resource Information Center (HRIC) at (919) 684-5600.

The minimum voluntary contribution amount is $25.00 per pay period or 1% of pay. The maximum contribution amount is 80% of your salary per pay period.

Effective Date
Since your contribution is by means of a salary reduction agreement, the HRIC needs to receive the salary reduction agreement at least 30 days prior to the pay date.

Excess Contributions
If you have made voluntary contributions in excess of the limit for a plan year, you must notify the HRIC, in writing, of the excess amount. If notification occurs on or before March 1 following the plan year in which the excess contribution was made, the excess amount is adjusted to reflect any credited investment gain or loss through the end of the calendar year of the excess contribution, and will be distributed no later than April 15 of the following calendar year. You are responsible for determining whether your contributions are within the dollar limitations and for payment of any tax or penalty if the dollar limitations are exceeded.

Employee Contributory Account
All of your voluntary contributions to the plan are allocated to an employee contributory account maintained on your behalf by the plan investment carrier(s) that you designate.

Duke’s Contribution
Duke’s contribution is determined each year and published prior to the beginning of the plan year (January 1 to December 31). You can obtain the contribution formula for the current plan year at: hr.duke.edu/dukecontribution.

For information regarding the amount of Duke’s contribution for prior plan years, contact the HRIC.

Employer’s Contributory Account
All of Duke’s contributions to the plan on your behalf are allocated to an employer contributory account maintained on your behalf by the investment carrier that you designate.

In the event that you do not designate an investment carrier for your plan contributions, those contributions will be invested with the designated default vendor, as determined by the Plan Administrator.

Changes to or Termination of Agreements
Either you or Duke may terminate or change a salary reduction agreement by giving at least 30 days
written notice of the date of termination. If you terminate your employment with Duke, your salary reduction agreement will automatically terminate and contributions will cease.

**Discontinuance of Contributions upon Termination of Employment**
If you terminate your employment, Duke will discontinue making contributions as of your date of termination.

**Plan Contributions After Normal Retirement Date**
If you are employed by Duke and eligible to make voluntary contributions and/or eligible to receive the Duke contribution, you may continue your contributions on eligible salary and Duke will continue to make contributions until the end of the month in which you retire or terminate employment.

**Plan Contributions during Leaves of Absence**
If you are on a leave of absence with pay, Duke will continue to make contributions and you may continue making contributions to the plan.

If you are on a leave of absence without pay, Duke will discontinue making contributions and you may not make any contributions to the plan.

**Plan Contributions during Sabbatical**
If you are granted sabbatical leave, Duke will continue to make contributions based on actual pay received.

**Plan Contributions during Disability Leave**
Employees eligible for the Duke contribution to the Faculty and Staff Retirement Plan will receive the contribution while on disability leave and approved for coverage by the Duke Long Term Disability Plan. No employee contribution is required to receive the Duke contribution.

**Contributions to Other Retirement Plans**
Duke is required by law to collect information regarding certain employees who participate in a retirement plan with another employer. If you have participated or will participate in another employer-sponsored retirement plan during this calendar year AND own or have owned (during this calendar year) more than 50% of that business (such as consulting practice), please contact the HRIC at (919) 684-5600 to speak to the Retirement Plan Manager. Duke will need to collect some information pertaining to your contributions to the retirement plan sponsored by that business. (See IRS Publication 571)

**Rollover Contributions**
The investment carriers at their discretion may accept rollover contributions but only to the extent that they constitute eligible rollover distributions (as defined in the Internal Revenue Code) from an eligible retirement plan (as defined in the Internal Revenue Code) and are directly rolled over from an eligible retirement plan or accepted by an investment carrier from you within 60 days of your receipt of such contributions from an eligible retirement plan.
Vesting of Plan Contributions

Vesting of Plan Contributions
Vesting means ownership of the amount in your Plan account. Once you are vested, you have an irrevocable right to the amount in your account adjusted for any gains or losses. You are always 100% vested in your voluntary contributions, however, vesting rules apply to Duke’s contribution.

Employees Hired Before January 1, 2012
You are always 100% vested in your voluntary contribution and will always be 100% vested in Duke’s contribution. If you terminate on or after January 1, 2012 and are reemployed, you will remain 100% vested in Duke’s contribution.

If you were previously employed at Duke and separated from service prior to 2002, please contact the HRIC at (919) 684-5600 to reestablish vesting.

Employees Hired January 1, 2012 or Thereafter
You are always 100% vested in your voluntary contributions and you will become 100% vested in Duke’s contribution to your employer contributory account upon:

- Completion of three (3) Years of Service,
- Attainment of age 65 while employed by Duke,
- Being hired after age 65,
- Death while employed by Duke, or
- Approval for long term disability under the Duke Long Term Disability Plan.

Forfeiture of Duke’s Contribution
Once you are 100% vested in Duke’s contribution, your employer contributory account cannot be forfeited. However, if you terminate employment from Duke before you are 100% vested in your employer contributory account, the non-vested portion of your employer contributory account including earnings will be forfeited upon the earlier of:

- The day in which you receive a full distribution of your employee contributory account; or
- The day in which you are separated from Duke for five (5) or more years.

Restoration of Duke’s Contribution
If you are reemployed by Duke before being separated for five (5) or more years and you received a full distribution of your employee contributory account, your employer contributory account will be restored unadjusted by any gains or losses if you repay in full the amount distributed, unadjusted by any gains or losses, within five (5) years from the date of reemployment. However, if you are reemployed by Duke after being separated from Duke for five (5) or more years, your employer contributory account will not be restored.

Years of Service
For the purpose of vesting in your employer contributory account, your Years of Service includes all periods of employment when you are a Duke employee, whether continuous or not, including periods of employment when you are not eligible to participate in the plan or eligible to receive Duke’s contribution.
Investment Options

Tiered Investment Choices
Duke has formed an Investment Advisory Committee (IAC) to ensure that you have access to high quality investment options at the lowest reasonable cost. The IAC is comprised of key Duke University and Duke University Health System administrators who work closely with expert consultants who specialize in investment management. The IAC has chosen a group of funds that are regularly monitored to ensure that they remain appropriate investment options for Duke's plan.

To make it easier to navigate your choices, investments are grouped into three tiers. Funds in Tier 1 and Tier 2 have been specifically chosen by the IAC for the Duke Faculty and Staff Retirement Plan based on their suitability for use in a diversified retirement savings portfolio and their competitive expense level. These funds are benchmarked annually to ensure that their performance and cost remain competitive. Other funds are available in Tier 3, but they are not monitored regularly by the IAC.

- **Tier 1: Asset Allocation Funds**
  This tier includes two types of funds that offer a way to make a single choice for your retirement needs: Target Date Funds and a Balanced Fund.

- **Tier 2: Core Funds**
  These funds represent the primary asset classes (stocks, bonds, and short-term instruments) and have been chosen by the IAC based on their suitability for inclusion in a customized retirement portfolio. You can select from this group of “best-in-class” funds to build your own diversified portfolio. Your preferred investment carrier will have resources available to help you.

- **Tier 3: Other Funds**
  These funds are not monitored regularly by the IAC, so you will be responsible for monitoring the holdings and performance of these funds to ensure they remain in line with your investment strategy.

Additional information about the tiered structure and a listing of the investment options currently available under the plan can be obtained by contacting the investment carriers or at: hr.duke.edu/tiered.

Investment Performance and Participant Fee Disclosure Information

The fee disclosure information which includes fees and services associated with the plan is available at hr.duke.edu/performance. This disclosure is intended to provide you with important information to assist you in making informed decisions about the management of your plan account and the investment of your retirement savings.

The prospectus for each investment option is also a major source of information and is available from the investment carriers. A prospectus describes the investment option’s objectives and policies which are governed solely by the investment carriers’ agreements, and contains information required by the Securities and Exchange Commission on subjects such as the investment option’s performance, services, restrictions, officers and directors, and expenses. You are strongly encouraged to read the fee disclosure, the prospectus and other available literature before investing in a particular fund.

Your Investment Carriers
Each of Duke’s investment carriers offer investment options in the same tiered structure, providing you with the opportunity to build a diversified investment portfolio without having to spread your investments over multiple providers. The approved investment carriers are:

- Fidelity Investments (Fidelity)
- TIAA
- The Vanguard Group (Vanguard)
- VALIC.

Duke has the right, upon reasonable notice to you, to add or eliminate an investment carrier or investment options.

Your Rights to Direct Your Contributions
You are solely responsible for making the decisions regarding the investment of your employee contributory account and employer contributory account. It is your responsibility to initiate and complete any procedure required by an investment carrier to enroll in or maintain an investment option.

Your employee contributory account and employer contributory account may be divided among investment carriers and their investment options in any whole percentages (but not fractions of a percent) that you select, except that you may not direct any portion of your employer contributory account to a TIAA Group Supplemental Retirement Annuity (GSRA).
Your Default Investment Options
If you fail to select an investment carrier for your employer contributory account, that account will be automatically invested with the investment carrier or carriers in the same proportions as your employee contributory account until changed by you.

If you fail to select an investment carrier for your employer contributory account and you do not make voluntary contributions, those employer contributions will be automatically invested with the default carrier, as designated by the Plan Administrator.

If you select an investment carrier but do not make investment elections with that investment carrier, your contributions will be automatically invested in the default investment fund established under the Plan for that carrier. Contributions invested in a default investment fund will remain invested in the default fund until you direct otherwise.

Making Changes to Your Investments
You may change the investments of your future plan contributions (subject to certain restrictions and/or fees imposed by the investment carriers) by completing the appropriate forms available through your investment carrier.

Transfer of Your Plan Contributions
You may transfer, in whole or in part, existing contributions in either your employee or your employer contributory account from one investment carrier to another. The value of your account at the time of transfer is based on current market value and is subject to any gains or losses.

The transfer is effected by completing the appropriate forms available from the investment carrier and is subject to the restrictions and fees contained in the agreements with the applicable investment carriers.

It is intended that the plan constitute a plan described in Section 404(c) of the Employee Retirement Income Security Act of 1974 (ERISA) and that the fiduciaries of the plan, including Duke and the Investment Advisory Committee, shall be relieved of liability for any losses or lack of gains which are the direct and necessary result of investment instructions given by you or your beneficiary. Accordingly, you are encouraged to consult an investment or financial adviser before making investment decisions.
Retirement Benefits

The plan is designed to provide you with a retirement income. Plan contributions (yours and Duke’s), plus interest, earnings, and capital appreciation on the contributions will be used to provide your retirement benefits.

The normal retirement date under the plan is the day on which you attain age 65. However, you may elect to retire at any age following termination of employment with Duke. Upon separation of service from Duke, you may elect to receive benefits under the plan or postpone the commencement of your benefits up to any date permitted under the investment carrier’s contract or agreement but not beyond April 1 of the calendar year following your attainment of age 70½ or, if later, termination of employment with Duke.

Following your termination of employment from Duke, you may continue to direct the investment of your employee contributory account and employer contributory account among the investment options offered by your investment carrier(s), subject to such investment carrier’s restrictions and fees. You also may transfer your employee contributory account and/or the vested portion of your employer contributory account to an Individual Retirement Account (IRA), an eligible retirement plan, or from one investment carrier to another, subject to tax regulations and the restrictions and fees imposed by the applicable investment carrier.

You should contact your investment carrier(s) in order to arrange for retirement benefits or other distributions to begin.

Commencement of Benefit Payments

Employee Contributory Account

Subject to any restriction, limitation, or fee contained in the contract or agreement with any applicable investment carrier, withdrawals and distributions from your employee contributory account may commence upon the occurrence of any one of the following events:

- Your retirement, or
- Your death, or
- Your termination of employment with Duke, or
- Your attainment of age 59½, or
- Your disability, which is defined in Section 72(m)(7) of the Code as the inability to engage in any substantial gainful activity due to any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration, or
- You encounter a financial hardship as defined in the Internal Revenue Code and relevant regulations, applying applicable “safe harbor” rules, and as determined by the investment carrier holding the amounts requested for distribution, and upon submission to said investment carrier of such determination of hardship. If you receive a hardship distribution, you will be suspended from making voluntary contributions to the plan for a period of six months and may be subject to other restrictions that are imposed under federal law. It is your responsibility to restart your contributions once your six month suspension has ended.

You should contact the applicable investment carrier(s) prior to the commencement of benefit payments from your employee contributory account to determine if any restrictions, limitations, or fees apply.

Employer Contributory Account

Subject to any restriction, limitation, or fee contained in the contract or agreement with any applicable investment carrier, withdrawals and distributions from the vested portion of your employer contributory account may commence only upon the occurrence of any one of the following events:

- Your retirement, or
- Your death, or
- Your termination of employment at Duke, or
- Your attainment of age 67, or
- Your disability (as defined in the previous page).

You should contact the applicable investment carrier(s) prior to the commencement of benefit payments from your employer contributory account to determine if any restrictions, limitations, or fees apply.

Loans

The plan permits loans to be taken from your employee contributory account subject to any restrictions, limitations, or fees imposed by
investment carrier. You are solely responsible for complying with the investment carrier’s rules. Loans are offered by TIAA and VALIC.

**Taxation of Benefit Payments**

**Taxation of Pre-tax Contributions**

Benefit payments from your pre-tax voluntary contributions or Duke contribution are included in your income in the year of payment. In addition, substantial tax penalties may be imposed on withdrawals prior to attainment of age 59½, death or disability. You should consult your accountant, tax attorney, or other qualified financial adviser before making a withdrawal from the plan.

