This benefit booklet describes the Duke University and Duke University Health System EMPLOYEE health plan (the PLAN). Blue Cross and Blue Shield of North Carolina provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Please read this benefit booklet carefully.

The benefit plan described in this booklet is an EMPLOYEE health benefit plan, subject to the Employee Retirement Income Security Act of 1974 (ERISA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A summary of benefits, conditions, limitations and exclusions is set forth in this benefit booklet for easy reference.

In the event of a conflict between this benefit booklet and the terms in the PLAN document, the PLAN document will control.

Amendment and/or Termination of the PLAN
The PLAN ADMINISTRATOR expects this PLAN to be continued indefinitely, but the PLAN ADMINISTRATOR reserves the right to terminate the PLAN at any time with respect to its EMPLOYEES by a written instrument signed by an officer of the PLAN ADMINISTRATOR. Such termination may be made without the consent of the MEMBERS, or any other persons. The PLAN ADMINISTRATOR also reserves the right to amend the PLAN, including reduction or elimination of benefits or COVERED SERVICES. Amendments shall be made only in accordance with the provisions of the PLAN. The PLAN ADMINISTRATOR will provide notice to MEMBERS within sixty days of the adoption of any amendment that results in a material reduction in COVERED SERVICES or benefits.

Grandfathered Health Plan Disclosure
The PLAN ADMINISTRATOR believes this health benefit plan is 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.

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 your PLAN ADMINISTRATOR at Duke University and Duke University Health Systems.

Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross and Blue Shield Association.
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IMPORTANT INFORMATION REGARDING THE PLAN:

In accordance with applicable federal law, the PLAN will not discriminate against any health care provider acting within the scope of their license or certification, or against any person who has received a break on their premium, or taken any other action to endorse his or her right under applicable federal law. Further, the PLAN shall not impose eligibility rules or variations in premiums based on any specified health status-related factors unless specifically permitted by law.

This benefit booklet provides important information about your benefits and can help you understand how to maximize them. To help you become familiar with some common insurance terms concerning what you may owe after visiting your PROVIDER, see the chart below:

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Copayment</strong></td>
<td>The fixed dollar amount you must pay for some COVERED SERVICES at the time you receive them. Copayments are not credited to the OUT-OF-POCKET LIMIT or the deductible.</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>The dollar amount you must incur for COVERED SERVICES in a BENEFIT PERIOD before benefits are payable under the PLAN. The deductible does not include coinsurance, charges in excess of the ALLOWED AMOUNT, amounts exceeding any maximum, or expenses for noncovered expenses. If DEPENDENTS are covered, you each have an individual deductible and your family has a combined family deductible. Amounts applied to your OUT-OF-NETWORK deductible are credited to your IN-NETWORK deductible. However, amounts applied to your IN-NETWORK deductible are not credited to your OUT-OF-NETWORK deductible.</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>Your share of the costs of a covered health service, after you have met your BENEFIT PERIOD deductible. This is stated as a percentage of the ALLOWED AMOUNT. The coinsurance listed is your share of the cost of a COVERED SERVICE.</td>
</tr>
<tr>
<td><strong>OUT-OF-POCKET LIMIT</strong></td>
<td>The total amount of coinsurance you pay for COVERED SERVICES in a BENEFIT PERIOD before the PLAN pays 100%. OUT-OF-POCKET LIMIT does not include copayments, deductible, charges over ALLOWED AMOUNTS, charges for artificial insemination, and charges for noncovered services. Charges applied to your OUT-OF-NETWORK coinsurance are credited to your IN-NETWORK OUT-OF-POCKET LIMIT. However, charges applied to your IN-NETWORK coinsurance are not credited to your OUT-OF-NETWORK OUT-OF-POCKET LIMIT.</td>
</tr>
</tbody>
</table>

Please note: This health benefit plan was not specifically designed to be a high deductible health plan ("HDHP") under the Tax Code, and therefore is not intended to be paired with a health savings account ("HSA"). Check with a tax advisor to ensure qualification before you pair this health benefit plan with an HSA.

As you read this benefit booklet, keep in mind that any word you see in small capital letters (SMALL CAPITAL LETTERS) is a defined term and appears in "Glossary" at the end of this benefit booklet.

**Aviso Para AFILIADOS Que No Hablan Ingles**

Este manual de beneficios contiene un resumen en inglés de sus derechos y beneficios que le ofrece el PLAN. Si tiene dificultad en entender alguna sección de este manual, por favor llame al ADMINISTRADOR DEL PLAN para recibir ayuda.

**Using Informational Graphics**

Graphic symbols are used throughout this benefit booklet to call your attention to certain information and requirements.

**Definitions**

This symbol calls attention to definitions of important terms throughout this benefit booklet. Additional terms are in the "Glossary" at the end of this benefit booklet. If you are unsure of the meaning of a term, please check "Glossary."

**Cross-Reference**
Throughout this benefit booklet, cross-references direct you to read other sections of the benefit booklet when necessary.

**Call for PRIOR REVIEW and CERTIFICATION Required**

This symbol calls attention to medical/surgical services which require PRIOR REVIEW and CERTIFICATION in order to avoid a partial or full denial of benefits.

**Limitations and Exclusions**

Each subsection in "COVERED SERVICES" describes not only what is covered, but may also list some limitations and exclusions that specifically relate to a particular type of service. Limitations and exclusions that apply to all services are listed in "What Is Not Covered?"
Toll-Free Phone Numbers, Website and Addresses

<table>
<thead>
<tr>
<th>BCBSNC Website: bcbsnc.com</th>
<th>Find a network PROVIDER by location or specialty, get information about top-performing facilities and information and news about BCBSNC.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEMBER Services Website: mybcbsnc.com</td>
<td>Use our secure website that reflects your specific benefits and information to verify benefits and eligibility, check claims status, download claim and other forms, manage your account, request new ID CARDS, get helpful wellness information and more.</td>
</tr>
<tr>
<td>BCBSNC Customer Service: 1-877-275-9787 8 a.m. - 9 p.m. Monday-Friday, except holidays</td>
<td>For questions regarding your benefits, claims inquiries, and new ID CARD requests or to voice a complaint.</td>
</tr>
<tr>
<td>PRIOR REVIEW and CERTIFICATION: To request, MEMBERS call: 1-877-275-9787 PROVIDERS call: 1-800-672-7897</td>
<td>Some services require PRIOR REVIEW and CERTIFICATION from BCBSNC before they are considered for coverage. The list of these services may change from time to time. Current information about which services require PRIOR REVIEW can be found online at mybcbsnc.com.</td>
</tr>
<tr>
<td>Out of North Carolina Care: 1-800-810-BLUE(2583)</td>
<td>For help in obtaining care outside of North Carolina or the U.S., call this number or visit bcbs.com.</td>
</tr>
<tr>
<td>HealthLine Blue℠: 1-877-477-2424</td>
<td>Talk to a nurse 24/7 to receive timely information and advice on a number of health-related issues. Nurses are available by phone in both English and Spanish.</td>
</tr>
</tbody>
</table>
## Toll-Free Phone Numbers, Website and Addresses (cont.)

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Condition Care</strong></td>
<td>1-800-260-0091</td>
<td>Talk to a Condition Care Coach for information about programs and support for managing specific health conditions, such as asthma, diabetes, heart failure, coronary artery disease and COPD.</td>
</tr>
<tr>
<td><strong>Condition Care Maternity</strong></td>
<td>1-855-301-2229</td>
<td>Speak one-on-one with a specialized maternity nurse for the support you need. The 24/7 BabyLine® can provide information about programs and support for managing your pregnancy.</td>
</tr>
<tr>
<td><strong>Healthy Outcomes Customer Service</strong></td>
<td>1-877-719-9004</td>
<td>Talk with a representative to receive assistance with any technical issues with the website, including navigation and browser compatibility, as well as questions about the Healthy Outcomes program.</td>
</tr>
<tr>
<td><strong>Wellness Coaching</strong></td>
<td>1-888-292-5444</td>
<td>Wellness Coaches provide behavioral support to help you manage lifestyle issues. Wellness support is available by phone, as well as by e-mail and live chat.</td>
</tr>
<tr>
<td><strong>Medical Claims Filing</strong></td>
<td>BCBSNC Claims Department PO Box 35 Durham, NC 27702-0035</td>
<td>Mail completed medical claims to this address.</td>
</tr>
</tbody>
</table>
Value-Added Programs

These programs are not covered benefits and are outside of the PLAN. BCBSNC does not accept claims or reimburse for these goods or services and MEMBERS are responsible for paying all bills. The PLAN ADMINISTRATOR and BCBSNC may change or discontinue these programs at any time.

| **Chiropractic Services** | 1-877-275-9787  
8 a.m. - 9 p.m. Monday-Friday, except holidays |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>For information about discounts on chiropractic services and a practitioner directory, call or visit <a href="http://mybcbsnc.com">mybcbsnc.com</a>.</td>
<td></td>
</tr>
</tbody>
</table>

| **TruHearing™** | 1-877-343-0745  
1-800-975-2674 (TTY toll-free) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>For information about discounts on hearing aids, call or visit <a href="http://mybcbsnc.com">mybcbsnc.com</a>.</td>
<td></td>
</tr>
</tbody>
</table>

| **Blue365™** | 1-855-511-2583  
8 a.m. - 6 p.m. Monday-Friday, except holidays |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and wellness information support and services, and special MEMBER savings available 365 days a year.</td>
<td></td>
</tr>
</tbody>
</table>

| **Davis Vision®** | 1-888-897-9350  
8 a.m. - 11 p.m. Monday-Friday  
9 a.m. - 4 p.m. Saturday  
12 p.m. - 4 p.m. Sunday |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>For information about discounts on corrective laser eye surgery, call or visit <a href="http://mybcbsnc.com">mybcbsnc.com</a>.</td>
<td></td>
</tr>
</tbody>
</table>
This section provides a summary of your Blue Options benefits. A more complete description of your benefits is found in "COVERED SERVICES." General exclusions may also apply - please see "What Is Not Covered?" As you review the "Summary of Benefits" chart, keep in mind:

- Copayment amounts are fixed dollar amounts the MEMBER must pay for some COVERED SERVICES
- Multiple OFFICE VISITS or emergency room visits on the same day may result in multiple copayments
- Coinsurance percentages shown in this section are the part that you pay for COVERED SERVICES
- Amounts applied to deductible and coinsurance are based on the ALLOWED AMOUNT
- Amounts applied to the deductible also count toward any visit or day maximums for those services

- If your benefit level for services includes deductible and coinsurance, your PROVIDER may collect an estimated amount of these at the time you receive services.