In the case of certain benefit payments, you may defer taxation on the payment by electing a direct rollover of all or part of such distributions to an IRA or another employer’s eligible retirement plan that accepts rollovers. If a benefit payment is eligible for direct rollover treatment but you do not elect rollover treatment, the investment carrier is required to withhold 20% of the taxable portion of the benefit payment.

For more information about the taxation of benefit payments or whether a benefit payment is eligible for direct rollover treatment, contact your investment carrier(s).

**Taxation of Roth After-Tax Contributions**

In general, to make a qualified tax- and penalty-free withdrawal of Roth contributions and earnings, the following conditions must be met:

- The account must have been established for at least five years, and
- The withdrawal must be taken at or after age 59½, or as the result of disability or death.

The five year period begins on January 1 of the year you make your first Roth after-tax contribution, which can be made at any time during the year. Even if you contribute in December, you will still receive a year’s credit. Also, you don’t have to make a contribution every year. Your first contribution “starts the clock.”

Distributions that do not meet these conditions are considered nonqualified withdrawals. Nonqualified withdrawals are treated as a prorated return of Roth contributions and earnings. The portion of the distribution that represents earnings will be subject to ordinary income tax and possibly a 10% federal penalty tax for early distributions. However, the portion of the withdrawal that represents a return of Roth contributions would not be subject to tax.

For more information about the taxation of Roth after-tax contributions or whether a distribution is a qualified withdrawal, contact your investment carrier.

**Forms of Benefit Payments**

Once you are eligible to begin receiving benefit payments, you can elect any of the payment options available by the investment carrier(s) you selected.

If you do not elect a payment option, plan contributions will remain invested in the investment options selected until such time as you initiate payment.

**Normal Form of Benefit Payment**

The normal form of benefit payment is an annuity; however, if you are invested in mutual funds and you wish to receive all or a portion of your benefits in the form of an annuity, you must transfer such amounts to an annuity product. Otherwise, amounts held in mutual funds will be paid in the form of a lump sum distribution unless you elect an optional form of payment.

If you are not married on the date benefit payments commence, benefits will be paid in the form of a single life annuity unless you elect an optional form of payment. Under a single life annuity, monthly benefit payments are made for your lifetime, and at your death, all benefit payments will stop.

If you are married on the date benefit payments commence, benefits will automatically be paid in the form of a joint and survivor annuity, unless you and your spouse elect an optional form of payment. Under a joint and survivor annuity, monthly benefit payments are made for your lifetime and, at your death, your surviving spouse will receive monthly benefit payments equal to 50% or more (depending on your election) of your monthly benefit. After the surviving spouse dies, all benefit payments will stop.

**Optional Forms of Benefit Payment**

If you do not wish to receive benefit payments under the normal forms of payment, you can elect any one of the optional forms of payment to the extent offered by the investment carrier(s), which may include: 1) lump sum payment, 2) installment payments, 3) annuity with period certain, or 4) eligible rollover. The election of an optional form of payment must be made during the 180-day period before benefit payments begin. In addition, if you are married when benefit payments begin, your spouse must give
written, notarized consent to the optional form of payment within the same 180-day period.

For more information about the optional forms of payments available, contact your investment carrier(s).

**Rollover Distribution**
If you become an employee of another employer that maintains an eligible retirement plan, you may elect to roll over the assets of your employee contributory account and the vested portion in your employer contributory account to the other employer’s plan subject to any restrictions, limitations, or fees of the investment carrier or other employer.

**Qualified Domestic Relations Orders**
The plan will comply with the terms of a qualified domestic relations order to the extent that the order is consistent with the terms of the plan as determined by the Plan Administrator or applicable investment carrier that has responsibility for qualified domestic relations orders.
Designation of Beneficiaries and Survivor Benefits

Designating a Beneficiary
A beneficiary or beneficiaries are individuals you designate to receive benefits from the plan in the event of your death. It is important for you to designate one or more beneficiaries on the beneficiary designation form that is filed with your investment carrier(s), so that benefits can be paid how you intend rather than being paid to your estate and involving a lengthy court process.

If you are not married, you can name anyone as a beneficiary. If you are married, your surviving spouse must be the beneficiary to at least 50% of your plan benefits unless your spouse provides written, notarized consent to the designation of a different beneficiary or beneficiaries.

You may change your beneficiary at any time (subject to the spousal consent requirement) by submitting a revised beneficiary designation form to the investment carrier(s). If your marital status changes, you should review your beneficiary designation. For example, your marriage will automatically revoke and revise a designation of a non-spouse beneficiary to 50% of your plan benefits.

Survivor Benefits
If you die before your benefit payments begin, the full value of your plan benefits will be paid to your designated beneficiary(ies). If you are married and die before your benefit payments begin, your spouse, unless you elected otherwise and your spouse consented, is entitled to receive 50% of your plan benefits in the form of an actuarially equivalent life annuity or other option permitted by the investment carrier. The remaining 50% will be payable to your designated beneficiary, which may be your spouse or other beneficiary. If you wish to leave more than 50% of your plan benefits to a beneficiary other than your spouse, you and your spouse must waive the survivor life annuity and the waiver of the spouse must be notarized. You generally must be at least 35 years old to waive the survivor life annuity benefit.

If you die without having named a beneficiary, all plan benefits shall be distributed in accordance with the terms of the applicable investment carrier’s agreement except as otherwise described in the preceding paragraph regarding a surviving spouse’s interest.

Your beneficiary may elect to withdraw the assets, in whole or in part, in any manner acceptable to the investment carrier which may include lump sum, installment, and annuity payments.

In the event you die after your benefit payments have commenced, then depending on the form of payment elected before death, your beneficiary will receive either nothing (if a single life annuity or a lump sum payment was elected) or the balance of your benefits (if your beneficiary is also your co-annuitant) in the form of a survivor annuity or in installments for the duration of the payment period you elected.

Additional Rules

Divorce
If you have designated your spouse as the beneficiary, your divorce will automatically revoke a designation of your ex-spouse unless you submit a new beneficiary designation again designating your ex-spouse or a qualified domestic relation order designating your ex-spouse as your beneficiary.

Minors
If you are naming minor beneficiaries, you will need to consider who will manage the plan benefits until the minor(s) can legally take ownership of the account upon reaching the age of majority.

You may designate a minor as your beneficiary of the plan; however, payments will be made to their legal guardian, custodian or parent of the minor.

Other Situations

Your designated beneficiary must be alive (and any entity designated as beneficiary must be in existence) at the time of your death in order to be entitled to receive any undistributed plan benefits. If your beneficiary dies within 120 hours of your death, plan benefits will not be paid to your beneficiary. Instead, plan benefits will be distributed to your alternative beneficiaries.

In the event that you or your beneficiary dies as a result of a criminal act involving any other beneficiary and that beneficiary is convicted of such criminal act, he or she shall not be entitled to receive any undistributed plan benefits.

Required Documentation
In each case, appropriate documentation must be provided to your investment carrier(s) in order for the foregoing rules to apply. The investment carrier(s) or Duke will not be liable if any distribution or transfer was made to a beneficiary in the absence of such documentation.
Plan Information

Plan Name
The Duke University Faculty and Staff Retirement Plan

Employer Identification Number
Assigned by IRS
56-0532129 (Duke University)
56-2070036 (Duke University Health System Inc.)

Plan Number assigned by Plan
001

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
Duke University 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 the Benefits Office, is responsible for the day-to-day operations of the Plan. However, the Plan Administrator has delegated to the Investment Carrier(s) 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
Duke Investment Advisory Committee

Type of Benefit Plan Provided
Defined Contribution Plan. All benefits under the Plan are provided through individually owned and fully funded annuity contracts or custodial accounts as described in Section 403(b) of the Internal Revenue Code.

Agent for Service of Legal Process
AVP, Benefits
Duke University
705 Broad St.
Durham, NC 27708-0502
(919) 684-5600

Funding of the Plan
Plan is funded by the employer contributions and/or the employee voluntary contributions. Contributions are remitted to the applicable investment carrier(s).

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.

The Employee Retirement Income Security Act of 1974 (“ERISA”) created the Pension Benefit Guaranty Corporation (“PBGC”), which provides federal insurance for certain retirement benefits. The benefits under this Plan are NOT insured by the PBGC. The PBGC insures only pension plans that promise a fixed level of benefits without regard to whether sufficient contributions have actually been made. Under this Plan, the benefits promised are exactly equal to contributions actually made (adjusted for investment experience), so no insurance is provided.

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.

Controlling Effect of Plan Documents, Governance, and Interpretation
The plan document for the Duke University Faculty and Staff Retirement Plan is a separate legal document and governs the plan’s 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 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 plan shall in all cases be interpreted in a manner that is consistent with (i) a single “retirement plan” within the meaning of ERISA, and (ii) the exclusion from gross income of benefits provided hereunder in accordance with Internal Revenue Code Section 403(b) and other Internal Revenue Codes that may apply.

Your Rights Under ERISA
You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (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 plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan 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
plan, 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.

- In addition to creating rights for plan participants, ERISA imposes duties on the people who are responsible for the operation of the plan. 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. 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. Or you can 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.

**Your Rights Under USERRA**

Under the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA), eligible staff may make up missed contributions to the Plan and eligible exempt staff may receive the Duke contribution after re-employment with Duke following a leave from Duke to enter the U.S. Armed Forces or other eligible service as defined by USERRA. Timeframes for returning to Duke following service and the required type of discharge (e.g. honorable) are defined in USERRA. The period during which you can make up voluntary contributions is equal to three (3) times the period of your Qualified Military Service, up to a maximum of five (5) years. For example, if your Qualified Military Service period is one year, you have three (3) years following the date of your reemployment to contribute make-up voluntary contributions. The amount of the make-up voluntary contributions is subject to the dollar limit(s) that applied during the Qualified Military Service and is in addition to the usual contribution limit. You can change, terminate, or resume your voluntary contributions during the make-up period without penalty for termination. If you want to make-up voluntary contributions, contact Benefits to help you establish your make-up voluntary contributions.
Claims and Appeals Procedures

If your application for benefits is denied in whole or in part by an investment carrier or if you believe that you are being denied any rights under the plan, such as eligibility, participation, and contribution rights, you (or your beneficiary, if applicable) may file a claim with the Plan Administrator under the following claims and appeals procedures.

To file a claim under the plan, you or your authorized representative must submit a written statement that includes the basis of your claim. The statement must be dated and signed by you or your authorized representative and must include an address and telephone number.

If your claim is denied, you will normally receive a written or electronic notice of the denial within 90 days (or within 180 days if special circumstances require additional time to process your claim) following the Plan Administrator’s receipt of the claim. If additional time is needed, you or your authorized representative will receive, within the first 90 days, a written or electronic notice of extension that will explain what special circumstances make the extension necessary and will indicate the date a final decision is expected to be made. The notice will explain: (i) the specific reasons for the denial, (ii) references to the plan provisions upon which the denial is based, (iii) a statement that you are entitled to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relating to your claim for benefits, and (iv) a statement of your right to bring a civil action under Section 502(a) of ERISA.

If your claim is denied in whole or in part, you or your authorized representative may appeal the denial to the Staff Fringe Benefits Committee (the Committee). The appeal must be in writing and must be filed with the Committee within 60 days after receiving the notice of denial. You may request that your appeal be given full and fair review; taking into account all claim related comments, documents, records, and other information you have submitted without regard to whether such information was submitted or considered under the initial decision. You also may submit additional written comments, documents, records, and other information relating to your claim. You may review all pertinent documents and submit issues and comments in writing in connection with the appeal and may request reasonable access to, and copies of, all documents, records, and other information relating to your claim free of charge.

If the Committee denies your claim upon review, you will normally receive a written or electronic notice within 60 days (or within 120 days if special circumstances require additional time to process your claim) following the Committee’s receipt of the claim. If additional time is needed, you or your authorized representative will receive, within the first 60 days, a written or electronic notice of extension that will explain what special circumstances make the extension necessary and will indicate the date a final decision is expected to be made. The notice will explain: (i) the specific reasons for the denial, (ii) references to the plan provisions upon which the denial is based, (iii) a statement that you are entitled to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relating to your claim for benefits, and (iv) a statement of your right to bring a civil action under Section 502(a) of ERISA.

The Staff Fringe Benefits Committee’s decision will be final and binding.

You may reach the Plan Administrator and the Staff Fringe Benefits Committee at the following address:

Duke Benefits
Duke University
705 Broad St.
Box 90502
Durham, NC 27708
Definitions

**ANNUITY:** An amount paid at regular intervals (generally monthly) upon retirement. This amount is guaranteed by an insurance company and is payable depending on the option selected.

**BENEFICIARY:** The individual(s), trust(s), or other entity (ies) you designate to receive benefits from the plan in the event of your death.

**EFFECTIVE DATE:** January 1, 2018, the date of this summary as most currently updated.

**EMPLOYEE CONTRIBUTORY ACCOUNT:** A separate account maintained by each investment carrier for your contributions (including voluntary contributions and, to the extent permitted by the investment carrier, rollover contributions), and the income, expenses, gains and losses attributable to such contributions.

**EMPLOYER:** Duke University, Duke University Health System, Inc., and any other corporation or entity that adopts this plan with the approval of the University.

**EMPLOYER CONTRIBUTORY ACCOUNT:** A separate account maintained by each investment carrier for contributions made by Duke on your behalf, and the income, expenses, gains and losses attributable to such contributions.


**INVESTMENT CARRIER:** One or more of the companies selected by the University to provide investment options.

**NORMAL RETIREMENT DATE:** The day on which you attain age 65.

**PARTICIPANT:** Every eligible employee enrolled in the plan and every individual who has vested rights to benefits under the plan.

**PLAN:** The Duke University Faculty and Staff Retirement Plan, and all agreements, applications, and designations relating to it.

**PLAN CONTRIBUTIONS:** The money you and Duke contribute to be invested for the purpose of providing retirement benefits.

**PROSPECTUS:** The official document which describes an investment fund and offers its shares for sale. It contains information required by the Securities and Exchange Commission on such subjects as the fund’s investment objectives and policies, services, investment restrictions, officers and directors, and expenses. The prospectus is a major source of information on the investment(s) of its fund and should be read carefully.

**QUALIFIED MILITARY SERVICE:** Military service which entitles the employee to full reemployment rights as prescribed by the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) upon his or her return to employment with the University.

**UNIVERSITY:** Duke University (also referred to as “Duke” and “the University”). However, the term “Duke” also includes Duke University Health System.

**VESTING:** Vesting means ownership of the market value of your account. You are always 100% vested in your own voluntary contributions. Vesting only applies to Duke's contribution. Once you are vested, you have an irrevocable right to the amount of the Duke contribution in your account adjusted for gains or losses.

**VOLUNTARY CONTRIBUTIONS:** A voluntary election to make contributions from your salary on a pre-tax basis, Roth after-tax basis or a combination of both by means of a salary reduction agreement.

**YEARS OF SERVICE:** All periods of employment when you are a Duke employee, whether continuous or not, including periods of employment when you are not eligible to participate in the plan or you are not eligible to receive Duke Contribution.
Duke provides two retirement plans for employees who are paid on the biweekly payroll: the Employees’ Retirement Plan (ERP) and the Faculty and Staff Retirement Plan.

You are eligible to participate in the Employees’ Retirement Plan as a biweekly-paid Duke employee, if you:

- Have reached age 21, and
- Have worked at least 1,000 hours during your first year of employment or in any future fiscal year.

For employees on the biweekly payroll, the Faculty and Staff Retirement Plan allows eligible employees to voluntarily save additional money for their retirement.

The term “Duke” is used throughout this document. For purposes of this summary, “Duke” refers to the University, Duke University Health System, Inc., and any other entity which is or becomes controlled by Duke University and where, upon appropriate action by the Board of Trustees, the employees of that entity are included in the membership of this plan.

This is a summary plan description of the Duke Faculty and Staff Retirement Plan provisions for non-exempt employees. It highlights the main provisions of the plan but is subject to the terms of the legal documents, which may be modified from time to time. Where this description and the official plan documents vary, the official plan documents are the final authority. Duke reserves the right to change or terminate this benefit or your eligibility for benefits under the plan. This description of the Duke Faculty and Staff Retirement Plan is not an employment contract or any type of employment guarantee.
Duke Faculty and Staff Retirement Plan
for Non-Exempt Employees

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Note: The abbreviation “HRIC” is used frequently throughout this document and refers to the Human Resource Information Center (919-684-5600).
Eligibility and Participation

Eligibility
You are eligible to participate in the plan if you are an employee paid on the biweekly payroll.

You are not eligible to participate in the plan if you are classified as: a graduate or undergraduate student worker or otherwise exempt from FICA taxes; or a non-resident alien who does not have earned income from Duke that constitutes income from sources within the United States.

Participation
You may participate in the plan upon employment and make your own voluntary contributions by completing and properly executing the investment carrier applications and the enrollment/retirement contribution form. Enrollment information is included in your new hire packet or you may log on to: hr.duke.edu/retirementmanager.

The investment carriers offered under the Faculty and Staff Retirement Plan are:
- Fidelity Investments (Fidelity)
- TIAA
- VALIC
- The Vanguard Group (Vanguard).
Duke Faculty and Staff Retirement Plan
Provisions for Non-Exempt Employees

Your Voluntary Contributions
You may make elective (or “voluntary”) contributions from your salary on a pre-tax basis, Roth after-tax basis or a combination of both by means of a salary reduction agreement.

Pre-Tax Contributions
When you contribute to the plan on a pre-tax basis, you pay no current federal or state income tax on the salary directed into the plan. It is important to understand that you are not avoiding paying taxes on these contributions permanently; instead you are deferring the payment of taxes until the time you receive a distribution from the plan.

Roth After-Tax Contributions
When you contribute on a Roth after-tax basis, you pay current federal or state income tax on the salary directed into the plan; however, you can make tax-free withdrawals of your contributions—and any earnings—provided that you are at least 59½ and made your first Roth after-tax contribution at least five years earlier.

Contribution Limitations
Your combined voluntary contributions which include pre-tax and Roth contributions are limited by Internal Revenue Service (IRS) rules. Your contribution limit for each plan year (January 1 to December 31) can be viewed on the Duke Retirement Manager website. Duke Retirement Manager is a secure website where you can enroll, make changes to your contributions and view information about your retirement plan. Please see instructions for accessing the site at hr.duke.edu/retirementmanager.

In addition, the limits contained in Sections 403(b) or 415 of the Code may apply to limit your voluntary contributions. If you have questions about your contribution limits, contact the Human Resource Information Center (HRIC) at (919) 684-5600.

The minimum voluntary contribution amount is $12.50 per pay period or 1% of pay. The maximum contribution amount is 80% of your salary per pay period.

Effective Date
Since your contribution is by means of a salary reduction agreement, the HRIC needs to receive the salary reduction agreement at least 30 days prior to the pay date.

Excess Contributions
If you have made voluntary contributions in excess of the limit for a plan year, you must notify the HRIC, in writing, of the excess amount. If notification occurs on or before March 1 following the plan year in which the excess contribution was made, the excess amount is adjusted to reflect any credited investment gain or loss through the end of the calendar year of the excess contribution, and will be distributed no later than April 15 of the following calendar year. You are responsible for determining whether your contributions are within the dollar limitations and for payment of any tax or penalty if the dollar limitations are exceeded.

Plan Contributions after Normal Retirement Date
If you are employed by Duke as an eligible employee after the Normal Retirement Date, you may continue your contributions on eligible salary.

Plan Contributions during Leaves of Absence
If you are on a leave of absence with pay, you may continue making contributions to the plan. If you are on a leave of absence without pay, you may not make any contributions to the plan.

Contributions to Other Retirement Plans
Duke is required by law to collect information regarding certain employees who participate in a retirement plan with another employer. If you have participated or will participate in another employer-sponsored retirement plan during this calendar year...
AND own or have owned (during this calendar year) more than 50% of that business (such as consulting practice), please contact the HRIC at (919) 684-5600 to speak to the Retirement Plan Manager. Duke will need to collect some information pertaining to your contributions to the retirement plan sponsored by that business. (See IRS Publication 571)

Rollover Contributions
The investment carriers at their discretion may accept rollover contributions but only to the extent that they constitute eligible rollover distributions (as defined in the Internal Revenue Code) from an eligible retirement plan (as defined in the Internal Revenue Code) and are directly rolled over from an eligible retirement plan or accepted by an investment carrier from you within 60 days of your receipt of such contributions from an eligible retirement plan.

Termination of Employment
If you terminate your employment with Duke, your salary reduction agreement will automatically terminate and your contributions will cease.

Maintenance of Account
All contributions made (including rollover contributions to the extent permitted by the investment carrier), and the income, expenses, gains and losses attributable to such contributions are allocated to separate accounts maintained by each investment carrier.

Vesting of Contributions
All contributions you make to the plan are fully and immediately "vested," that is, you have an irrevocable right to.
Investment Options

Tiered Investment Choices
Duke has formed an Investment Advisory Committee (IAC) to ensure that you have access to high quality investment options at the lowest reasonable cost. The IAC is comprised of key Duke University and Duke University Health System administrators who work closely with expert consultants who specialize in investment management. The IAC has chosen a group of funds that are regularly monitored to ensure that they remain appropriate investment options for Duke’s plan.

To make it easier to navigate your choices, investments are grouped into three tiers. Funds in Tier 1 and Tier 2 have been specifically chosen by the IAC for the Duke Faculty and Staff Retirement Plan based on their suitability for use in a diversified retirement savings portfolio and their competitive expense level. These funds are benchmarked annually to ensure that their performance and cost remain competitive. Other funds are available in Tier 3, but they are not monitored regularly by the IAC.

Tier 1: Asset Allocation Funds
This tier includes two types of funds that offer a way to make a single choice for your retirement needs: Target Date Funds and a Balanced Fund.

Tier 2: Core Funds
These funds represent the primary asset classes (stocks, bonds, and short-term instruments) and have been chosen by the IAC based on their suitability for inclusion in a customized retirement portfolio. You can select from this group of “best-in-class” funds to build your own diversified portfolio. Your preferred investment carrier will have resources available to help you.

Tier 3: Other Funds
These funds are not monitored regularly by the IAC, so you will be responsible for monitoring the holdings and performance of these funds to ensure they remain in line with your investment strategy.

Additional information about the tiered structure and a listing of the investment options currently available under the plan can be obtained by contacting the investment carriers or at: hr.duke.edu/tiered.

Investment Performance and Participant Fee Disclosure Information
The fee disclosure information which includes fees and services associated with the plan is available at hr.duke.edu/performance. This disclosure is intended to provide you with important information to assist you in making informed decisions about the management of your plan account and the investment of your retirement savings.

The prospectus for each investment option is also a major source of information and is available from the investment carriers. A prospectus describes the investment option’s objectives and policies which are governed solely by the investment carriers’ agreements, and contains information required by the Securities and Exchange Commission on subjects such as the investment option’s performance, services, restrictions, officers and directors, and expenses. You are strongly encouraged to read the fee disclosure, the prospectus and other available literature before investing in a particular fund.

Your Investment Carriers
Each of Duke’s investment carriers offers investment options in the same tiered structure, providing you with the opportunity to build a diversified investment portfolio without having to spread your investments over multiple providers. The investment carriers are:

- Fidelity Investments (Fidelity)
- TIAA
- VALIC
- The Vanguard Group (Vanguard).

Duke has the right, upon reasonable notice to you, to add or eliminate an investment carrier or investment options.

Your Rights to Direct Your Contributions
You are solely responsible for making the decisions regarding the investment of your contributions. It is your responsibility to initiate and complete any procedure required by an investment carrier to enroll in or maintain an investment option.

Your contributions may be divided among investment carriers and their investment options in any whole percentages (but not fractions of a percent) that you select.

Your Default Investment Options
If you select an investment carrier but do not make investment elections with that investment carrier, your contributions will be automatically invested in the default investment fund established under the Plan for that carrier. Contributions invested in a
default investment fund will remain invested in the default fund until you direct otherwise.

Making Changes to Your Investments
You may change the investment of your future plan contributions (subject to certain restrictions and/or fees imposed by the investment carriers) by completing the appropriate forms available through your investment carrier.

Transfer of Your Plan Contributions
You may transfer, in whole or in part, existing contributions from one investment carrier to another. The value of your account at the time of transfer is based on current market value and is subject to any gains or losses.

The transfer is effected by completing the appropriate forms available from the investment carrier and is subject to the restrictions and fees contained in the agreements with the applicable investment carriers.

It is intended that the plan constitute a plan described in Section 404(c) of the Employee Retirement Income Security Act of 1974 (ERISA) and that the fiduciaries of the plan, including Duke and the Investment Advisory Committee, shall be relieved of liability for any losses or lack of gains which are the direct and necessary result of investment instructions given by you or your beneficiary. Accordingly, you are encouraged to consult an investment or financial adviser before making investment decisions.
Retirement Benefits

The plan is designed to provide you with a retirement income. Plan contributions, plus interest, earnings, and capital appreciation on the contributions, will be used to provide your retirement benefits.

The normal retirement date under the plan is the end of the month in which you attain age 65. However, you may elect to retire at any age following termination of employment with Duke. Upon termination of employment, you may elect to receive plan benefits or may postpone the commencement of your benefits up to any date permitted under the investment carrier’s contract or agreement, but not beyond April 1 of the calendar year following your attainment of age 70½, or if later, termination of employment with Duke.

Following your termination of employment from Duke, you may continue to direct the investment of your contributions among the investment options offered by your investment carrier(s) subject to such investment carrier’s restrictions and fees. You also may transfer your contributions to an Individual Retirement Account (IRA), an eligible retirement plan, or from one investment carrier to another, subject to tax regulations and the restrictions and fees imposed by the applicable investment carriers.

You should contact your investment carrier(s) in order to arrange for retirement benefits or other distributions to begin.

Commencement of Benefit Payments

Subject to any restriction, limitation, or fee contained in the contract or agreement with any applicable investment carrier, withdrawals of your contributions may commence upon the occurrence of any one of the following events:

- Your retirement, or
- Your death, or
- Your termination of employment with Duke, or
- Your attainment of age 59½, or
- Your disability, which is defined in Code Section 72(m)(7) as the inability to engage in any substantial gainful activity due to any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration, or
- You encounter a financial hardship as defined in the Internal Revenue Code and relevant regulations, applying applicable “safe harbor” rules, and as determined by the investment carrier holding the amounts requested for distribution, and upon submission to said investment carrier of such determination of hardship. If you receive a hardship distribution, you will be suspended from making voluntary contributions to the plan for a period of six months and may be subject to other restrictions that are imposed under federal law. It is your responsibility to restart contributions after the six month suspension has ended.