- To receive IN-NETWORK benefits, you must receive care from a Blue Options IN-NETWORK PROVIDER. However, in an EMERGENCY, or when IN-NETWORK PROVIDERS are not reasonably available as determined by BCBSNC’s access to care standards, you may also receive IN-NETWORK benefits for care from an OUT-OF-NETWORK PROVIDER. Please see "OUT-OF-NETWORK Benefit Exceptions" and "EMERGENCY Care" for more information. Access to care standards are available on the BCBSNC website at bcbnsc.com or by calling BCBSNC Customer Service at the number listed on your ID CARD or in "Who To Contact?"

- If you see an OUT-OF-NETWORK PROVIDER, you will receive OUT-OF-NETWORK benefits unless otherwise approved by BCBSNC.

Please Note: The list of IN-NETWORK PROVIDERS may change from time to time, so please verify that the PROVIDER is still in the Blue Options network before receiving care. Find a PROVIDER on the BCBSNC website at bcbnsc.com or call BCBSNC Customer Service at the number listed on your ID CARD or in "Who to Contact?"
BENEFIT PERIOD - January 1, 2015 through December 31, 2015
Benefit payments are based on where services are received and how services are billed.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PREVENTIVE CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Exams</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRIMARY CARE PROVIDER</td>
<td>$20 copayment</td>
<td>Benefits not available</td>
</tr>
<tr>
<td>SPECIALIST</td>
<td>$45 copayment</td>
<td>Benefits not available</td>
</tr>
<tr>
<td>This includes: routine physical exams, well-baby care, well-child care, and immunizations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Screenings</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRIMARY CARE PROVIDER</td>
<td>$20 copayment</td>
<td>30% after deductible*</td>
</tr>
<tr>
<td>SPECIALIST</td>
<td>$45 copayment</td>
<td>30% after deductible*</td>
</tr>
<tr>
<td>This includes: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, newborn hearing screening, and prostate-specific antigen tests.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nutritional Counseling</strong></td>
<td>No Charge</td>
<td>30% after deductible*</td>
</tr>
<tr>
<td>(limited to 6 visits per BENEFIT PERIOD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PROVIDER’S Office</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>See Outpatient for OUTPATIENT CLINIC or HOSPITAL-based services. OFFICE VISITS for the evaluation and treatment of obesity are limited to a combined IN- and OUT-OF-NETWORK maximum of four visits per BENEFIT PERIOD. Any visits in excess of these BENEFIT PERIOD MAXIMUMS are not COVERED SERVICES.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OFFICE VISIT Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRIMARY CARE PROVIDER</td>
<td>$20 copayment</td>
<td>30% after deductible*</td>
</tr>
<tr>
<td>SPECIALIST</td>
<td>$45 copayment</td>
<td>30% after deductible*</td>
</tr>
<tr>
<td>This includes: office SURGERY, x-rays and lab tests.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CT scans, MRIs, MRAs and PET scans</td>
<td>10% after deductible</td>
<td>30% after deductible*</td>
</tr>
<tr>
<td>IUD insertion</td>
<td>$200 copayment</td>
<td>30% after deductible*</td>
</tr>
</tbody>
</table>

*Percentage of allowable charges after deductible
<table>
<thead>
<tr>
<th>Benefits</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>REHABILITATIVE and HABILITATIVE THERAPIES</td>
<td>$45 copayment</td>
<td>30% after deductible*</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>$45 copayment</td>
<td>30% after deductible*</td>
</tr>
</tbody>
</table>

Combined IN- and OUT-OF-NETWORK BENEFIT PERIOD MAXIMUMS apply to home, office and outpatient settings. 30 visits per BENEFIT PERIOD for physical/occupational therapy, including chiropractic services. 20 visits per BENEFIT PERIOD for speech therapy. Any visits in excess of these BENEFIT PERIOD MAXIMUMS are not COVERED SERVICES. See “Therapies” in “COVERED SERVICES” for additional benefits that apply for DEPENDENTS.

<table>
<thead>
<tr>
<th>Physical and Occupational Therapy - Inpatient Facility</th>
<th>10% after deductible</th>
<th>30% after deductible*</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTHER THERAPIES</td>
<td>No Charge</td>
<td>30% after deductible*</td>
</tr>
</tbody>
</table>

Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See Outpatient for OTHER THERAPIES provided in an outpatient setting.

<table>
<thead>
<tr>
<th>INFERTILITY Services</th>
<th>Package Price: see COVERED SERVICES section</th>
</tr>
</thead>
</table>

Limitations apply to infertility services. See "INFERTILITY Services" for additional information. Any services in excess of the LIFETIME MAXIMUM are not COVERED SERVICES.

<table>
<thead>
<tr>
<th>Routine Eye Exam</th>
<th>$45 copayment</th>
<th>Benefits not available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keratoconus</td>
<td>10% after deductible</td>
<td>30% after deductible*</td>
</tr>
</tbody>
</table>

(Diagnosis code 371.6 & 371.62)

*Percentage of allowable charges after deductible
### SUMMARY OF BENEFITS (cont.)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obesity Treatment/Weight Management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRIMARY CARE PROVIDER</td>
<td>$20 copayment</td>
<td>30% after deductible*</td>
</tr>
<tr>
<td>SPECIALIST</td>
<td>$45 copayment</td>
<td>30% after deductible*</td>
</tr>
<tr>
<td><strong>Outpatient Physician Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient HOSPITAL and HOSPITAL-based Services</td>
<td>10% after deductible</td>
<td>30% after deductible*</td>
</tr>
<tr>
<td>Bariatric Surgery (available only at Duke Regional Hospital) - $2,500 copayment.</td>
<td>$2,500 copayment</td>
<td>Benefits not available</td>
</tr>
<tr>
<td>Panniculectomy Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OFFICE VISITS for the evaluation and treatment of obesity are limited to a combined IN- and OUT-OF-NETWORK maximum of four visits per BENEFIT PERIOD. Any visits in excess of these BENEFIT PERIOD MAXIMUMS are not COVERED SERVICES.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### URGENT CARE Centers, Emergency Room, and Ambulance

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>URGENT CARE Centers</td>
<td>$35 copayment</td>
<td>$35 copayment</td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>$250 copayment</td>
<td>$250 copayment</td>
</tr>
</tbody>
</table>

If admitted to the HOSPITAL from the emergency room, the emergency room copayment does not apply; instead, inpatient HOSPITAL benefits apply to all COVERED SERVICES provided in both the emergency room and during inpatient hospitalization. If held for observation, the emergency room copayment does not apply; instead, outpatient benefits apply to all COVERED SERVICES provided in both the emergency room and during observation. If you are sent to the emergency room from an URGENT CARE center, you may be responsible for both the emergency room copayment and the URGENT CARE copayment.

| Ambulance Services       | 10% after deductible     | 10% after deductible*     |
| Air Ambulance - (No benefits IN NETWORK or OUT OF NETWORK provided for medical evacuation.) |

### AMBULATORY SURGICAL CENTER

| Ambulatory Surgical Services | 10% after deductible     | 30% after deductible*     |
| IUD insertion               | $200 copayment           | 30% after deductible*     |

*Percentage of allowable charges after deductible
### Summary of Benefits

<table>
<thead>
<tr>
<th>Benefits</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Services</td>
<td>10% after deductible</td>
<td>30% after deductible*</td>
</tr>
<tr>
<td>HOSPITAL and HOSPITAL-based Services</td>
<td>10% after deductible</td>
<td>30% after deductible*</td>
</tr>
<tr>
<td>HOSPITAL-based or OUTPATIENT CLINIC Services</td>
<td>10% after deductible</td>
<td>30% after deductible*</td>
</tr>
<tr>
<td>IUD insertion</td>
<td>$200 copayment</td>
<td>30% after deductible*</td>
</tr>
<tr>
<td>Therapy Services</td>
<td>10% after deductible</td>
<td>30% after deductible*</td>
</tr>
</tbody>
</table>

Includes SHORT-TERM REHABILITATIVE THERAPIES and OTHER THERAPIES including dialysis; see PROVIDER’S Office for visit maximums.