You should contact the applicable investment carrier(s) prior to the commencement of benefit payments to determine if any restrictions, limitations, or fees apply.

Loans

The plan permits loans to be taken against your contributions subject to any restrictions, limitations, or fees imposed by investment carrier. You are solely responsible for complying with the investment carrier’s rules. Loans are offered by TIAA and VALIC.

Taxation of Benefit Payments

Taxation of Pre-Tax Contributions

Benefit payments from your pre-tax voluntary contributions are included in your income in the year of payment. In addition, substantial tax penalties may be imposed on withdrawals prior to attainment of age 59 ½, death, or disability. You should consult your accountant, tax attorney, or other qualified financial adviser before making a withdrawal from the plan.

In the case of certain benefit payments, you may defer taxation on the payment by electing a direct rollover of all or part of such distributions to an IRA or another’s employer’s eligible retirement plan that accepts rollovers. If a benefit payment is eligible for direct rollover but you do not elect a direct rollover treatment, the investment carrier is required to withhold 20% of the taxable portion of the benefit payment.

For more information about the taxation of benefit payments or whether a benefit payment is eligible for direct rollover treatment, contact your investment carrier(s).
Taxation of Roth After-Tax Contributions
In general, to make a qualified tax- and penalty-free withdrawal of Roth contributions and earnings, the following conditions must be met:

- the account must have been established for at least five years, and
- the withdrawal must be taken at or after age 59½, or as the result of disability or death.

The five year period begins on January 1 of the year you make your first Roth after-tax contribution, which can be made at any time during the year. Even if you contribute in December, you will still receive a year's credit. Also, you don’t have to make a contribution every year. Your first contribution “starts the clock.”

Distributions that do not meet these conditions are considered nonqualified withdrawals. Nonqualified withdrawals are treated as a prorated return of Roth contributions and earnings. The portion of the distribution that represents earnings will be subject to ordinary income tax and possibly a 10% federal penalty tax for early distributions. However, the portion of the withdrawal that represents a return of Roth contributions would not be subject to tax.

For more information about the taxation of Roth after-tax contributions or whether a distribution is a qualified withdrawal, contact your investment carrier.

Forms of Benefit Payments
Once you are eligible to begin receiving benefit payments, you may elect any of the payment options that are available with the investment carrier(s) selected.

If you do not elect a payment option, plan contributions will remain invested in the investment options selected until you initiate payment.

Normal Form of Benefit Payment
The normal form of benefit payment is an annuity; however, if you are invested in mutual funds and you wish to receive all or a portion of your benefits in the form of an annuity, you must transfer such amounts to an annuity product. Otherwise, amounts held in mutual funds will be paid in the form of a lump sum distribution unless you elect an optional form of payment.

If you are not married on the date benefit payments commence, benefits will automatically be paid in the form of a single life annuity unless you elect an optional form of payment. Under a single life annuity, monthly benefit payments are made for your lifetime, and at your death, all benefit payments will stop.

If you are married on the date benefit payments commence, benefits will automatically be paid in the form of a Joint and Survivor Annuity, unless you and your spouse elect an optional form of payment. Under a Joint and Survivor Annuity, monthly benefit payments are made for your lifetime and, at your death, your surviving spouse will receive monthly benefit payments equal to 50% or more (depending on your election) of your monthly benefit. After your surviving spouse dies, all benefit payments will stop.

Optional Forms of Benefit Payment
If you do not wish to receive benefit payments under the normal form of payment, you can elect any one of the optional forms of payment, to the extent offered by the investment carrier(s), which may include: (1) lump sum payments, (2) installment payments, (3) annuity with period certain, or (4) eligible rollover. The election of an optional form of payment must be made during the 180-day period before benefit payments begin. In addition, if you are married when benefit payments begin, your spouse must give written, notarized consent to the optional form of payment within the same 180-day period.

For more information about the optional forms of payments available, contact your investment carrier.

Rollover Distribution
If you become an employee of another employer that maintains an eligible retirement plan, you may elect to have your contributions rollover to the other employer’s plan subject to any restrictions, limitations, or fees of the investment carrier or other employer.

Qualified Domestic Relations Orders
The plan will comply with the terms of a qualified domestic relations order to the extent that the order is consistent with the terms of the plan as determined by the Plan Administrator or applicable investment carrier that has responsibility for qualified domestic relations orders.
Designation of Beneficiaries and Survivor Benefits

Designating a Beneficiary

A beneficiary or beneficiaries are individuals you designate to receive benefits from the plan in the event of your death. It is important for you to designate one or more beneficiaries on the beneficiary designation form that is filed with your investment carrier(s), so that benefits can be paid how you intend rather than being paid to your estate and involving a lengthy court process.

If you are not married, you can name anyone as a beneficiary. If you are married, your surviving spouse must be the beneficiary to at least 50% of your plan benefits unless your spouse provides written, notarized consent to the designation of a different beneficiary or beneficiaries.

You may change your beneficiary at any time (subject to the spousal consent requirement) by submitting a revised beneficiary designation form to the investment carrier. If your marital status changes, you should review your beneficiary designation. For example, your marriage will automatically revoke and revise a designation of a non-spouse beneficiary to 50% of your plan benefits.

Survivor Benefits

If you die before your benefit payments begin, the full value of your plan benefits will be paid to your designated beneficiary (ies). If you are married and die before your benefit payments begin, your spouse, unless you elected otherwise and your spouse consented, is entitled to receive 50% of your plan benefits in the form of an actuarially equivalent life annuity or other option permitted by the investment carrier. The remaining 50% will be payable to your designated beneficiary who may be your spouse or other beneficiary. If you wish to leave more than 50% of your plan benefits to a beneficiary other than your spouse, you and your spouse must waive the survivor life annuity and the waiver of your spouse must be notarized. You generally must be at least 35 years old to waive the survivor life annuity benefit.

If you die without having named a beneficiary, all plan benefits shall be distributed in accordance with the terms of the applicable investment carrier’s agreement except as otherwise described in the preceding paragraph regarding your surviving spouse’s interest.

A beneficiary may elect to withdraw the assets, in whole or in part, in any manner acceptable to the investment carrier which may include lump sum, installment, and annuity payments.

In the event you die after your benefit payments have commenced, then depending on the form of payment elected before death, your beneficiary will receive either nothing (if a single life annuity or a lump sum payment was elected) or the balance of your benefits (if your beneficiary is also your co-annuitant) in the form of a survivor annuity or in installments for the duration of the payment period you elected.

Additional Rules

Divorce

If you have designated your spouse as the beneficiary, your divorce will automatically revoke a designation of your ex-spouse unless you submit a new beneficiary designation again designating your ex-spouse or a qualified domestic relation order designating your ex-spouse as your beneficiary.

Minors

If you are naming minor beneficiaries, you will need to consider who will manage the plan benefits until the minor(s) can legally take ownership of the account upon reaching the age of majority.

You may designate a minor as your beneficiary of the plan; however, payments will be made to their legal guardian, custodian or parent of the minor.

Other Situations

Your designated beneficiary must be alive (and any entity designated as beneficiary must be in existence) at the time of your death in order to be entitled to receive any undistributed plan benefits. If your beneficiary dies within 120 hours of your death, plan benefits will not be paid to your Beneficiary. Instead, plan benefits will be distributed to your alternative beneficiaries.

In the event that you or your beneficiary dies as a result of a criminal act involving any other
beneficiary and that beneficiary is convicted of such criminal act, he or she shall not be entitled to receive any undistributed plan benefits.

**Required Documentation**

In each case, appropriate documentation must be provided to your investment carrier(s) in order for the foregoing rules to apply. The investment carrier(s) or Duke will not be liable if any distribution or transfer was made to a beneficiary in the absence of such documentation.
Plan Information

Plan Name
The Duke University Faculty and Staff Retirement Plan

Employer Identification
Number Assigned by IRS
56-0532129 (Duke University)
56-2070036 (Duke University Health System Inc.)

Plan Number Assigned by Plan
001

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
Duke University 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 Investment Carrier(s) 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
Duke Investment Advisory Committee

Type of Benefit Plan Provided
Defined Contribution Plan. All benefits under the Plan are provided through individually owned and fully funded annuity contracts or custodial accounts as described in Section 403(b) of the Internal Revenue Code.

Agent for Service of Legal Process
AVP, Benefits
Duke University
705 Broad St.
Durham, NC 27708-0502
(919) 684-5600

Funding of the Plan
Plan is funded by the employee with voluntary contributions and/or the employer contributions. Contributions are remitted to the applicable investment carrier(s).

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.

The Employee Retirement Income Security Act of 1974 ("ERISA") created the Pension Benefit Guaranty Corporation ("PBGC"), which provides federal insurance for certain retirement benefits. The benefits under this Plan are NOT insured by the PBGC. The PBGC insures only pension plans that promise a fixed level of benefits without regard to whether sufficient contributions have actually been made. Under this Plan, the benefits promised are exactly equal to contributions actually made (adjusted for investment experience), so no insurance is provided.

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.

Controlling Effect of Plan Documents, Governance, and Interpretation
The plan document for the Duke University Faculty and Staff Retirement Plan is a separate legal document and governs the plan’s 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 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 plan shall in all cases be interpreted in a manner that is consistent with (i) a single “retirement plan” within the meaning of ERISA, and (ii) the exclusion from gross income of benefits provided hereunder in accordance with Internal Revenue Code Section 403(b) and other Internal Revenue Codes that may apply.

Your Rights Under ERISA
You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (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 plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan 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 plan, collective bargaining agreements, and
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.

Your Rights Under USERRA

Under the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA), eligible staff may make up missed contributions to the Plan after re-employment with Duke following a leave from Duke to enter the U.S. Armed Forces or other eligible service as defined by USERRA. Timeframes for returning to Duke following service and the required type of discharge (e.g. honorable) are defined in USERRA. The period during which you can make up voluntary contributions is equal to three (3) times the period of your Qualified Military Service, up to a maximum of five (5) years. For example, if your Qualified Military Service period is one year, you have three (3) years following the date of your reemployment to contribute make-up voluntary contributions. The amount of the make-up voluntary contributions is subject to the dollar limit(s) that applied during the Qualified Military Service and is in addition to the usual contribution limit. You can change, terminate, or resume your voluntary contributions during the make-up period without penalty for termination. If you want to make-up voluntary contributions, contact Benefits to help you establish your make-up voluntary contributions.
Claims and Appeals Procedures

If your application for benefits is denied in whole or in part by an investment carrier or if you believe that you are being denied any rights under the plan, such as eligibility, participation, and contribution rights, you (or your beneficiary, if applicable) may file a claim with the Plan Administrator under the following claims and appeals procedures.

To file a claim under the plan, you or your authorized representative must submit a written statement that includes the basis of your claim. The statement must be dated and signed by you or your authorized representative and must include an address and telephone number.

If your claim is denied, you will normally receive a written or electronic notice of the denial within 90 days (or within 180 days if special circumstances require additional time to process your claim) following the Plan Administrator’s receipt of the claim. If additional time is needed, you or your authorized representative will receive, within the first 90 days, a written or electronic notice of extension that will explain what special circumstances make the extension necessary and will indicate the date a final decision is expected to be made. The notice will explain: (i) the specific reasons for the denial, (ii) references to the plan provisions upon which the denial is based, (iii) a statement that you are entitled to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relating to your claim for benefits, and (iv) a statement of your right to bring a civil action under Section 502(a) of ERISA.

If the Committee denies your claim upon review, you will normally receive a written or electronic notice within 60 days (or within 120 days if special circumstances require additional time to process your claim) following the Committee’s receipt of the claim. If additional time is needed, you or your authorized representative will receive, within the first 60 days, a written or electronic notice of extension that will explain what special circumstances make the extension necessary and will indicate the date a final decision is expected to be made. The notice will explain: (i) the specific reasons for the denial, (ii) references to the plan provisions upon which the denial is based, (iii) a statement that you are entitled to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relating to your claim for benefits, and (iv) a statement of your right to bring a civil action under Section 502(a) of ERISA.

The Staff Fringe Benefits Committee’s decision will be final and binding.

You may reach the Plan Administrator and the Staff Fringe Benefits Committee at the following address:

Duke Benefits
Duke University
705 Broad St.
Box 90502
Durham, NC 27708
Definitions

ANNUITY: An amount paid at regular intervals (generally monthly) upon retirement. This amount is guaranteed by an insurance company and is payable depending on the option selected.

BENEFICIARY: The individual(s), trust(s) or other entity(ies) you designate to receive benefits from the plan in the event of your death.

EFFECTIVE DATE: January 1, 2018, the date of this summary as most currently updated.

EMPLOYEES PAID BIWEEKLY: Employees who are paid on the non-exempt payroll of the University or Duke University Health System.

EMPLOYER: Duke University, Duke University Health System, Inc., and any other corporation or entity that adopts this plan with the approval of the University.


INVESTMENT CARRIER: One or more of the companies selected by the University from time to time to provide investment options.

NORMAL RETIREMENT DATE: The last day of the month in which you attain the age of 65 years.

PARTICIPANT: Every eligible employee enrolled in the plan and every individual who has vested rights to benefits under the plan.

PLAN: The Duke University Faculty and Staff Retirement Plan, and all contracts and agreements, applications, and designations relating to it.

PLAN CONTRIBUTIONS: The money you contribute to be invested for the purpose of providing retirement benefits.

PROSPECTUS: The official document that describes an investment fund and offers its shares for sale. It contains information required by the Securities and Exchange Commission on such subjects as the fund’s investment objectives and policies, services, investment restrictions, officers and directors, and expenses. The prospectus is a major source of information on the investment(s) of its fund and should be read carefully.

QUALIFIED MILITARY SERVICE: Military service which entitles the employee to full reemployment rights as prescribed by the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) upon his or her return to employment with the University.

UNIVERSITY: Duke University (also referred to as “Duke” and “the University”). However, the term “Duke” also includes Duke University Health System.

VESTING: Vesting means ownership of the market value of your account. You are always 100% vested in your own voluntary contributions. Vesting only applies to Duke’s contribution. If you have received Duke’s contribution, once you are vested, you have an irrevocable right to the amount of the Duke contribution in your account adjusted for gains or losses.

VOLUNTARY CONTRIBUTIONS: A voluntary election to make contributions from your salary on a pre-tax basis, Roth after-tax basis or a combination of both by means of a salary reduction agreement.
**Duke Employees’ Retirement Plan**

The Employee’s Retirement Plan of Duke University (the “ERP” or 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.

On the following pages, you will find valuable information describing the features of the Plan, including:

- 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.

This Summary describes the provisions of the Employees’ Retirement Plan as they apply to employees of Duke University or Duke University Health System, Inc., except certain Commissioned Police Officers, who are paid biweekly. These provisions apply to the Plan as it existed on May 1, 2016. Please read this Summary carefully and share it with your family.

The term “Duke” is used throughout this document. For purposes of this Summary Plan Description, “Duke” refers to the University, Duke University Health System, Inc., and any other entity which is or becomes controlled by Duke University and where, upon appropriate action by the Board of Trustees, the employees of that entity are included in the membership of this Plan.

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 is grandfathered 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 grandfather status continues for the course of this relationship only.
# Duke Employees’ Retirement Plan

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Eligibility

You are eligible to become a member in the ERP as a biweekly-paid Duke employee, if you:

- Have reached age 21, and
- Have worked at least 1,000 hours of service during your first year of employment or in any future fiscal year.

For plan purposes, the fiscal year begins with the first pay date in July and ends with the last pay date in the following June (specifically, it is the 12 month period ending on the last payroll in June).

You are not eligible to participate in the Plan if you are eligible to receive employer contributions under the Duke Faculty and Staff Retirement Plan.

You are automatically enrolled as of the first day of the month on or immediately after meeting the eligibility requirements.

If you terminate employment with Duke and are later reemployed as an eligible employee, you will be automatically eligible to participate in the Plan.

Who Pays the Cost?
Duke completely funds the Plan. You are not required or allowed to contribute to the Plan.
How the Plan Works
The Plan offers a variety of retirement dates to give you more flexibility in deciding when to retire.

Normal Retirement
You will be eligible for a normal retirement pension on the last day of the month of your 65th birthday (your “Normal Retirement Date”). If you retire on your normal retirement date, your benefit payments begin on the first day of the month after your retirement date.

Early Retirement
You may retire at any time after you reach age 45 and complete 15 years of credited service. You may begin receiving your benefit payments on the first day of any month after meeting these requirements. However, your benefits will be reduced to reflect the longer period of time that they will be paid to you.

Postponed Retirement
You may decide to continue working past your Normal Retirement Date. During this time, you will continue to earn benefits as provided under the terms of the Plan.

What is continuous service?
Continuous service is used to determine your right to receive certain benefits under the Plan, including a vested benefit if you should leave Duke before you qualify for retirement. You earn a year of continuous service for each fiscal year in which you work at least 1,000 hours of service. In counting your hours worked, certain paid time off such as for sickness and vacation are included.

What is credited service?
Credited service is used to determine your eligibility for early retirement and the amount of any plan benefit. Credited service includes all of your continuous service after you become a Plan member. If you have fewer than 1,000 hours of service from your membership date to the end of the fiscal year in which you become a member, you will receive partial credited service for that year. If you are no longer an employee eligible to participate in the Plan, but you are still an employee of Duke, you stop accruing credited service when you are no longer an eligible employee, except for purpose of determining eligibility for early retirement.

What is vesting?
Being vested means you own, or have a non-forfeitable right to, the value of your retirement benefit. Participants are vested after five years of continuous service after age 18, or upon attaining age 65.
Leaving Duke before Retirement

If you leave Duke before you are age 65 or before you meet the requirements for early retirement, you are eligible for a pension benefit if you are vested (see definition on previous page).

You may receive this pension benefit:

- Beginning the month after you reach age 65, or
- Any time after age 45 if you have 15 years of Credited service when you leave Duke.

If the total lump sum value of your benefit is $10,000 or less, you may receive a lump sum payment rather than receive your benefit as a monthly pension. However, if the lump sum value of your benefit exceeds $10,000, the benefit will be paid as a monthly benefit either the month after you reach age 65 or any time after age 45 if you have 15 years of credited service.

Disability

If you become disabled and qualify for benefits under Duke’s Disability Program or Workers’ Compensation, you continue to earn benefits under this Plan while disabled. You will receive credited service based on your work schedule prior to becoming disabled and credit for earnings based on your pay rate in effect before Disability Program or Workers’ Compensation payments began.

You can choose to have payments begin at your Normal or Early Retirement Date (any time after age 45 with 15 years of credited service). However, the amount will be reduced if you choose to receive payments before your Normal Retirement Date, and you will no longer receive credited service under the Plan.
How Your Benefit Is Calculated

At Normal Retirement

When you retire at your Normal Retirement Age (65), your annual normal retirement benefit is equal to:

- 1.25% of your average final compensation; times
- Your years of credited service up to 20; plus
- 1.66% of your average final compensation; times
- Your years of credited service over 20.

Your benefit is figured on an annual basis. You receive 1/12 of your annual benefit each month. The formula above shows how much you would receive if payments start at your Normal Retirement Date and continue for your lifetime only. If payments start earlier or if you choose a payment option with benefits continuing to someone after your death, your benefit will be reduced.

What is average final compensation?

Average final compensation is the average of your annual earnings in your highest-paid five consecutive fiscal years during your last 10 years of credited service before retirement. If you have fewer than five years of credited service, all your years of credited service are counted in determining your average final compensation. Also, if you do not have a full year of credited service in your first year of membership, your earnings for that fiscal year will be counted only if this results in a higher average final compensation.

What are annual earnings?

Annual earnings means your regular earnings, including overtime. Any contributions you make to the Duke Faculty and Staff Retirement Plan or other pre-tax deductions are included.

What happens to my unused sick leave or carry-over bank hours?

If you are an active Plan member paid on the biweekly payroll when you leave Duke, your unused sick or carry-over bank hours are converted to a fraction of a year and added to your years of credited service for the purpose of calculating your benefit.

Example I: John

Age at retirement: 65
Years of credited service: 40
Average final compensation: $32,000

Here is how John’s benefit is calculated:

\[1.25\% \times 32,000 \times 20 = 8,000\]
\[1.66\% \times 32,000 \times 20 = 10,624\]

Annual benefit: $18,624

John would receive $1,552 per month ($18,624 ÷ 12) from the Plan for the remainder of his life. If he wanted payments to continue to someone else after his death, his benefit would be reduced (see “Optional Forms of Payment” on page 230).

Example II: Sue

Age at retirement: 65
Years of credited service: 30
Average final compensation: $36,000

Here is how Sue’s benefit is calculated:

\[1.25\% \times 36,000 \times 20 = 9,000\]
\[1.66\% \times 36,000 \times 10 = 5,976\]

Annual benefit: $14,976

Sue would receive $1,248 per month ($14,976 ÷ 12) from the Plan for the remainder of her life. If she wanted payments to continue to someone else after her death, her benefit would be reduced (see “Optional Forms of Payment” on page 230).
At Early Retirement

If you retire early (age 45 with 15 years of credited service), your benefit is calculated according to the formula for normal retirement, but is based on service and average final compensation up to your early retirement date. Please note that if you have 20 or more years of service at the time of your termination and you commence your benefit early at or after age 55, you are eligible for enhanced early retirement factors. You elect when payments start.

- If payments start at your normal retirement date, you’ll receive your full benefit as figured under the Plan formula.
- If payments start before your normal retirement date, your benefit will be reduced by an early retirement reduction factor to reflect the longer period of time that it will be paid to you. There are two sets of early retirement reduction factors. Your age and years of credited service at the time you terminate will determine which set of early reduction factors applies to you. Refer to the tables for details.

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Example III: Catherine
Age at termination: 55  
Years of credited service: 20  
Average final compensation: $36,000

Here is how Catherine’s benefit is calculated:  
1.25% x $36,000 x 20 = $9,000

This is the annual amount payable at Catherine’s Normal Retirement Date (age 65). If she wanted to begin payments immediately, her benefit would be reduced using the factor in the table: $9,000 x .700 = $6,300.

Catherine would receive $525 per month ($6,300 ÷ 12) from the Plan for the remainder of her life. If she wanted payments to continue to someone else after her death, her benefit would be reduced (see “Optional Forms of Payment” on page 230).
Early Retirement:
If you terminate employment with less than 20 Years of Credited Service or terminate employment prior to age 55 with 20 or more Years of Credited Service

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Example IV: Sam
Age at termination: 58
Years of credited service: 18
Average final compensation: $32,000

Here is how Sam’s benefit is calculated:
1.25% x $32,000 x 18 = $7,200

This is the annual amount payable at Sam’s Normal Retirement Date (age 65). If he wanted to begin payments immediately, his benefit would be reduced using the factor in the table:
$7,200 x .562 = $4,046.40.

Sam would receive $337.20 per month ($4,046.40 ÷ 12) from the Plan for the remainder of his life. If he wanted payments to continue to someone else after his death, his benefit would be reduced (see “Optional Forms of Payment” on page 230).
At Postponed Retirement

If you remain employed by Duke beyond your Normal Retirement Date or you return to service after your Normal Retirement Date, your benefit will be increased by your additional credited service worked after your Normal Retirement Date.

The benefit will be calculated in one of two ways, according to whichever method produces the larger benefit for you:

1. Your benefit is calculated according to the normal retirement formula, based on your credited service and average final compensation up to age 65. Your benefit is then increased (not less than 10%) each year between the age of 65 and the date payments actually begin to reflect the shorter period during which you are expected to receive payments. Finally, it is adjusted for any optional form of benefit payment you select.

2. Your benefit is calculated under the normal retirement formula, based on your credited service and average final compensation up to your postponed retirement date and adjusted for any optional form of benefit payment you select.
How Your Benefit Is Paid

When it is time to receive your retirement benefit, you can select one of several forms of payment. The options are all **actuarially** equal even though they provide payment in different amounts and over different time periods.

**Automatic Forms of Payment**

**Single at Retirement**
If you are single on the date you begin receiving payments, you will receive a Single Life Annuity. This benefit is paid in the form of a monthly annuity for the remainder of your lifetime.

**Married at Retirement**
If you are married when you retire, you will receive payment in the form of a 50% Joint and Survivor Annuity. You will receive a reduced monthly benefit during your lifetime. Upon your death, your spouse will receive a benefit of 50% of your reduced monthly benefit for the remainder of his or her lifetime.

In the event that your spouse dies or your marital status changes after you have selected this option but before your payments begin, you will receive the automatic form of payment for single participants unless you make another election.

If you have already started receiving payments when your spouse dies, you will continue receiving the same amount until your death. Your monthly pension will not increase even though there is no longer a beneficiary. Your pension will end at your death, even if you should later remarry.

**If the Value of Your Benefit is $1,000 or Less**
If the total lump sum value of your benefit under the Plan when you terminate employment with Duke is $1,000 or less, your benefit will be paid automatically to you in a single cash lump sum amount. You may not elect an optional form of payment. This lump sum payment will be paid as soon as practicable after your termination of employment with Duke. The lump sum payment is in full satisfaction of the amounts payable to you from the Plan, unless you are reemployed at Duke and earn additional credited service in the Plan. There are no amounts payable to your spouse or beneficiary. For more information about lump sums, refer to the “Lump Sum” and “If the Value of Your Benefits is $5,000 or Less” section on page 231.

Optional Forms of Payment

In addition to the automatic forms of payment, there are five optional forms of payment:

1. Single Life Annuity
2. 100% Joint and Survivor Annuity
3. 75% Joint and Survivor Annuity
4. 50% Joint and Survivor Annuity
5. Lump Sum Payment
6. Level Income Option

**Single Life Annuity**
This benefit is paid in the form of a monthly annuity for the remainder of your lifetime. No benefit is paid after your death.

**If You Are Married**
If you are married (to a same or opposite sex spouse) and wish to designate someone other than your spouse as beneficiary, or to elect a payment option other than one of the joint and survivor annuities, your election will not be valid unless you have your spouse’s written, notarized consent on a Plan form. The consent must acknowledge that your spouse is waiving the right to receive survivor benefits from the Plan, and acknowledge the form of benefit and/or alternate beneficiary designated.
100% Joint and Survivor Annuity
You receive a reduced monthly benefit during your lifetime. Upon your death, your beneficiary receives an equal monthly benefit for the remainder of his or her lifetime.

75% Joint and Survivor Annuity
You receive a reduced monthly benefit during your lifetime. Upon your death, your beneficiary receives a benefit of 75% of your reduced monthly benefit for the remainder of his or her lifetime.

50% Joint and Survivor Annuity
You receive a reduced monthly benefit during your lifetime. Upon your death, your beneficiary receives a benefit of 50% of your reduced monthly benefit for the remainder of his or her lifetime.