<table>
<thead>
<tr>
<th><strong>Outpatient Diagnostic Services</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient lab tests and mammography,</td>
<td>10% after deductible</td>
<td>30% after deductible*</td>
</tr>
<tr>
<td>when performed alone (physician and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HOSPITAL-based services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient lab tests and mammography,</td>
<td>10% after deductible</td>
<td>30% after deductible*</td>
</tr>
<tr>
<td>when performed with another service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Services</td>
<td>10% after deductible</td>
<td>30% after deductible*</td>
</tr>
<tr>
<td>HOSPITAL and HOSPITAL-based Services</td>
<td>10% after deductible</td>
<td>30% after deductible*</td>
</tr>
<tr>
<td>Outpatient x-rays, ultrasounds, and other</td>
<td>10% after deductible</td>
<td>30% after deductible*</td>
</tr>
<tr>
<td>diagnostic tests, such as EEGs, EKGs and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pulmonary function tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CT scans, MRIs, MRAs, and PET scans</td>
<td>10% after deductible</td>
<td>30% after deductible*</td>
</tr>
</tbody>
</table>

*Percentage of allowable charges after deductible
## SUMMARY OF BENEFITS (cont.)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td>10% after deductible</td>
<td>30% after deductible*</td>
</tr>
<tr>
<td><strong>HOSPITAL and HOSPITAL-based Services</strong></td>
<td>10% after $450 per admission copayment and deductible for Duke University Hospital, Duke Regional Hospital and Duke Raleigh Hospital; $550 per admission copay and deductible for all other IN-NETWORK HOSPITAL facilities</td>
<td>30% after $700 per admission copayment and deductible*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes maternity delivery, prenatal and post-delivery care. If you are in a HOSPITAL as an inpatient at the time you begin a new BENEFIT PERIOD, you may have to meet a new deductible for COVERED SERVICES from DOCTORS or OTHER PROFESSIONAL PROVIDERS.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SKILLED NURSING FACILITY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10% after $250 per admission copayment and deductible</td>
<td>30% after $250 per admission copayment and deductible*</td>
</tr>
<tr>
<td>Combined IN- and OUT-OF-NETWORK maximum of 60 days per BENEFIT PERIOD. Services applied to the deductible count towards this day maximum. Any services in excess of these BENEFIT PERIOD MAXIMUMS are not COVERED SERVICES.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10% after deductible</td>
<td>30% after deductible*</td>
</tr>
<tr>
<td>Includes DURABLE MEDICAL EQUIPMENT, HOSPICE services, MEDICAL SUPPLIES, orthotic devices, private duty nursing, PROSTHETIC APPLIANCES, and home health care. Orthotic devices for correction of POSITIONAL PLAGIOCEPHALY are limited to one device per MEMBER per lifetime. When covered, benefits for hearing aids are limited to one hearing aid per hearing impaired ear every 36 months for MEMBERS under the age of 22. Home health care is limited to a combined IN- and OUT-OF-NETWORK maximum of 100 days per BENEFIT PERIOD, and home health care visits applied to the deductible count towards this day maximum. Any services in excess of these BENEFIT PERIOD or LIFETIME MAXIMUMS are not COVERED SERVICES.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wigs - related to radiation or chemotherapy (limited to 1 wig per BENEFIT PERIOD with a $400 maximum)</td>
<td>10% after deductible</td>
<td>10% after deductible*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Percentage of allowable charges after deductible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**SUMMARY OF BENEFITS (cont.)**

<table>
<thead>
<tr>
<th>Benefits</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIFETIME MAXIMUM, Deductible, and OUT-OF-POCKET LIMIT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following deductibles and maximums apply to the services listed above in the &quot;Summary of Benefits&quot; unless otherwise noted.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LIFETIME MAXIMUM</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Unlimited for all services, except orthotic devices for POSITIONAL PLAGIOCEPHALY and INFERTILITY. Transgender surgery services are limited to $50,000 per lifetime. If you exceed any LIFETIME MAXIMUM, additional services of that type are not covered. In this case, you may be responsible for the entire amount of the PROVIDER'S billed charge.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual, per BENEFIT PERIOD</td>
<td>$100</td>
<td>$500</td>
</tr>
<tr>
<td>Family, per BENEFIT PERIOD</td>
<td>$300</td>
<td>$1,500</td>
</tr>
<tr>
<td>Charges for the following do not apply to the BENEFIT PERIOD deductible:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• inpatient newborn care for well baby.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OUT-OF-POCKET LIMIT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual, per BENEFIT PERIOD</td>
<td>$2,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family, per BENEFIT PERIOD</td>
<td>$6,000</td>
<td>$9,000</td>
</tr>
</tbody>
</table>

**CERTIFICATION Requirements**

Certain services require PRIOR REVIEW and CERTIFICATION by the PLAN in order to receive benefits. See “COVERED SERVICES” and “PRIOR REVIEW (Pre-Service)” in “UTILIZATION MANAGEMENT” for additional information.
Duke Options gives you the freedom to choose any provider - the main difference will be the cost to you. Benefits are available for services from a PROVIDER that is recognized by BCBSNC as eligible. For a list of eligible PROVIDERS, please visit the BCBSNC website at [bcbsnc.com](http://bcbsnc.com) or call BCBSNC Customer Service at the number listed in "Who to Contact?" Here's a look at how it works:

<table>
<thead>
<tr>
<th>Type of PROVIDER</th>
<th>IN-NETWORK PROVIDERS are health care professionals and facilities that have contracted with BCBSNC, or a PROVIDER participating in the BlueCard® program. ANCILLARY PROVIDERS outside North Carolina are considered IN-NETWORK only if they contract directly with the Blue Cross or Blue Shield plan in the state where services are provided, even if they participate in the BlueCard® program. See &quot;Glossary&quot; for a description of ANCILLARY PROVIDERS and the criteria for determining where services are received. The list of IN-NETWORK PROVIDERS may change from time to time. IN-NETWORK PROVIDERS are listed on the BCBSNC website at <a href="http://bcbsnc.com">bcbsnc.com</a>, or call BCBSNC Customer Service at the number listed in &quot;Who to Contact?&quot;</th>
<th>OUT-OF-NETWORK PROVIDERS are not designated as Blue Options PROVIDERS by BCBSNC. Also see &quot;OUT-OF-NETWORK Benefit Exceptions.&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALLOWED AMOUNT vs. Billed Amount</td>
<td>If the billed amount for COVERED SERVICES is greater than the ALLOWED AMOUNT, you are not responsible for the difference. You only pay any applicable copayment, deductible, coinsurance, and noncovered expenses. (See Filing Claims below for additional information.)</td>
<td>You may be responsible for paying any charges over the ALLOWED AMOUNT in addition to any applicable deductible, coinsurance, noncovered expenses and CERTIFICATION penalty amounts, if any except for EMERGENCY SERVICES in the case of an EMERGENCY.</td>
</tr>
<tr>
<td>Referrals</td>
<td>BCBSNC does not require you to obtain any referrals.</td>
<td>BCBSNC does not require you to obtain any referrals.</td>
</tr>
<tr>
<td>After-hours Care</td>
<td>If you need nonemergency services after your PROVIDER’S office has closed, please call your PROVIDER’S office for their recorded instructions.</td>
<td></td>
</tr>
<tr>
<td>Care Outside of North Carolina</td>
<td>Your ID CARD gives you access to participating PROVIDERS outside the state of North Carolina through the BlueCard program, and benefits are provided at the IN-NETWORK benefit level.</td>
<td>If you are in an area that has participating PROVIDERS and you choose a PROVIDER outside the network, you will receive the lower OUT-OF-NETWORK benefit. Also see &quot;OUT-OF-NETWORK Benefit Exceptions.&quot;</td>
</tr>
</tbody>
</table>
HOW DUKE OPTIONS WORKS (cont.)

<table>
<thead>
<tr>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIOR REVIEW</td>
<td>Out-of-NETWORK PROVIDERS are not obligated by contract to request PRIOR REVIEW by BCBSNC. You are responsible for ensuring that you or your OUT-OF-NETWORK PROVIDER requests PRIOR REVIEW by BCBSNC.</td>
</tr>
</tbody>
</table>

Filing Claims

| IN-NETWORK PROVIDERS in North Carolina are responsible for filing claims directly with BCBSNC. However, you will have to file a claim if you do not show your ID CARD when you obtain a PRESCRIPTION from an IN-NETWORK pharmacy, or the IN-NETWORK pharmacy’s records do not show as eligible for coverage. In order to recover the full cost of the PRESCRIPTION minus any applicable copayment or coinsurance you owe, return to the IN-NETWORK pharmacy within 14 days of receiving your PRESCRIPTION so that it can be reprocessed with your correct eligibility information and the pharmacy will make a refund to you if necessary. If you are unable to return to the pharmacy within 14 days, mail claims in time to be received within 18 months of the date of the service in order to receive IN-NETWORK benefits. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the MEMBER. |

| You may have to pay the OUT-OF-NETWORK PROVIDER in full and submit your own claim to BCBSNC. Mail claims in time to be received within 18 months of the date the service was provided. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the MEMBER. |

OUT-OF-NETWORK Benefit Exceptions

In an EMERGENCY, in situations where IN-NETWORK PROVIDERS are not reasonably available as determined by BCBSNC’s access to care standards, or in continuity of care situations, OUT-OF-NETWORK benefits will be paid at your IN-NETWORK benefit level. However, you may be responsible for charges billed separately by the PROVIDER which are not eligible for additional reimbursement. If you are billed by the PROVIDER, you will be responsible for paying the bill and filing a claim with BCBSNC.

For more information, see one of the following sections: "EMERGENCY Care" in "COVERED SERVICES," or "Continuity of Care" in "UTILIZATION MANAGEMENT." For information about BCBSNC’s access to care standards, see the BCBSNC website at bchsnc.com and type "access to care" in the search bar. If you believe an IN-NETWORK PROVIDER is not reasonably available, you can help assure that benefits are paid at the correct benefit level by calling BCBSNC before receiving care from an OUT-OF-NETWORK PROVIDER.

Carry Your IDENTIFICATION CARD

Your ID CARD identifies you as a Duke Options MEMBER. Be sure to carry your ID CARD with you at all times and present it each time you seek health care.
For ID CARD requests, please visit the BCBSNC website at mybcbsnc.com or call BCBSNC Customer Service at the number listed in "Who to Contact?"

**The Role of a PRIMARY CARE PROVIDER (PCP) or SPECIALIST**

THE PLAN does not require that you designate a PCP to manage your health care. However, it is important for you to maintain a relationship with a PCP, who will help you manage your health and make decisions about your health care needs. If you change PCPs, be sure to have your medical records transferred, especially immunization records, to provide your new DOCTOR with your medical history. You should participate actively in all decisions related to your health care and discuss all treatment options with your health care PROVIDER regardless of cost or benefit coverage. PCPs are trained to deal with a broad range of health care issues and can help you to determine when you need a SPECIALIST. PROVIDERS from medical specialties such as family practice, internal medicine and pediatrics may participate as PCPs.

Please visit the BCBSNC website at bchsnc.com or call BCBSNC Customer Service to confirm that the PROVIDER is in the network before receiving care.

If your PCP or SPECIALIST leaves the BCBSNC PROVIDER network and they are currently treating you for an ongoing special condition, see "Continuity of Care" in "UTILIZATION MANAGEMENT."

Upon the request of the MEMBER and subject to approval by BCBSNC, a SPECIALIST treating a MEMBER for a serious or chronic disabling or life-threatening condition can act as the MEMBER'S PCP. The selected SPECIALIST would be responsible for providing and coordinating the MEMBER'S primary and specialty care. The selection of a SPECIALIST under these circumstances shall be made under a treatment plan approved by the SPECIALIST and BCBSNC, with notice to the PCP, if applicable. A request may be denied where it is determined that the SPECIALIST cannot appropriately coordinate the MEMBER'S primary and specialty care.

To make this request, or if you would like the professional qualifications of your PCP or IN-NETWORK SPECIALIST, you may call BCBSNC Customer Service at the number listed in "Who to Contact?"
Blue Options covers only those services that are MEDICALLY NECESSARY. Also keep in mind as you read this section:

- **Certain services require PRIOR REVIEW and CERTIFICATION in order for you to avoid a partial (penalty) or full denial of benefits. General categories of services are noted below as requiring PRIOR REVIEW. Also see "PRIOR REVIEW/Pre-Service" in "UTILIZATION MANAGEMENT" for information about the review process, and visit the BCBSNC website at mybcbsnc.com or call BCBSNC Customer Service to ask whether a specific service requires PRIOR REVIEW and CERTIFICATION.**

- Exclusions and limitations apply to your coverage. Service-specific exclusions are stated along with the benefit description in "COVERED SERVICES." Exclusions that apply to many services are listed in "What Is Not Covered?" To understand the exclusions and limitations that apply to each service, read "COVERED SERVICES," "Summary of Benefits" and "What Is Not Covered?"

- You may receive, upon request, information about Blue Options, its services and DOCTORS, including this benefit booklet with a benefit summary, and a directory of IN-NETWORK PROVIDERS.

- You may also receive, upon request, information about the procedure and medical criteria used by BCBSNC to determine whether a procedure, treatment, facility, equipment, drug or device is MEDICALLY NECESSARY and eligible for coverage, INVESTIGATIONAL or EXPERIMENTAL, or requires PRIOR REVIEW and CERTIFICATION by BCBSNC. BCBSNC medical policies are guides considered by BCBSNC when making coverage determinations. If you need more information about medical policies, see the BCBSNC website at bcbns.com, or call BCBSNC Customer Service at the number listed in "Who to Contact?"

### Office Services

Care you receive as part of an OFFICE VISIT, or house call is covered with a copayment, except as otherwise noted in this benefit booklet. Some PROVIDERS may get ancillary services, such as laboratory services, medical equipment and supplies or SPECIALTY DRUGS, from third parties. In these cases, you may be billed directly by the ANCILLARY PROVIDER. Benefit payments for these services will be based on the type of ANCILLARY PROVIDER, its network status, and how the services are billed.

A copayment will not apply if you only receive services such as allergy shots or other injections and are not charged for an OFFICE VISIT.

Some DOCTORS or OTHER PROVIDERS may practice in OUTPATIENT CLINICS or provide HOSPITAL-based services in their offices. These services are covered as outpatient services and are listed as HOSPITAL-based or OUTPATIENT CLINIC. See "Summary of Benefits."

Please check with your PROVIDER before your visit to determine if your PROVIDER will collect deductible and coinsurance, or you can call BCBSNC Customer Service at the number listed in "Who to Contact?" for this information.

### Office Services Exclusion

- Certain self-injectable PRESCRIPTION DRUGS that can be self-administered. The list of these drugs may change from time to time. See the BCBSNC website at bcbns.com or call BCBSNC Customer Service for a list of these drugs excluded in the office.

### PREVENTIVE CARE

The PLAN covers PREVENTIVE CARE services that can help you stay safe and healthy.

Some services are only available IN-NETWORK as indicated below.

**PREVENTIVE CARE COVERED SERVICES** include:

**Routine Physical Examinations and Screenings**

One routine physical examination and related diagnostic services per BENEFIT PERIOD will be covered for each MEMBER age three and older.

This benefit is only available IN-NETWORK.
Well-Baby and Well-Child Care
These services are covered for each MEMBER including periodic assessments as recommended by the American Academy of Pediatrics and the United States Preventive Services Task Force.

This benefit is only available IN-NETWORK.

Immunizations
The full series of standard immunizations recommended by the Centers for Disease Control and Prevention (CDC) and the American Academy of Family Physicians (AAFP) is covered. NOTE: the shingles vaccine is covered in accordance with the Food and Drug Administration (FDA) guidelines.

This benefit is only available IN-NETWORK, except for meningococcal vaccine which is also available OUT-OF-NETWORK.

Immunizations Exclusion
- Immunizations required for occupational hazard or international travel, unless specifically covered by the PLAN.

Please log on to the BCBSNC website at mybcbsnc.com and type "preventive care" into the search box for the most up-to-date information or call BCBSNC at 1-877-275-9787.

Routine Eye Exams
Benefits are only available IN-NETWORK.

The PLAN provides coverage for one routine comprehensive eye examination per BENEFIT PERIOD. Diagnosis and treatment of medical conditions of the eye, and drugs administered for purposes other than for a visual examination, are not considered to be part of a routine eye exam and are subject to the benefits, limitations and exclusions of the PLAN.

Routine Eye Exams Exclusions
- Fitting for contact lenses, glasses or other hardware
- Diagnostic services that are not a component of a routine vision examination.

The following benefits are available IN-NETWORK and OUT-OF-NETWORK.

See the “Summary of Benefits,” since benefits may vary depending on where services are received.

Bone Mass Measurement Services
The PLAN covers one scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass during any 23-month period for certain qualified individuals only. Additional follow-up bone mass measurement tests will be covered if MEDICALLY NECESSARY.

Qualified individuals include MEMBERS who have any one of the following conditions:

- Estrogen-deficient and at clinical risk of osteoporosis or low bone mass
- Radiographic osteopenia anywhere in the skeleton
- Receiving long-term glucocorticoid (steroid) therapy
- Primary hyperparathyroidism
- Being monitored to assess the response or effect of commonly accepted osteoporosis drug therapies
- History of low-trauma fractures
- Other conditions, or receiving medical therapies known to cause osteoporosis or low bone mass.

Colorectal Screening
Colorectal cancer examinations and laboratory tests for cancer are covered for any symptomatic or asymptomatic MEMBER who is at least 50 years of age, or is less than 50 years of age and at high risk for colorectal cancer. Increased/high-risk individuals are those who have a higher potential of developing colon cancer because of a personal or family history of certain intestinal disorders. Some of these procedures are considered SURGERY, such as colonoscopy and sigmoidoscopy, and others are considered lab tests, such as hemoccult screenings.

Gynecological Exam and Cervical Cancer Screening
The cervical cancer screening benefit includes the examination and laboratory tests for early detection and screening of cervical cancer, and a DOCTOR'S interpretation of the lab results. Coverage for cervical cancer screening includes Pap smear screening, liquid-based cytology, and human papillomavirus detection, and shall follow the American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

**Newborn Hearing Screening**
Coverage is provided for newborn hearing screening ordered by a DOCTOR to determine the presence of permanent hearing loss.

**Ovarian Cancer Screening**
For female MEMBERS ages 25 and older at risk for ovarian cancer, an annual screening, including a transvaginal ultrasound and a rectovaginal pelvic examination, is covered. A female MEMBER is considered "at risk" if she:
- has a family history with at least one first-degree relative with ovarian cancer, and a second relative, either first-degree or second-degree with breast, ovarian, or nonpolyposis colorectal cancer; or
- tested positive for a hereditary ovarian cancer syndrome.

**Prostate Screening**
One prostate-specific antigen (PSA) test or an equivalent serological test will be covered per male MEMBER per BENEFIT PERIOD. Additional PSA tests will be covered if recommended by a DOCTOR.

**Screening Mammograms**
The PLAN provides coverage for one baseline mammogram for any female MEMBER between the ages of 35 and 39. Beginning at age 40, one screening mammogram will be covered per female MEMBER per BENEFIT PERIOD, along with a DOCTOR'S interpretation of the results. More frequent or earlier mammograms will be covered as recommended by a DOCTOR when a female MEMBER is considered at risk for breast cancer.