Lump Sum
At retirement, if the lump sum value of your benefit is between $5,000 and $10,000, you may request that your benefit be paid to you in a single sum. You can choose:

- A direct payment to you, in which case federal law requires that 20% of this amount be withheld for income taxes, or
- A direct rollover to another tax-qualified plan, such as an IRA, or
- A direct rollover to a Roth IRA.

If you receive a direct payment prior to age 59½, you may be subject to an additional tax. You may still roll over all or part of a direct payment to you if you do so within 60 days of receiving the payment. However, to avoid taxes, you will have to contribute an additional amount equal to the 20% that was withheld.

You may wish to consult a tax adviser before you make this choice.

Level Income Option
If you retire before you reach age 65, you receive larger benefit payments from the Plan before Social Security benefits start, and smaller benefit payments after Social Security benefits start. Your combined income from the Plan and Social Security will be as level as possible throughout your retirement. No benefit is paid after your death.

If the Value of Your Benefits Is $5,000 or Less
If the lump sum value of your benefits is $5,000 or less, your benefit can only be paid to you in a single lump sum instead of a monthly annuity. Spousal consent is not required for a distribution election of a small lump sum. You can choose:

- A direct payment to you, in which case federal law requires that 20% of this amount be withheld for income taxes, or
- A direct rollover to another tax-qualified plan, such as an IRA, or
- A direct rollover to a Roth IRA.

Federal law may limit the payment options available to you or may restrict benefit accruals, depending on the funded status of the Plan. If any of these restrictions become applicable, you will be notified by the Plan Administrator.

See “Tax Regulations” on page 236 for more information about the taxation of a lump sum benefit.
Selecting a Payment Option

To receive a benefit when you retire, you must complete election forms and other necessary documents. Your application cannot be completed and signed more than 90 days before your benefit is to begin.

You can elect, change, or cancel a payment option any time before your pension payments begin. Your option election becomes effective when your pension begins. After payments start, you cannot change your beneficiary and/or your form of payment in any way, as your choices are then irrevocable. If you die before your payments begin, your election becomes void. See “At Your Death: Before Your Pension Begins” on the next page for more information.

Benefits must begin no later than the 60th day after the close of the Plan Year in which the later of the following occurs:

- Your 65th birthday, or
- The tenth anniversary of your separation from service.

If you are age 70½, there are additional requirements for commencing your benefit. Consult a tax advisor if you have not yet commenced your benefit.
At Your Death

Before Your Pension Begins:

Protection for Your Spouse
If you die before beginning to receive your retirement benefit, and are either married throughout the one-year period ending on the date of your death, or are in a same-sex spousal equivalent relationship registered with Duke throughout the one-year period ending on the date of your death (this partner was registered with Duke HR prior to January 1, 2016 and you were hired prior to January 1, 2016), your surviving spouse or same-sex spousal equivalent will receive a benefit from the Plan. For this purpose, spouse includes both same and opposite sex spouses. The benefit will be 50% of the reduced benefit you would have received had you retired under the 50% Joint and Survivor Annuity (see page 231).

Your spouse or same-sex spousal equivalent has this protection if you die:

- In active service after becoming vested (five years of continuous service) or
- After termination of service with a normal early or vested retirement benefit, but before payments begin.

If you die after becoming vested, your spouse’s benefit is payable on the first of the month following the month of your death. If he or she chooses, your spouse may elect to postpone the receipt of the benefit. However, same-sex spousal equivalents do not have the option to postpone benefits. If you are not married at the time of your death, no benefits are payable from the Plan.

After Your Pension Begins:
If you die after your retirement benefit has commenced, and you have elected a form of benefit that will continue to be paid to your beneficiary after your death (for example, the 100% Joint and Survivor Annuity, 75% Joint and Survivor Annuity, or the 50% Joint and Survivor Annuity), then after your death, your benefit will continue to be paid in the form you elected at the time you commenced your benefit and will be paid to the beneficiary you elected at the time of your commencement (as described above.)

Please be aware that if your beneficiary is a minor or determined to be incompetent, and a conservator, guardian, or other person legally charged with his care has been appointed, any benefits to which your beneficiary is entitled shall be payable to such conservator, guardian, or other person legally charged with his care. The decision of the Retirement Board or its delegate in such matters shall be final, binding, and conclusive upon all affected or interested parties. Neither the Plan nor any representative of the Plan has any duty to see to the proper application of such payments.
Assignment of Benefits

Your benefits under this Plan are solely for you (or your beneficiary). Generally, they cannot be assigned to anyone else. However, the Plan will honor qualified domestic relations orders relating to provisions for child support, alimony payments, or marital property rights.

A qualified domestic relations order is a judgment or decree that:

- Provides for child support, alimony, or marital property rights to your spouse, former spouse, child, or other dependent;
- Is made under a state domestic relations law, including community property law;
- Creates or recognizes the right of an “alternate payee” (your spouse, former spouse, child, or other dependent) to receive all or a portion of your benefits;
- Does not change the amount or form of plan benefits; and
- Is not in excess of your vested accrued benefit, determined as of the date of the order.

The Plan Administrator will promptly notify you and your alternate payee upon receipt of a domestic relations order. You will be informed of the Plan’s procedures for determining its qualification. Within 18 months, the Plan Administrator must determine if the order is qualified and notify both you and your alternate payee accordingly.

If an order is determined to be a qualified domestic relations order, a distribution will be made according to its terms.

How you can lose your benefits

You should be aware of the following circumstances which could cause you to lose or forfeit some or all of your benefits under the ERP:

- You quit or your employment is terminated before you complete five years of continuous service (i.e., become vested).
- Your benefit is limited by the Internal Revenue Code.
- All or part of your benefit is assigned to an alternate payee pursuant to a qualified domestic relations order.

Please also note, that if you die while you are in active service and before you have attained eligibility for any retirement benefit (early, deferred, normal, etc.), then no benefit will be payable to you.

If you are considering delaying the commencement of benefits or are entitled to commence and have failed to do so, we suggest you review how the failure to commence your benefit will impact your benefit and your personal circumstances. So that you can commence your benefit at the required time, please be sure to keep your address current with the Plan Administrator so that the Plan Administrator can send you the appropriate documents.
How to File a Claim

You or your beneficiary may make a claim for benefits under the Plan by making a written request to the Plan Administrator. The Plan Administrator will decide whether you or your beneficiary is entitled to any benefits and, if so, the amount of the benefit. Send your claim to:

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

If Your Claim Is Denied

If your claim for benefits is denied in part or in full, you will be notified in writing within 90 days after receipt of the claim by the Plan Administrator. If an extension is needed, the Plan Administrator will notify you before the end of the initial 90-day period that an additional 90 days are needed to review your claim. The extension notice will state the special circumstances requiring the additional time and the date the final decision is expected.

The denial notice will:

• State the reason(s) for the denial,
• State the Plan provisions on which the denial is based,
• Provide a description of any additional information or material required by the Plan Administrator to reverse the denial and explain the need for such material or information, and
• Describe the procedures you must follow to have your claim reviewed.

Within 60 days of receiving the denial notice, you or your authorized representative may make a written request for a review. The request may ask for an opportunity to review the documents related to the denial and may state issues and comments indicating the reason the denial is being challenged.

The Plan Administrator has 60 days to notify you of the review decision, unless special circumstances require an extension. The notification will cite Plan provisions on which the decision is based. If an extension is needed, the Plan Administrator will notify you before the end of the initial 60-day period that an additional 60 days are needed to review your claim. If the decision on review is not furnished within such time, the claim will be deemed denied.

The decision of the Plan Administrator regarding the claim shall be final, binding, and conclusive upon all affected or interested parties.

Authority of Plan Administrator

The Plan Administrator has the exclusive responsibility and complete discretionary authority to construe the terms of this Plan, to determine status and eligibility for benefits, and to resolve all interpretive, equitable, and other questions that shall arise in the operation and administration of this Plan.
Additional Information

Your Rights Under USERRA
Under the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA), you will continue to accrue continuous and credited service credits if you leave Duke to enter the U.S. Armed Forces, and return to Duke while your re-employment rights are protected. You must give advance notice to Duke of your military leave and satisfy certain other requirements, including timely re-employment with Duke when your military leave ends.

If you die while performing USERRA-qualified military service, you will earn service credit in the Plan as if you returned to work on the date preceding death and terminated employment on the actual date of death.

Return to Work After Retiring

Work Schedule of 19 Hours or Fewer per Week
If you retire under the Plan and are later re-employed at Duke, your benefit will continue and any optional benefit you elected will remain in effect as long as you are regularly scheduled to work 19 hours or fewer per week. When you retire again, your benefit will be increased by the additional benefit you earned, if any, during your re-employment.

If you are re-employed before your Normal Retirement Date and you are married, your spouse will be covered for the benefit described in the section “Protection for Your Spouse” (see page 233), but only with respect to any additional benefit earned after your re-employment.

Work Schedule of More Than 19 Hours per Week
If you retire under the Plan and are later re-employed by Duke, your payments will stop if you are regularly scheduled to work more than 19 hours per week. If you are re-employed on or after your Normal Retirement Date, any optional form of payment you elected remains in effect unless you elect a different payment option. If you are re-employed before your Normal Retirement Date:

- Any optional benefit you elected will be void, and
- If you are married, your spouse will be covered for the benefit described in “Protection for Your Spouse.” (page 236)

When you retire again, your benefit will be recalculated using the benefit formula then in effect and all of your service and earnings, with an adjustment to recognize the benefits you received before you were re-employed.

Social Security Benefits
Your retirement benefits from Social Security — for which you and Duke pay taxes — are supplemented by your pension plan income. If you were born before January 1, 1938, full Social Security benefits begin at age 65. If you were born after that date, full benefits begin between ages 65 and 67, depending on your date of birth. Reduced benefits can begin any time after age 62.

Your spouse also will receive a Social Security benefit at the retirement age explained above or reduced benefits at or after age 62. Your spouse’s benefit is based on your compensation — unless a higher benefit is earned based on his or her own compensation.

In addition to retirement benefits, Social Security provides:
- Disability benefits,
- Survivor benefits, and
- Hospital, surgical, and other medical benefits under Medicare.

You must apply for Social Security benefits — they are not paid automatically. You can contact your local Social Security office for details or visit the Social Security Administration’s web site at www.ssa.gov.

Legal Limitations
Government rules limit the total benefits payable under Duke’s retirement and savings plans. You will be notified in the unlikely event your benefits would be affected by these rules.

Tax Regulations
When you receive a distribution from the pension plan, it generally will be subject to federal income tax, and in some cases, state and local taxes.

The following special rules apply if you receive a lump sum payment:
- Generally, the taxable portion of any lump sum payment is subject to 20% automatic federal withholding tax. You may defer income tax and avoid the 20% withholding tax by directing the plan to roll over all or a portion of the taxable part of this payment to a traditional IRA or another qualified plan.
• If you do not directly roll over all or part of your taxable distribution, the taxable portion which is not rolled over will be paid directly to you. That amount will be subject to 20% withholding.

• If any portion of your lump sum distribution is paid directly to you, you have the right to roll over all or any part of it to an IRA or another qualified plan within 60 days after you receive the distribution. When you file your income taxes, you might qualify for a refund up to the amount withheld if you deposit the entire distribution (including an amount equal to the 20% withheld). That means you would need to substitute money from other sources for the 20% withheld.

Future of the Plan
While Duke expects to continue the Plan indefinitely, it reserves the right by written action of its Board of Trustees, or an authorized officer of Duke acting on behalf of the Board of Trustees, to amend or terminate the Plan at any time. However, federal law guarantees that you will be fully vested in the benefits you earned up to the date of termination. The following additional guarantees apply:

• If there is enough money in the Plan to provide retirement benefits earned to the date of the Plan’s termination, Plan assets would be used to buy annuities, payable at retirement, for each participant. Small benefits may be cashed out in a lump sum if annuities are not otherwise payable. Only then would any residual assets revert to Duke, and

• If the assets are not sufficient to provide these annuities and cash outs, Plan assets would be used, as provided by law, first to pay expenses, then to provide for the benefits of retired participants and beneficiaries, vested active participants and terminated vested former participants, and other participants, in that order. If the assets are not sufficient to provide all these benefits, certain benefits may be paid by the Pension Benefit Guaranty Corporation.

Pension Benefit Guaranty Corporation
Your pension benefits under this Plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

• Normal and early retirement benefits,
• Disability benefits, if you become disabled before the plan terminates, and
• Certain benefits for your survivors.

The PBGC guarantee generally does not cover:

• Benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates,
• Some or all of the benefit increases and new benefits based on plan provisions that have been in place for fewer than five years at the time the plan terminates
• Benefits that are not vested because you have not worked long enough for Duke,
• Benefits for which you have not met all of the requirements at the time the plan terminates,
• Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan’s normal retirement age, and
• Non-pension benefits such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain benefits are not guaranteed, you still may receive some of them from the PBGC depending on how much money the Plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask the Plan Administrator or contact:

Pension Benefit Guaranty Corporation
PO Box 151750
Alexandria, VA 22315-1750
(800) 400-7242 or (202) 326-4000

TTY/TDD users may call the federal relay service toll-free at (800) 877-8339 and ask to be connected to (800) 400-7242.