A female MEMBER is "at risk" if she:
- Has a personal history of breast cancer
- Has a personal history of biopsy-proven benign breast disease
- Has a mother, sister, or daughter who has or has had breast cancer, or
- Has not given birth before the age of 30.

**Obesity Treatment/Weight Management**
The PLAN provides coverage for OFFICE VISITS for the evaluation and treatment of obesity; see "Summary of Benefits" for visit maximums. Bariatric SURGERY must meet these criteria: severely obese (BMI of 40 or more); or, significant co-morbid condition (BMI 35-39); meet physician's medical/psychological criteria; be employed at Duke in a benefit eligible category for at least five continuous years; and have participated in an approved weight loss program for six months - see website. This SURGERY is only available at Duke Regional Hospital with a copayment of $2,500. For more information, please visit [www.hr.duke.edu/benefits/health/obesity.html](http://www.hr.duke.edu/benefits/health/obesity.html). The PLAN also provides benefits for panniculectomy surgery. This benefit is only available IN-NETWORK with a $2,500 copayment.

The PLAN provides benefits for a total of six nutritional counseling visits per BENEFIT PERIOD to an IN- or OUT-OF-NETWORK PROVIDER. The nutritional counseling visits may include counseling specific to achieving or maintaining a healthy weight. When you see an IN-NETWORK PROVIDER in an office-based setting, any applicable copayment, or coinsurance or deductible is waived for these six visits. If you go to an OUT-OF-NETWORK PROVIDER, deductible and coinsurance will apply. Nutritional counseling visits are separate from the obesity-related OFFICE VISITS noted above.

**Obesity Treatment/Weight Management Exclusions**
- PRESCRIPTION DRUGS for short-term and long-term use in the treatment of clinical obesity
- Removal of excess skin from the abdomen, arms or thighs, except as specifically described above
- Any costs associated with membership in a weight management program except as specifically described above
- Any treatment or regimen, medical or surgical for the purpose of reducing or controlling the weight of the member except as specifically described above.

**Diagnostic Services**
Diagnostic procedures such as laboratory studies, radiology services and other diagnostic testing, which may include electroencephalograms (EEGs), electrocardiograms (ECGs), Doppler scans and pulmonary function tests (PFTs), help your DOCTOR find the cause and extent of your condition in order to plan for your care. Multiple radiology or imaging procedures on the same date of service and/or during the same patient encounter may not be eligible for separate reimbursement.

Certain diagnostic imaging procedures, such as CT scans, PET scans and MRIs, may require PRIOR REVIEW and CERTIFICATION or services will not be covered.

Your DOCTOR may refer you to a freestanding laboratory, or a sample collection device for these procedures. Separate benefits for interpretation of diagnostic services by the attending DOCTOR are not provided in addition to benefits for that DOCTOR’S medical or surgical services, except as otherwise determined by the PLAN.

Benefits may differ depending on where the service is performed and if the service is received with any other service or associated with a surgical procedure. See "Summary of Benefits."

Diagnostic Services Exclusion

● Lab tests that are not ordered by your DOCTOR or OTHER PROVIDER.

EMERGENCY Care

The PLAN provides benefits for EMERGENCY SERVICES.

An EMERGENCY is the sudden and unexpected onset of a condition of such severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

● Placing the health of an individual, or with respect to a pregnant woman the health of the pregnant woman or her unborn child, in serious jeopardy
● Serious physical impairment to bodily functions
● Serious dysfunction of any bodily organ or part
● Death.

Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock and other severe, acute conditions are examples of EMERGENCIES.

What to Do in an EMERGENCY

In an EMERGENCY, you should seek care immediately from an emergency room or other similar facility. If necessary and available, call 911 or use other community EMERGENCY resources to obtain assistance in handling life-threatening EMERGENCIES. If you are unsure if your condition is an EMERGENCY, you can call HealthLine Blue and a HealthLine Blue nurse will provide information and support that may save you an unnecessary trip to the emergency room.
Benefits for services in the emergency room

<table>
<thead>
<tr>
<th>Situation</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>You go to an IN-NETWORK HOSPITAL emergency room.</td>
<td>Applicable ER copayment and/or coinsurance. PRIOR REVIEW and CERTIFICATION are not required.</td>
</tr>
<tr>
<td>You go to an OUT-OF-NETWORK HOSPITAL emergency room.</td>
<td>Benefits paid at the IN-NETWORK copayment or coinsurance level and based on the billed amount. You may be responsible for your OUT-OF-NETWORK deductible if applicable, and for charges billed separately which are not eligible for additional reimbursement. You may be required to pay the entire bill at the time of service and file a claim. PRIOR REVIEW and CERTIFICATION are not required.</td>
</tr>
<tr>
<td>You are held for observation.</td>
<td>Outpatient benefits apply to all COVERED SERVICES received in the emergency room and during the observation.</td>
</tr>
<tr>
<td>You are admitted to the HOSPITAL from the ER following EMERGENCY SERVICES.</td>
<td>Inpatient HOSPITAL benefits apply for all COVERED SERVICES received in the emergency room and during hospitalization. PRIOR REVIEW and CERTIFICATION are required for inpatient hospitalization and other selected services following EMERGENCY SERVICES (including screening and stabilization) in order to avoid a penalty. You may need to transfer to an IN-NETWORK HOSPITAL once your condition is stabilized in order to continue receiving IN-NETWORK benefits.</td>
</tr>
<tr>
<td>You get follow-up care (such as OFFICE VISITS or therapy) after you leave the ER or are discharged.</td>
<td>Use IN-NETWORK PROVIDERS to receive IN-NETWORK benefits. Follow-up care related to the EMERGENCY condition is not considered an EMERGENCY.</td>
</tr>
</tbody>
</table>

URGENT CARE
The PLAN also provides benefits for URGENT CARE services. When you need URGENT CARE, call your PCP, a SPECIALIST or go to an URGENT CARE PROVIDER. If you are not sure if your condition requires URGENT CARE, you can call HealthLine Blue.

Family Planning
The PLAN covers these family planning services:
- Information and counseling on contraception, including prescribing a contraceptive;
- Coverage and insertion of an intrauterine device (IUD);
- Fitting a diaphragm;
- Vasectomy;
- Elective tubal ligation;
- Voluntary termination of pregnancy, covered only for EMPLOYEE, EMPLOYEE'S spouse, but not other enrolled DEPENDENTS; and
- Depo-Provera and oral contraceptives are covered under your Prescription Drug Program and must be purchased at a participating pharmacy using your pharmacy card.

Your copayment depends on the type of treatment involved. For instance, if the treatment is given in a physician's office, you must make the PRIMARY CARE or SPECIALIST Copayment. Insertions of IUD's are subject to a $200 copayment.

Copayments for Depo-Provera and oral contraceptives are specified in your Prescription Drug Program document.

Maternity Care
Maternity care benefits, including prenatal care, labor and delivery and post-delivery care, are available to all female MEMBERS. However, maternity benefits for DEPENDENT CHILDREN cover only treatment for COMPLICATIONS OF
PREGNANCY. A copayment may apply for the OFFICE VISIT to diagnose pregnancy, and the inpatient copayment for delivery and other pregnancy related admissions applies for the remainder of your maternity care benefits.

<table>
<thead>
<tr>
<th></th>
<th>Mom</th>
<th>Newborn</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prenatal care</strong></td>
<td>Care related to the pregnancy before birth</td>
<td></td>
<td>A copayment may apply for the OFFICE VISIT to diagnose pregnancy. Deductible and coinsurance apply for the remainder of maternity care benefits.</td>
</tr>
<tr>
<td><strong>Labor &amp; delivery services</strong></td>
<td>No PRIOR REVIEW required for inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Mothers choosing a shorter stay are eligible for a home health visit for post-delivery follow-up care if received within 72 hours of discharge.</td>
<td>No PRIOR REVIEW required for inpatient well-baby care for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Benefits include newborn hearing screening ordered by a DOCTOR to determine the presence of permanent hearing loss. (Please see PREVENTIVE CARE in &quot;Summary of Benefits.&quot;).</td>
<td>For the first 48/96 hours, only one admission copayment or BENEFIT PERIOD deductible is required for both mother and baby.</td>
</tr>
<tr>
<td><strong>Post-delivery services</strong></td>
<td>All care for the mother after the baby’s birth that is related to the pregnancy. In order to avoid a penalty, PRIOR REVIEW and CERTIFICATION are required for inpatient stays extending beyond 48/96 hours.</td>
<td>After the first 48/96 hours, whether inpatient (sick baby) or outpatient (well baby), the newborn must be enrolled for coverage as a DEPENDENT CHILD. according to the rules in &quot;When Coverage Begins and Ends.&quot; For inpatient services following the first 48/96 hours, PRIOR REVIEW and CERTIFICATION are required in order to avoid a penalty.</td>
<td>The baby must meet the individual BENEFIT PERIOD deductible if applicable. If the newborn must remain in the HOSPITAL beyond the mother’s prescribed length of stay for any reason, the newborn is considered a sick baby and charges are subject to the BENEFIT PERIOD deductible if the newborn is added and covered under the policy.</td>
</tr>
</tbody>
</table>

For information on CERTIFICATION, contact BCBSNC Customer Service at the number listed in "Who to Contact?"