Additional information about the PBGC’s pension insurance program is available through the PBGC’s web site on the Internet at www.pbgc.gov.
Your Rights Under ERISA

Receive Information About Your Plan and Benefits

As a participant in the Duke ERP, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- 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 plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and updated summary plan descriptions.
- Receive a copy of the plan’s annual funding report. The Plan Administrator is required by law to furnish each participant with a copy of this annual funding notice.
- Obtain a statement telling you whether you have a right to receive a benefit 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 benefit, the statement will tell you how many more years you have to work to get a right to a benefit. 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.

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 plan. The people who operate your plan, called “fiduciaries”, 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 a 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 which 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 the 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 the 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. Any legal action challenging a denial must be brought within one year of the denial on appeal.
**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 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. Or you can 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 live assistance by calling the toll-free contact center at (866) 487-2365.
Administrative Information

This section provides administrative information about the Plan, but is subject to the terms of the Plan, which may be modified from time to time. Where this description and the official documents vary, the official Plan documents or insurance contracts are the final authority. This description of administrative information is not an employment contract or any type of employment guarantee. No one speaking on behalf of the Plan or purporting to speak on behalf of the Plan can change the terms or provisions of the official Plan documents.

The Plan Administrator will help resolve any problem you might have regarding your rights to benefits. The official Plan documents, insurance contracts, and related information are available if you want to review these materials. If, for some reason, it becomes necessary to contact the U.S. Labor Management Services Administration, Department of Labor, you will need to provide the information contained in this section to properly identify the applicable plan.

Plan Name
The plan is the Employees’ Retirement Plan of Duke University.

Employer and Plan Identification Numbers
The Employer Identification Number (EIN) assigned by the IRS is 56-0532129. The plan number assigned by Duke is 002.

Plan Type
The Plan is a defined benefit pension plan.

Plan Sponsor
The Plan Sponsor is Duke University. You may contact the Plan Sponsor at the following address:

Duke Benefits
705 Broad Street
Box 90502
Durham, NC 27708

Plan Administrator
The Plan’s Retirement Board has the exclusive responsibility and complete discretionary authority to control the operation and administration of this Plan, with all powers necessary to enable it to carry out such responsibility properly. These powers include, but are not limited to, the power to construe the terms of this Plan, to determine status and eligibility for benefits, and to resolve all interpretive, equitable, and other questions that shall arise in the operation and administration of this Plan.

The Duke University Assistant Vice President, Human Resources, Benefits has been appointed by the Retirement Board to perform the Plan’s administrative duties. You can contact the Plan Administrator at:

Assistant Vice President
Human Resources Benefits
Duke University
705 Broad Street
Box 90502
Durham, NC 27708-0502

Plan Funding
This Plan is funded by Duke’s contributions, which are transferred to a trust. Any dividends or other refunds from a group insurance policy will be returned to the applicable trust.

Plan Trustee
The Bank of New York Mellon
One Wall Street
New York, NY 10286

Investment Responsibility
DUMAC Inc.
280 S. Mangum St.
Suite 210
Durham, NC 27701-3675

Agent for Service of Legal Process
Pamela Bernard
Office of Counsel
310 Blackwell St., 4th Floor
Box 104124
Durham, NC 27710

Service of legal process also may be made on the Plan Administrator or the Trustee for the Plan.

Plan Year
The Plan Year is from July 1 to June 30. The year for record keeping purposes is essentially the same, although the actual record keeping year ends on the last day of the last biweekly pay period in June, and the next year starts on the following day.
**Plan Costs**

Duke completely funds the Plan. You are not required or allowed to contribute to the Plan. All costs for general plan administration and investment management are paid from the assets of the plan’s trust unless otherwise paid by Duke.

**Plan Sponsor’s Authority**

Duke will have full discretion and authority to determine questions concerning the interpretation or administration of this plan, including, without limitation, all questions relating to eligibility for plan benefits. Duke has discretionary authority to grant or deny benefits under this plan. Duke’s determinations shall be conclusive and binding regarding all persons for all purposes.

This is a summary plan description of the Duke Employees’ Retirement Plan. It highlights the main provisions of the Plan, but is subject to the terms of the legal documents, which may be modified from time to time. Where this description and the official documents vary, the official plan documents are the final authority. Duke reserves the right to change or terminate this benefit or your eligibility for benefits under the Plan. This description of the Employees’ Retirement Plan is not an employment contract or any type of employment guarantee.
Educational Benefits
Duke Employee Tuition Assistance Program

Duke offers an Employee Tuition Assistance Program that provides reimbursement of tuition for classes taken at Duke or any other higher educational institution accredited by the Southern Association of Colleges and Schools with a physical presence in North Carolina. The purpose of the program is to encourage and increase professional development opportunities for 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 two years of continuous full-time service.

The term “Duke” is used throughout this document. For purposes of this benefit program description, “Duke” refers to the University, Duke University Health System, Inc., and any other entity which is or becomes controlled by Duke University and where, upon appropriate action by the Board of Trustees, the employees of that entity are included in the membership of this program.
## Duke Employee Tuition Assistance Program

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Eligibility and Enrollment

Eligibility for Coverage
You are eligible to apply for the program if you:

• Have completed two or more years 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 two year 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 the first day of class. (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, prior to the first day of classes.

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.

House Staff are not eligible for the Employee Tuition Assistance Program. However, once a House Staff member moves into a regular faculty position, prior to any break in service, the continuous service date as House Staff is used for calculating eligibility for this program.

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 his/her eligibility for ETAP throughout the period of the leave. Time away from work during an FMLA 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
- Must provide academic credit
- Must be listed in the institution’s course catalogue
- Must be taken at Duke or any other higher educational institution in North Carolina that is accredited by the Southern Association of Colleges and Schools and has a physical presence in North Carolina.
- 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
- Must be approved by your supervisor prior to the first day of class

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 accredited by the Southern Association of Colleges and Schools 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.

A list of schools accredited by the Southern Association of Colleges and Schools is available online at www.sacscoc.org/membershipInfo.asp or by calling (404) 679-4500.

Completed applications must be submitted to Benefits Administration prior to the first day of class.

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. Schools without a physical presence in North Carolina are not eligible for reimbursement.

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 to the HRIC at (919) 684-5600 within 60 days following successful completion of the course 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. Schools that are not accredited by the Southern Association of Colleges and Schools and schools without a physical presence in North Carolina are not eligible for reimbursement.

Certification programs that do not provide academic credit and correspondence courses are not eligible for tuition reimbursement. Additionally, tuition costs associated with thesis or dissertation course-work or masters papers are not eligible for tuition reimbursement. Also, courses which are solely research are not covered by this program, even if the
course provides credit hours. (This includes individual research under the direction of program faculty.)

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 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. 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 and your supervisor should complete and submit the application by mail or fax prior to the first day of class to:

Duke Human Resources Benefits
Employee Tuition Assistance Program
Administrator
P.O. Box 90502
Durham, NC 27705
Fax: (919) 681-8774
Phone: (919) 684-5600

Please retain a copy of your confirmation statement to assure your application was approved. It is your responsibility to ensure you have received approval since faculty fax transmissions (sending or receiving) are beyond the program’s control.

University employee applications must have approval of supervisor/manager. Health system employee applications must have approval of supervisor/manager and associate operating officer.

Duke Human Resources Benefits will send you a confirmation statement by email or fax within 10 business days after Benefits receives your completed application. The confirmation statement will indicate whether your application has been approved for reimbursement. Please retain a copy of your confirmation statement to assure your application was approved. It is your responsibility to ensure you have received approval since faulty fax transmissions (sending or receiving) are beyond the program’s control. Reimbursements will not be processed without approval prior to the first day of class.

How to Get Reimbursed
Within 60 days of course completion, send official institutional documentation of successful completion (a “C” grade or better, “Pass” or “Satisfactory”) and proof of the tuition payment* (Reimbursement Request Form) to:

Duke Human Resources Benefits
Employee Tuition Assistance Program
Administrator
P.O. Box 90502
Durham, NC 27705
Fax: (919) 681-8774
Phone: (919) 684-5600

Please retain a copy of your confirmation statement to assure your application was approved. It is your responsibility to ensure you have received approval prior to requesting reimbursement, since faulty fax transmissions (sending or receiving) are beyond the program’s control.

If you do not submit the required documentation within 60 days of course completion, you forfeit the reimbursement.

Please allow four weeks for reimbursement following receipt of your proof of tuition payment and grade information.

If you have your pay direct deposited, then your tuition reimbursement payment will be direct deposited into your account. This will be separate from your payroll deposit. A notice will be sent to you from Employee Travel & Reimbursement once the check has been deposited.
If you receive a paycheck rather than direct deposit for your normal paycheck, your tuition reimbursement will be in a separate check that you will need to pick up at the Employee Travel & Reimbursement Office (located at the American Tobacco Campus in the Washington Building). A notice will also be sent to you from Employee Travel & Reimbursement informing you that the check is ready to be picked up.

*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**

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, then you must repay 50% of the amount reimbursed over $2,500. Refer to the chart on this page for an example of the repayment 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, as indicated in SAP.

**Departmental/Manager Responsibility**

The supervisor/manager approval must be granted prior to the first day of class. 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 this employee gives notice of termination and this employee leaves before repaying the tuition benefit, the employee’s department will be responsible, for repaying the funds and the repayment amount will be deducted from the department's budget. 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 his or her 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.

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**Repayment Calculation Example:**

**Employee's last day worked:** April 8, 2017

**Two year look back period:**
April 8, 2015 to April 8, 2017

<table>
<thead>
<tr>
<th>Date of Tuition Payment</th>
<th>Amount of Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 15, 2004</td>
<td>$3,500</td>
</tr>
<tr>
<td>December 15, 2004</td>
<td>$1,500</td>
</tr>
<tr>
<td>May 16, 2015*</td>
<td>$1,750</td>
</tr>
<tr>
<td>December 16, 2015*</td>
<td>$2,400</td>
</tr>
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</table>

*Total tuition payments made within two year look back period: $4,150

Sub-total: $2,500

**Amount to be repaid by employee (50% of $1,650):** $825
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.
Duke Children’s Tuition Grant Program

The Children’s Tuition Grant 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 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 may be 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 may be 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 document. For purposes of this Benefit program description, “Duke” refers to the University, Duke University Health System, Inc., and any other entity which is or becomes controlled by Duke University and where, upon appropriate action by the Board of Trustees, the employees of that entity are included in the membership of this program.

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 is grandfathered 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 grandfather status continues for the course of this relationship only.
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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 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.

Employees must also be either:

• A current Duke University employee who has completed service credit while employed within the University or Medical Center, or

• Grandfathered as being 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.)

Note: An employee of Duke Regional or Duke Raleigh, for example, is not grandfathered for eligibility purposes.

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.

House Staff are not eligible for the Children’s Tuition Grant Program. However, once a House Staff member moves into a regular faculty position, prior to any break in service, the continuous service date as House Staff 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 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 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. But, 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.

Grant-funded positions 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.

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). 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.

Your Eligible Children

Your eligible children include:

- Your natural, 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).

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.

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 summer school.

*Children of employees who were hired before January 1, 1999, will not be subject to the maximum age limitation.
Taxes and Withholding of 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 his or her 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. Also, several universities are on a quarterly calendar rather than a semester. The annual deductible is adjusted on a pro-rata basis for these schools.

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 his/her parents) are applied.

PLEASE NOTE: Requests for appeals of benefit payments must be made within 90 days of the payment or within 90 days of the beginning of the semester in which the payment was due. Otherwise, it is assumed that the amount of the payment is accurate.

Applications must be submitted within 90 days after the end of the application semester.
Other Information about the Children’s Tuition Grant Program

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 “grandfathered” 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.

Once you meet the Rule of 75 and the other Children’s Tuition Grant Program eligibility criteria upon retirement from Duke, you are able to retain the benefit if you become a working retiree at Duke. Additionally, the following conditions apply:

- If you do not meet the Rule of 75 prior to retirement, you will not be eligible for the program as a working retiree,
- 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,
- 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.

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.
How to Apply for the Children’s Tuition Grant Program

Grant application forms are available at the Human Resource Information Center and Duke’s web site at hr.duke.edu. Recertification of your continued eligibility, your child’s enrollment, and the school’s tuition costs is necessary each semester.

Apply as early as possible by completing the grant application form and forwarding it to your child’s school for certification. The school should return the completed form by mail or fax to:

Duke University
Benefits
705 Broad Street
Durham, NC 27708
Fax (919) 681-8774

Allow several weeks for this process to minimize delays in your child’s eligibility to register, late fees, and 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.
Other Benefits
Duke Severance Pay Program

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 document. For purposes of this Benefit Program Description, “Duke” refers to the University, Duke University Health System, Inc., and any other entity which is or becomes controlled by Duke University and where, upon appropriate action by the Board of Trustees, the employees of that entity are included in the membership of this program.
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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 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, student employee, a visiting student, 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 his or her 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.

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 Re-employed 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 Duke’s 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 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 date:

- September 1 for the fall semester,
- January 1 for the spring semester, and
- May 1 for the summer session.

PLEASE NOTE: Grant-funded positions are not eligible for severance benefits and would, therefore, not be eligible for continuance of the Children’s Tuition Grant benefit once lay-off status is established. 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.
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 Benefit 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
Currently only available to employees with a Washington, DC work address

The voluntary Commuter Benefits Program sponsored by Duke University is provided through WageWorks, 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. That’s as much as a 40% savings!