**Statement of Rights Under the Newborns’ and Mothers’ Health Protection Act**

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any HOSPITAL length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending PROVIDER (e.g., your DOCTOR, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a DOCTOR or other health care PROVIDER obtain CERTIFICATION for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain PROVIDERS or facilities, or to reduce your out-of-pocket costs, you may be required to obtain CERTIFICATION.
Termination of Pregnancy (Abortion)
Benefits for abortion are available through the first 16 weeks of a pregnancy for all female MEMBERS except DEPENDENT CHILDREN.

COMPLICATIONS OF PREGNANCY
Benefits for COMPLICATIONS OF PREGNANCY are available to all female MEMBERS including DEPENDENT CHILDREN. Please see "Glossary" for an explanation of COMPLICATIONS OF PREGNANCY.

INFERTILITY Services
Benefits are provided for certain services related to the diagnosis, treatment and correction of underlying causes of INFERTILITY for all MEMBERS except DEPENDENT CHILDREN, provided at Duke University Medical Center for EMPLOYEES with two years of service and their spouse or same sex domestic partner. Refer to "Summary of Benefits" for limitations that may apply.

The PLAN covers infertility services only when the following conditions are met:
1 An EMPLOYEE/spouse will not be eligible until the EMPLOYEE has 2 years of continuous service with Duke University or Duke University Health System;
2 Services are provided by the Duke Faculty in Reproductive Endocrinology;
3 The patient meets the specified protocol.

PLEASE NOTE: Decisions regarding infertility coverage are made in accordance with PLAN guidelines. Covered treatments have limitations on the number of services or cycles that are covered.

A Level 1 Care: SPECIALIST Visit Copayment. Must meet the criteria for being infertile, 24-month service period, services should be performed by PCP or generalist OB/GYN, or INFERTILITY Specialist.

Diagnostic Tests:
- Semen Analysis (when the male is covered)
- Documentation of ovulation (either a mid-luteal phase serum progesterone or an endometrial biopsy)
- Hysterosalpingogram

Treatment:
- Clomiphene citrate, letrozole, tamoxifen for approximately 4 ovulatory cycles (more cycles if a conception is established but not carried to viability)
- Intrauterine inseminations (usually coupled with clomiphene citrate)
- Treatment of insulin resistance in women with polycystic ovary syndrome with insulin sensitizers (metformin, troglitazone, etc.)
- Treatment of anovulation secondary to hyperprolactinemia with bormocriptine

B Level 2 Care: SPECIALIST Visit Copayment or Applicable OUTPATIENT SURGERY Copayment. Is undertaken by the RE&I Division, standard pre-certification required for surgical procedures as with non-infertility gynecologic indications, e.g., pain, excessive vaginal bleeding, etc.

Diagnostic Tests: (Performed as indicated with the appropriate pre-certification)
- Same tests as in Level 1
- Laparoscopy (with hydrotubation) which may be converted to a therapeutic procedure
- Office or hysteroscopy which may be converted therapeutic procedure
- 3-D Sonohysterography
- Semen profile (if the male is covered)
- MRI scan
- Screening for antiphospholipid antibodies (for the covered individual(s))
- Screening for cystic fibrosis

Treatments: Therapy will be undertaken as with comparable procedures done for noninfertility indications for those conditions for which a clear evidence-based approach is warranted.
- Lysis of pelvic adhesions when found during procedure (existing known pelvic adhesions subject to Level 3 Copayment)
COVERED SERVICES (cont.)

- Hysteroscopic resection of a uterine septum
- Surgical resection or ablation of endometriosis if found during procedure (if condition known in advance treatment subject to Level 3 Copayment)
- Abdominal cerclage

C  Level 3 Treatments: 50% Coinsurance Package Price. Please Contact Duke Fertility for details.
- Myomectomy (when infertility is the indication)
- Neosalpingostomy for tubal obstruction
- Ultrasound monitored clomiphene citrate/IUI
- Gonadotropin ovulation induction (limited to 3 per lifetime)
- Controlled ovarian hyperstimulation with intrauterine insemination using gonadotropins (limited to 3 per lifetime)
- In vitro fertilization limited to 3 per lifetime, including:
  - IVF with ICSI and/or assisted hatching
  - IVF with donor oocytes (patient is responsible for donor fee)
- Sperm donation with patient responsible for cost of sperm
- Office visits and follow up visits associated with Level 3 services

D  Exclusions From Level 3 Treatments
- Reversal of previous voluntary sterilization
- Infertility care if either of the partners has a history of a voluntary sterilization reversal
- Posthumous reproduction
- Posthumous sperm collection
- Donor sperm with directed donation of non-cryopreserved sperm
- Directed sperm donation NOT from the selected sperm bank
- Gamete intrafallopian transfer
- Zygote intrafallopian transfer except with severe cervical stenosis
- Gestational surrogacy (third party surrogacy)

Drug treatments for stimulating ovulation may be covered on a limited basis under the Prescription Drug Program with 50% coinsurance when purchased at a participating pharmacy using the pharmacy card. The prescribing physician must be affiliated with Duke Fertility.

Sterilization
This benefit is available for all MEMBERS. Sterilization includes female tubal occlusion and male vasectomy.

Contraceptives and Devices
Intrauterine devices are covered under the medical benefit; all other services are available through your pharmacy benefit. Your pharmacy benefit is not administered by BCBSNC. Please refer to your pharmacy benefit coverage for further information.

Family Planning Exclusions

- Oocyte and sperm donation
- Cryopreservation of oocytes, sperm, or embryos
- Surrogate mothers
- Care or treatment of the following:
  - maternity for DEPENDENT CHILDREN
  - elective termination of pregnancy (abortion) for DEPENDENT CHILDREN
  - reversal of sterilization
  - INFERTILITY for DEPENDENT CHILDREN
- Elective termination of pregnancy (abortion) after 16 weeks of pregnancy
● Contraceptive drugs and devices (see the Prescription Drug Program Booklet)
● SEXUAL DYSFUNCTION services
● INFERTILITY services unless EMPLOYEE has two years of continuous service
● Benefits for INFERTILITY or reduced fertility which results from a prior sterilization procedure.

**FACILITY SERVICES**

Benefits are provided for:

- Outpatient services received in a HOSPITAL, a HOSPITAL-based facility, NONHOSPITAL FACILITY or a HOSPITAL-based or OUTPATIENT CLINIC
- Inpatient services received in a HOSPITAL or NONHOSPITAL FACILITY. You are considered an inpatient if you are admitted to the HOSPITAL or NONHOSPITAL FACILITY as a registered bed patient for whom a room and board charge is made. Your IN-NETWORK PROVIDER is required to use the PPO network HOSPITAL where he/she practices, unless that HOSPITAL cannot provide the services you need. If you are admitted before the EFFECTIVE DATE, benefits will not be available for services received prior to the EFFECTIVE DATE.

PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance from BCBSNC for inpatient admissions to avoid a penalty, except for maternity deliveries and EMERGENCIES. See "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information. Also, the PLAN requires notification for MEMBERS who have Medicare as their primary coverage and who are admitted to a Medicare-certified HOSPITAL or NONHOSPITAL FACILITY.

- Surgical services received in an AMBULATORY SURGICAL CENTER
- COVERED SERVICES received in a SKILLED NURSING FACILITY. SKILLED NURSING FACILITY services are limited to a combined IN- and OUT-OF-NETWORK day maximum per BENEFIT PERIOD.

PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance from BCBSNC or services will not be covered. See "Summary of Benefits." However, CERTIFICATION is not required for MEMBERS who have Medicare as their primary coverage and who are admitted to a Medicare-certified SKILLED NURSING FACILITY.

**Other Services**

**Ambulance Services**

The PLAN covers services in a ground ambulance traveling:

- From a MEMBER’S home or scene of an accident or EMERGENCY to a HOSPITAL
- Between HOSPITALS
- Between a HOSPITAL and a SKILLED NURSING FACILITY

when such a facility is the closest one that can provide COVERED SERVICES appropriate to your condition. Benefits may also be provided for ambulance services from a HOSPITAL or SKILLED NURSING FACILITY to a MEMBER’S home when MEDICALLY NECESSARY.

The PLAN covers services in an air ambulance traveling from the site of an EMERGENCY to a HOSPITAL when such a facility is the closest one that can provide COVERED SERVICES appropriate to your condition. Air ambulance services are eligible for coverage only when ground transportation is not medically appropriate due to the severity of the illness or the pick-up point is inaccessible by land.

Nonemergency air ambulance services require PRIOR REVIEW and CERTIFICATION or services will not be covered.

**Ambulance Service Exclusions**

- No benefits are provided primarily for the convenience of travel.
- Transportation to or from a doctor’s office or dialysis center
- Transportation for the purpose of receiving services that are not considered covered services, even if the destination is an appropriate facility.

**Blood**

The PLAN covers the cost of transfusions of blood, plasma, blood plasma expanders and other fluids injected into the bloodstream. Benefits are provided for the cost of storing a MEMBER’S own blood only when it is stored and used for a previously scheduled procedure.
Blood Exclusion

- Charges for the collection or obtainment of blood or blood products from a blood donor, including the MEMBER in the case of autologous blood donation.

Clinical Trials

The PLAN provides benefits for participation in clinical trials phases II, III, and IV. Coverage is provided only for MEDICALLY NECESSARY costs of health care services associated with the trials, and only to the extent such costs have not been or are not funded by other resources. The MEMBER must meet all protocol requirements and provide informed consent in order to participate. The trial must involve the treatment of a life-threatening medical condition with services that are medically indicated and preferable for that MEMBER compared to non-investigational alternatives. In addition, the trial must:

- Involve determinations by treating physicians, relevant scientific data and opinions of relevant medical specialists
- Be approved by centers or groups funded by the National Institutes of Health, the U.S. Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Department of Defense or the Department of Veterans Affairs
- Be conducted in a setting and by personnel of high expertise based on training, experience and patient volume.