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.
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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 at the Duke HR Benefits single sign-on link (hr.duke.edu/benefits/medical/reimbursement/account.php). The first time you visit the single sign-on link, you will be asked for your ID Code in the self-identification process. Please use the last four digits of your Duke Unique ID Number. Once you’ve completed your WageWorks 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. Do not forget to enter your email address to receive confirmations electronically. Note that it is up to you to make changes through WageWorks—your transit or parking provider cannot notify us 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 1-877-WageWorks (1-877-924-3967) 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 www.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/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 Works

2018 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 2018, the IRS allows up to $255 per month for transit/vanpool expenses and up to $255 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 WageWorks 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 WageWorks and have them mailed to your home every month, in time for the month they are valid. WageWorks 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.
- **WageWorks Commuter Card (Transit)**: The WageWorks 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, WageWorks can automatically pay your parking facility. You just need to register with WageWorks to tell them where and how much you pay to park.
- **WageWorks 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.
Notes
# Duke 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:

1. The Duke University Welfare and Fringe Benefit Plan, under which the following welfare and fringe benefit 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.

2. 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.

   Summary Plan Descriptions are included in this booklet. If you are a monthly paid employee, please refer to the Duke University Faculty and Staff Retirement Plan for Exempt Employees. If you are a biweekly paid employee, please refer to the Duke University Faculty and Staff Retirement Plan for Non-Exempt Employees.

3. The Employees’ Retirement Plan of Duke University, 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.

   A Summary Plan Description is included in this booklet and will be provided to biweekly paid employees when they also become eligible for membership in the Employees’ Retirement Plan of Duke University.

4. 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 this 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 Benefit 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 chart shows 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.
<table>
<thead>
<tr>
<th>Name of Benefit Program</th>
<th>Program Type</th>
<th>Program Funding</th>
<th>ERISA Coverage</th>
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<td>• Duke Select HMO Medical Program</td>
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<tr>
<td>• Duke Basic HMO Medical Program</td>
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<td>Unfunded/general assets; employer and employee paid</td>
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<td>Unfunded/general assets; employer and employee paid</td>
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<tr>
<td>• Blue Care HMO Medical Program</td>
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<td>Unfunded/general assets; employer and employee paid</td>
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<td>Duke Dental Program</td>
<td>Welfare Benefit</td>
<td>Insured; employee paid</td>
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<td>Duke Vision Program</td>
<td>Welfare Benefit</td>
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<td>Cafeteria and Premium Conversion Program</td>
<td>Fringe Benefit IRC 125</td>
<td>Unfunded/general assets; employee paid with pre-tax contributions</td>
<td>NO</td>
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<td>Health Care Reimbursement Account Program</td>
<td>Welfare Benefit</td>
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<td>Dependent care Reimbursement Account Program</td>
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<td>Life Insurance Program</td>
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<tr>
<td>◦ Basic Life Insurance Program</td>
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<td>◦ Survivor Benefit Program</td>
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<td>◦ Business Travel and Accident Insurance Program</td>
<td>Insured; employer paid</td>
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<td>◦ Insurance Certificate Program</td>
<td>Unfunded/general assets; employer paid</td>
<td></td>
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<tr>
<td>◦ Supplemental Life Insurance Program</td>
<td>Insured; employee paid</td>
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<tr>
<td>◦ Personal Accident Insurance Program</td>
<td>Insured; employee paid</td>
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<tr>
<td>◦ Post-retirement Group Term Life Insurance Program</td>
<td>Insured; employee paid with pre-tax contributions</td>
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<td>◦ House Staff Members of Duke University Medical Center</td>
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<td>• Long Term Disability Program for House Staff Members of Duke University Medical Center</td>
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<td>Long Term Care Insurance Program</td>
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<td>Severance Pay Program</td>
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<td>Employee Tuition Assistance Program</td>
<td>Fringe Benefit IRC§ 117(d) and 127</td>
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<td>Children’s Tuition Grant Program</td>
<td>Fringe Benefit IRC§ 117(d)</td>
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<td>Name of Benefit Program</td>
<td>Program Type</td>
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<tr>
<td>Duke University Faculty and Staff Retirement Plan</td>
<td>403(b) defined contribution plan</td>
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<td>YES Plan No. 001</td>
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<tr>
<td>Employees’ Retirement Plan of Duke University</td>
<td>401(a) defined benefit plan</td>
<td>Funded; employer paid</td>
<td>YES Plan No. 002</td>
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<tr>
<td>Duke University Commissioned Police Officers Supplemental Retirement Plan</td>
<td>403(b) defined contribution plan</td>
<td>Funded; employer paid</td>
<td>YES Plan No. 004</td>
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</table>

**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 chart). Employee contributions for the Welfare and Fringe Benefit Plan 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 investment company.

**Plan Administrator**
Duke University is the Plan Administrator for the benefit 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 Benefit Committee, or the appeal process delegated to the applicable claim’s administrator as described in Summary Plan Description (ex. Blue Cross/Blue Shield of NC or Liberty Mutual Insurance) 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
**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.

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<th>Plan</th>
<th>Benefits Processor</th>
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<tr>
<td>Duke Select HMO Medical Program and Duke Basic HMO Medical Program</td>
<td>Aetna</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 981106</td>
</tr>
<tr>
<td></td>
<td>El Paso, TX 79998</td>
</tr>
<tr>
<td></td>
<td>(800) 385-3636</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>Duke Options PPO Medical Program and Blue Care HMO Medical Program</td>
<td>Blue Cross Blue Shield of North Carolina</td>
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<td>Claims Department</td>
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<tr>
<td></td>
<td>P.O. Box 35</td>
</tr>
<tr>
<td></td>
<td>Durham, NC 277702-0035</td>
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<tr>
<td></td>
<td>(877) 224-3305</td>
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<td></td>
<td><a href="http://www.bcbsnc.com/members/goduke">www.bcbsnc.com/members/goduke</a></td>
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<tr>
<td>Prescription Drug Benefits</td>
<td>Express Scripts Rx Services</td>
</tr>
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<td>P.O. Box 650322</td>
</tr>
<tr>
<td></td>
<td>Dallas, TX 75265-9946</td>
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<tr>
<td></td>
<td>(800) 717-6575</td>
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<td><a href="http://www.express-scripts.com">www.express-scripts.com</a></td>
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<tr>
<td>Behavioral Health and Substance Abuse Benefits</td>
<td>Cigna Behavioral Health</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>Chattanooga, TN 37422</td>
</tr>
<tr>
<td></td>
<td>(888) 253-8552</td>
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<td><a href="http://www.cignabehavioral.com">www.cignabehavioral.com</a></td>
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<td>Dental Program</td>
<td>Ameritas</td>
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<tr>
<td></td>
<td>(800) 487-5553</td>
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<td><a href="http://www.ameritasgroup.com/duke">www.ameritasgroup.com/duke</a></td>
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<td>Vision Program</td>
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<td></td>
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<td></td>
<td>Salt Lake City, Utah 84130</td>
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<tr>
<td></td>
<td>(800) 638-3120</td>
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<td></td>
<td><a href="http://www.myuhcvision.com">www.myuhcvision.com</a></td>
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<td>Cafeteria and Premium Conversion Program</td>
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<td></td>
<td>Box 90502</td>
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<td>Durham, NC 27708-0502</td>
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<td></td>
<td>(919) 684-5600</td>
</tr>
<tr>
<td>Reimbursement Account Programs</td>
<td>WageWorks</td>
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<td></td>
<td>P.O. Box 991</td>
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<td></td>
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<tr>
<td></td>
<td>(877) 924-3967</td>
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<tr>
<td>Basic Life Insurance Program</td>
<td>Metropolitan Life Insurance Company</td>
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<td>Group Life Claims</td>
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<td></td>
<td>Utica, NY 13504</td>
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<td>(800) 638-6420</td>
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<td>Survivor Benefit Program</td>
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<tr>
<td>Business Travel and Accident Insurance</td>
<td>ACE USA Accident &amp; Health</td>
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<td>Program</td>
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<tr>
<td></td>
<td>P.O. Box 15417</td>
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<tr>
<td></td>
<td>Wilmington, DE 19850/ International SOS</td>
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<tr>
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<td>(800) 336-0627</td>
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<td>Des Moines, IA 50306-9905</td>
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<tr>
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<td>(800) 552-9670</td>
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<td>Personal Accident Insurance Program</td>
<td>Mutual of Omaha</td>
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<td>Special Risks Claims</td>
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<td>Omaha, NE 68131-0156</td>
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<td></td>
<td>(800) 524-2334</td>
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<td>Post Retirement Group Term Life Insurance Program</td>
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<td></td>
<td>2508 Hinton St.</td>
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<tr>
<td></td>
<td>Raleigh, NC 27612</td>
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<tr>
<td></td>
<td>(919) 755-8684</td>
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<tr>
<td>Cigna Medial Benefits Abroad Program</td>
<td>Cigna Health &amp; Life Insurance Company</td>
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<tr>
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<td></td>
<td>(800) 243-1348 (outside USA)</td>
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<td>(302) 797-3535 (inside USA)</td>
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<td>Universal Life Insurance Program</td>
<td>North Carolina Mutual Life Insurance Company</td>
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<td>411 West Chapel Hill Street</td>
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<td>Durham, NC 27701</td>
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<td>(800) 635-4467</td>
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<tr>
<td>Disability Program</td>
<td>Liberty Life Assurance Company of Boston</td>
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<td></td>
<td>P.O. Box 49470</td>
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<td>Charlotte, NC 28277</td>
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<td>(800) 291-0112</td>
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<td>Voluntary Long Term Disability</td>
<td>Hartford Life and Accident Insurance Company</td>
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<td>Program</td>
<td>Hartford Plaza</td>
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<td>(800) 969-6447</td>
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<td>The Prudential Insurance Company of America</td>
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<td></td>
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<td>Newark, NJ 07102-3777</td>
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<td><strong>Employee Tuition Assistance Program</strong></td>
<td>Benefits Program Coordinator</td>
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<td><strong>Employee’s Retirement Plan of Duke University</strong></td>
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<td><strong>The Duke University Commissioned Police Officer Supplemental Retirement Plan</strong></td>
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<td><a href="http://www.fidelity.com/duke">www.fidelity.com/duke</a></td>
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**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 Benefit 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
Please direct any legal papers and summonses regarding Duke’s benefit plans to:

AVP, Benefits
Duke University
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 payment 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 law 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 Benefit Plan consists of the Duke University Welfare and Fringe Benefit 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 as in effect shall govern. If you would like to review the plan document, need more information, or have any questions, please contact Benefits.

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 contained in this booklet 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 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 79, 105(b), 106, 117(d), 127, 125, 129, or 403(b), whichever is 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). ERISA provides that all participants of plans subject to ERISA are entitled to the following. *See Section entitled “Plan Names, Numbers, Type, and Funding” on page 274-278 for the plans and benefit programs covered by ERISA.*

**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 to get 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 or 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. Or you can 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.
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 Re-employment
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” on page 291. Please note that USERRA and COBRA Eligibility run concurrently.
Your Rights Under HIPAA

(Medical Coverage)

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 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 exclusion.

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 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 needing 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”) on page 75 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.

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<tr>
<th>If coverage is lost because of any of the qualifying events...</th>
<th>You can continue coverage for yourself up to...</th>
<th>Each eligible dependent can continue coverage in the health or dental program for up to...</th>
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<td>Your employment with Duke terminates (for reasons other than gross misconduct).</td>
<td>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</td>
<td>18 months* from the date of the qualifying event</td>
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<td>Your scheduled work hours reduced to less than 20 hours per week</td>
<td>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</td>
<td>18 months* from the date of the qualifying event</td>
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<td>You die</td>
<td>Not applicable</td>
<td>36 months from the date of the qualifying event</td>
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<td>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)</td>
<td>Not applicable</td>
<td>36 months from the date of the qualifying event</td>
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*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 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 ADP. You and your dependents will be sent information about the application process, and the cost to continue coverage. If you don’t 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 Resource Information Center (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 ADP, 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 ADP 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 don’t notify ADP 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 ADP 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 ADP 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 University Health Plan
Effective Date: April 14, 2003
Revised: May 14, 2009

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 Options, Blue Care and Duke Plus medical benefits programs and 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 to provide coverage and services to all of the Health Plan’s participants. 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 also may 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.

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. 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 e-mail. 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 do so, 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 a record of 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.

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 or if 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:

Privacy Official
Duke University
Benefits Administration
705 Broad St.
Durham, NC 27705
Duke Cafeteria and Premium Conversion Program

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 don’t 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’s 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 document. For purposes of this Benefit Program Description, “Duke” refers to the University, Duke University Health System, Inc., and any other entity that is or becomes controlled by Duke University and where, upon appropriate action of the Board of Trustees, the employees of that entity are included in the membership of this program.
Duke Cafeteria and Premium Conversion Program

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Eligibility and Enrollment

Eligibility
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 page 300). 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 practicable 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 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, divorce, or legal separation;
- 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.

Several additional qualifying events are described more fully in the following pages. Additional information is also available in the Benefit Program Descriptions.
Significant Cost or Coverage Change

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
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.

You will be informed of your share of the premium or enrollment costs for continued enrollment during a leave. A letter will be sent to your home address within 15 working days of the date your leave begins.

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 procedures. With respect to any other questions, contact:

HRIC
Duke University
705 Broad St.
Box 90502
Durham, NC 27708-0502

It is intended that the Cafeteria and Premium Conversion Program qualify as a “cafeteria plan” 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 plan for such program to the extent required under federal tax laws or other applicable laws. It is further intended that the benefits provided hereunder 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 program. The written plan document for the Cafeteria and Premium Conversion Program is not an employment contract or any type of employment guarantee.

Revised January 2018
Notes