Clinical Trials Exclusions

- Clinical trials phase I
- Non-health care services, such as services provided for data collection and analysis
- INVESTIGATIONAL drugs and devices and services that are not for the direct clinical management of the patient.

Dental Treatment Covered Under Your Medical Benefit

The PLAN provides benefits for services provided by a duly licensed DOCTOR, DOCTOR of dental SURGERY or DOCTOR of dental medicine for diagnostic, therapeutic or surgical procedures, including oral SURGERY involving bones or joints of the jaw, when the procedure or dental treatment is related to one of the following conditions:

- Accidental injury of the sound teeth, jaw, cheeks, lips, tongue, roof and floor of the mouth
- CONGENITAL deformity, including cleft lip and cleft palate
- Removal of:
  - tumors which are not related to teeth or associated dental procedures
  - cysts which are not related to teeth or associated dental procedures
  - exostoses for reasons other than preparation of dentures.

Benefits are also provided for extractions, root canal therapy, crowns, bridges, and dentures necessary for treatment of accidental injury or for reconstruction for the conditions listed above. In addition, benefits may be provided for dentures and orthodontic braces if used to treat CONGENITAL deformity including cleft lip and cleft palate.

When any of the conditions listed above require surgical correction, benefits for SURGERY will be subject to MEDICAL NECESSITY review to examine whether or not the condition resulted in functional impairment. Examples of functional impairment include an impairment that affects speech or the ability to eat, or injury to soft tissue of the mouth.

In special cases, benefits are provided only for anesthesia and facility charges related to dental procedures performed in a HOSPITAL or AMBULATORY SURGICAL CENTER. This benefit is only available to DEPENDENT CHILDREN below the age of nine years, persons with serious mental or physical conditions and persons with significant behavioral problems. The treating PROVIDER must certify that the patient's age, condition or problem requires hospitalization or general anesthesia in order to safely and effectively perform the procedure. Other DENTAL SERVICES, including the charge for SURGERY, are not covered unless specifically covered by the PLAN.

In addition, benefits will be provided if a MEMBER is treated in a HOSPITAL following an accidental injury, and COVERED SERVICES such as oral SURGERY or reconstructive procedures are required at the same time as treatment for the bodily injury.

Unless reconstructive DENTAL SERVICES following accidental injury are related to the bones or joints of the jaw, face, or head, reconstructive DENTAL SERVICES are covered only when provided within two years of the accident.

PRIOR REVIEW and CERTIFICATION are required for certain surgical procedures or services will not be covered, unless treatment is for an EMERGENCY.
Dental Treatment Excluded Under Your Medical Benefit

Treatment for the following conditions:
- Injury related to chewing or biting
- Preventive dental care, diagnosis or treatment of or related to the teeth or gums
- Periodontal disease or cavities and disease due to infection or tumor

And except as specifically stated as covered, treatment such as:
- Dental implants or root canals
- Orthodontic braces
- Removal of teeth and intrabony cysts
- Procedures performed for the preparation of the mouth for dentures
- Crowns, bridges, implants, dentures or in-mouth appliances.

Diabetes-Related Services

All MEDICALLY NECESSARY diabetes-related services, including equipment, supplies, medications and laboratory procedures are covered. Diabetic outpatient self-management training and educational services are also covered.

See "Summary of Benefits," depending on where services are received.

DURABLE MEDICAL EQUIPMENT

Benefits are provided for DURABLE MEDICAL EQUIPMENT and supplies required for operation of equipment when prescribed by a DOCTOR. Equipment may be purchased or rented at the discretion of the PLAN. The PLAN provides benefits for repair or replacement of the covered equipment. Benefits will end when it is determined that the equipment is no longer MEDICALLY NECESSARY.

Certain DURABLE MEDICAL EQUIPMENT requires PRIOR REVIEW and CERTIFICATION or services will not be covered.

DURABLE MEDICAL EQUIPMENT Exclusions

- Appliances and accessories that serve no medical purpose or that are primarily for comfort or convenience
- Repair or replacement of equipment due to abuse or desire for new equipment.

Hearing Aids

The PLAN provides coverage for MEDICALLY NECESSARY hearing aids and related services that are ordered by a DOCTOR or a licensed audiologist for each MEMBER under the age of 22. Benefits are provided for one hearing aid per hearing-impaired ear, and replacement hearing aids when alterations to an existing hearing aid are not adequate to meet the MEMBER's needs. This benefit is limited to once every 36 months for MEMBERS under age 22. Benefits are also provided for the evaluation, fitting, and adjustments of hearing aids or replacement of hearing aids, and for supplies, including ear molds.

Home Health Care

Home health care services are covered when ordered by your DOCTOR for a MEMBER who is HOMEBOUND due to illness or injury, and you need part-time or intermittent skilled nursing care from a REGISTERED NURSE (RN) or LICENSED PRACTICAL NURSE (LPN) and/or other skilled care services like REHABILITATIVE and HABILITATIVE THERAPIES. Usually, a HOME HEALTH AGENCY coordinates the services your DOCTOR orders for you. Services from a home health aide may be eligible for coverage only when the care provided supports a skilled service being delivered in the home.

Home health care requires PRIOR REVIEW and CERTIFICATION or services will not be covered.

See "Summary of Benefits" for home health day limits.

Home Health Care Exclusions

- Dietitian services or meals
- Homemaker services, such as cooking and housekeeping
● Services that are provided by a close relative or a member of your household.

**Home Infusion Therapy Services**
Home infusion therapy is covered for the administration of PRESCRIPTION DRUGS directly into a body organ or cavity or via intravenous, intraspinal, intramuscular, subcutaneous or epidural routes, under a plan prescribed by a DOCTOR. These services must be provided under the supervision of an RN or LPN.

PRIOR REVIEW and CERTIFICATION are required for certain home infusion therapy services or services will not be covered.

**HOSPICE Services**
Your coverage provides benefits for HOSPICE services for care of a terminally ill MEMBER with a life expectancy of six months or less. Services are covered only as part of a licensed health care program centrally coordinated through an interdisciplinary team directed by a DOCTOR that provides an integrated set of services and supplies designed to give comfort, pain relief and support to terminally ill patients and their families.

**HOSPICE Services Exclusion**
● Homemaker services, such as cooking, housekeeping, and food or meal preparation.

**Lymphedema-Related Services**
Coverage is provided for the diagnosis, evaluation, and treatment of lymphedema. These services must be provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within their scope of practice. Benefits include MEDICALLY NECESSARY equipment, supplies and services such as complex decongestive therapy or self-management therapy and training. Gradient compression garments may be covered only with a PRESCRIPTION and when custom-fit for the patient.

**Lymphedema-Related Services Exclusion**
● Over-the-counter compression or elastic knee-high or other stocking products.

**MEDICAL SUPPLIES**
Coverage is provided for MEDICAL SUPPLIES.

To obtain MEDICAL SUPPLIES and equipment, please find a PROVIDER on the BCBSNC website at bcbsnc.com or call BCBSNC Customer Service.

**MEDICAL SUPPLIES Exclusion**
● MEDICAL SUPPLIES not ordered by a DOCTOR for treatment of a specific diagnosis or procedure.

**Orthotic Devices**
Orthotic devices, which are rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part, are covered if MEDICALLY NECESSARY and prescribed by a PROVIDER. Foot orthotics may be covered only when custom molded to the patient. Orthotic devices for correction of POSITIONAL PLAGIOCEPHALY, including dynamic orthotic cranioplasty (DOC) bands and soft helmets, are subject to a benefit limit of one device per MEMBER per lifetime.

**Orthotic Devices Exclusions**
● Pre-molded foot orthotics
● Over-the-counter supportive devices.

**Private Duty Nursing**
The PLAN provides benefits for MEDICALLY NECESSARY private duty services of an RN or LPN when ordered by your DOCTOR for a MEMBER who is receiving active care management. Private duty nursing provides more individual and continuous skilled care than can be provided in a skilled nursing visit through a HOME HEALTH AGENCY.

See “Care Management.”
Private duty nursing requires PRIOR REVIEW and CERTIFICATION or services will not be covered.

**Private Duty Nursing Exclusion**
- Services provided by a close relative or a member of your household.

**PROSTHETIC APPLIANCES**
The PLAN provides benefits for the purchase, fitting, adjustments, repairs, and replacement of PROSTHETIC APPLIANCES. The PROSTHETIC APPLIANCES must replace all or part of a body part or its function. The type of PROSTHETIC APPLIANCE will be based on the functional level of the MEMBER. Therapeutic contact lenses may be covered when used as a corneal bandage for a medical condition. Benefits include a one-time replacement of eyeglass or contact lenses due to a PRESCRIPTION change after cataract SURGERY.

Certain PROSTHETIC APPLIANCES require PRIOR REVIEW and CERTIFICATION or services will not be covered.

**PROSTHETIC APPLIANCES Exclusions**
- Dental appliances except when MEDICALLY NECESSARY for the treatment of temporomandibular joint disease or obstructive sleep apnea
- COSMETIC improvements, such as implantation of hair follicles and skin tone enhancements
- Lenses for keratoconus or any other eye procedure except as specifically covered under the PLAN.

**Surgical Benefits**
Surgical services by a professional or facility PROVIDER on an inpatient or outpatient basis, including pre-operative and post-operative care and care of complications, are covered. Surgical benefits include diagnostic SURGERY, such as biopsies, and reconstructive SURGERY performed to correct CONGENITAL defects that result in functional impairment of newborn, adoptive, and FOSTER CHILDREN.

Certain surgical procedures, including those that are potentially COSMETIC, require PRIOR REVIEW and CERTIFICATION or services will not be covered.

Multiple surgical procedures performed on the same date of service and/or during the same patient encounter may not be eligible for separate reimbursement.

For information about coverage of multiple surgical procedures, please refer to BCBSNC’s reimbursement policies, which are on the BCBSNC website at bcbns.com, or call BCBSNC Customer Service at the number listed in "Who to Contact?"

**Anesthesia**
Your anesthesia benefit includes coverage for general, spinal block or monitored regional anesthesia ordered by the attending DOCTOR and administered by or under the supervision of a DOCTOR other than the attending surgeon or assistant at SURGERY.

Benefits are not available for charges billed separately by the PROVIDER which are not eligible for additional reimbursement. Also, your coverage does not provide additional benefits for local anesthetics, which are covered as part of your surgical benefit.

**Mastectomy Benefits**
Under the Women's Health and Cancer Rights Act of 1998, the PLAN provides for the following services related to mastectomy SURGERY:
- Reconstruction of the breast on which the mastectomy has been performed
- SURGERY and reconstruction of the nondiseased 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.

See PROVIDER'S Office, or for external prostheses, see PROSTHETIC APPLIANCES in Other Services in the "Summary of Benefits."
Please note that the decision to discharge the patient following mastectomy SURGERY is made by the attending physician in consultation with the patient.

The benefits described above are subject to the same applicable deductibles, copayment or coinsurance and limitations as applied to other medical and surgical benefits provided under the PLAN.

**Transgender SURGERY**

Your health benefit plan provides coverage for hormone therapy and gender reassignment surgery for the treatment of gender identity disorders. PRIOR REVIEW and CERTIFICATION are required or services will not be covered. Surgical services are limited to a LIFETIME MAXIMUM of $50,000. See “Summary of Benefits.”

The following male to female gender reassignment SURGERY services are covered:
- Breast augmentation (mammoplasty)
- Feminizing genitoplasty
- Vaginoplasty
- Intersex SURGERY male to female

The following male to female gender reassignment SURGERY services are covered:
- Subcutaneous mastectomy (chest masculinization)
- Masculinizing genitoplasty
- Metaidioioplasty (post-testosterone stimulation of external genitals) performed under general anesthesia
- Testicular implants, placed six months after above surgery
- Phalloplasty (functional male organs constructed in a two or three stage procedure)
- Hysterectomy and bilateral salpingo-oophorectomy.

**Transgender SURGERY Exclusions**

- Services and procedures that are considered COSMETIC and unrelated to the covered transgender surgery benefits:
  - cosmetic services that may be used to make a person look more feminine including but not limited to procedures such as: plastic surgery of the nose; face lift; neck lift; malar implants, lip enhancement; facial bone reduction; plastic surgery of the eyelids; liposuction of the waist; reduction of the thyroid cartilage; hair removal; hair transplants; and surgery of the larynx, including shortening or tightening of the vocal cords
  - cosmetic services that may be used to make a person look more masculine including but not limited to procedures such as: chin implants; nose implants; and lip reduction.
- Speech therapy
- Sperm banking and embryonic freezing
- Restylane injections
- Any services performed to reverse gender reassignment surgery.

**Temporomandibular Joint (TMJ) Services**

The PLAN provides benefits for services provided by a duly licensed DOCTOR, DOCTOR of dental SURGERY, or DOCTOR of dental medicine for diagnostic, therapeutic or surgical procedures, including oral SURGERY involving bones or joints of the jaw, face or head when the procedure is related to TMJ disease. Therapeutic benefits for TMJ disease include splinting and use of intra-oral PROSTHETIC APPLIANCES to reposition the bones. Surgical benefits for TMJ disease are limited to SURGERY performed on the temporomandibular joint. If TMJ is caused by malocclusion, benefits are provided for surgical correction of malocclusion when surgical management of the TMJ is MEDICALLY NECESSARY. Please have your PROVIDER contact BCBSNC before receiving surgical treatment for TMJ.

**Temporomandibular Joint (TMJ) Services Exclusions**

- Treatment for periodontal disease
- Dental implants or root canals
- Crowns and bridges
- Orthodontic braces
- Orthognathic Surgery

PRIOR REVIEW and CERTIFICATION are required for certain surgical procedures or these services will not be covered, unless treatment is for an EMERGENCY.
● Occlusal (bite) adjustments
● Extractions.

Therapies
The PLAN provides coverage for the following therapy services for an illness, disease or injury when ordered by a DOCTOR or OTHER PROFESSIONAL PROVIDER.

REHABILITATIVE AND HABILITATIVE THERAPIES
The following therapies are covered:
● Occupational therapy and/or physical therapy (including chiropractic services and osteopathic manipulation) up to a one-hour session per day
● Speech therapy.

Benefits are limited to a combined IN-NETWORK and OUT-OF-NETWORK BENEFIT PERIOD visit maximum for each of these two categories of therapies: (1) occupational and/or physical therapy, or any combination of these therapies; and (2) speech therapy. These visit limits apply in all places of service except inpatient (e.g., outpatient, office and home) regardless of the type of PROVIDER (chiropractors, other DOCTORS, physical therapists). REHABILITATIVE and HABILITATIVE THERAPIES received while an inpatient are not included in the BENEFIT PERIOD MAXIMUM.

Additional benefits apply for speech and physical and/or occupational therapy for DEPENDENT CHILDREN up to age 18 related to developmental delay. Visit www.hr.duke.edu for requirements and additional information.

Benefits may vary depending on where services are received. See “Summary of Benefits” for additional information and any visit maximums.

OTHER THERAPIES
The PLAN covers:
● Cardiac rehabilitation therapy
● Pulmonary and respiratory therapy
● Dialysis treatment
● Radiation therapy

● Chemotherapy, including intravenous chemotherapy.

Chemotherapy benefits are based on where services are received. For chemotherapy received in conjunction with bone marrow or peripheral blood stem cell transplants, follow transplant guidelines described in "Transplants."

Therapy Exclusions
● Cognitive therapy
● Reintegration therapy
● Sensory integration therapy
● Group classes for pulmonary rehabilitation.

Transplants
The PLAN provides benefits for transplants, including HOSPITAL and professional services for covered transplant procedures. The PLAN provides care management for transplant services and will help you find a HOSPITAL or Blue Distinction Centers for Transplants that provides the transplant services required. Travel and lodging expenses may be reimbursed up to a $10,000 maximum per transplant based on BCBSNC guidelines that are available upon request from a transplant coordinator.

A transplant is the surgical transfer of a human organ, bone marrow, tissue, or peripheral blood stem cells taken from the body and returned or grafted into another area of the same body or into another body.

For a list of covered transplants, call BCBSNC Customer Service at the number listed in "Who to Contact?" to speak with a transplant coordinator and request PRIOR REVIEW. CERTIFICATION must be obtained in advance from BCBSNC for all transplant-related services in order to assure coverage of these services. Grafting procedures associated with reconstructive SURGERY are not considered transplants.

If a transplant is provided from a living donor to the recipient MEMBER who will receive the transplant:
• Benefits are provided for reasonable and necessary services related to the search for a donor up to a maximum of $10,000 per transplant.
• Both the recipient and the donor are entitled to benefits of this coverage when the recipient is a MEMBER. Benefits provided to the donor will be charged against the recipient's coverage.

Some transplant services are INVESTIGATIONAL and are not covered for some or all conditions or illnesses. Please see "Glossary" for an explanation of INVESTIGATIONAL.

Transplants Exclusions
• The purchase price of the organ or tissue if any organ or tissue is sold rather than donated to the recipient MEMBER
• The procurement of organs, tissue, bone marrow or peripheral blood stem cells or any other donor services if the recipient is not a MEMBER
• Transplants, including high dose chemotherapy, considered EXPERIMENTAL or INVESTIGATIONAL
• Services for or related to the transplantation of animal or artificial organs or tissues.
WHAT IS NOT COVERED?

Exclusions for a specific type of service are stated along with the benefit description in "COVERED SERVICES." Exclusions that apply to many services are listed in this section, starting with general exclusions and then the remaining exclusions are listed in alphabetical order. To understand all the exclusions that apply, read "COVERED SERVICES," "Summary of Benefits" and "What Is Not Covered?" The PLAN does not cover services, supplies, drugs or charges for:

- Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise provided by federal law
- Conditions that federal, state or local law requires to be treated in a public facility
- Any condition, disease, illness or injury that occurs in the course of employment, if the MEMBER, EMPLOYER or carrier is liable or responsible for the specific medical charge (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement
- Benefits that are provided by any governmental unit except as required by law
- Services that are ordered by a court that are otherwise excluded from benefits under this PLAN
- Any condition suffered as a result of any act of war or while on active or reserve military duty
- A dental or medical department maintained by or on behalf of an EMPLOYER, a mutual benefit association, labor union, trust or similar person or group
- Take-home drugs furnished by a HOSPITAL or NONHOSPITAL FACILITY
- For reimbursement of losses or damages caused by theft, negligence, acts of nature or any other reason
- Any illness or injury resulting from criminal activity or from taking part in the commission of an assault or felony
- Telephone or email consultations
- Devices for environmental accommodation
- Services in excess of any BENEFIT PERIOD MAXIMUM
- A benefit, drug, service or supply that is not specifically listed as covered in this benefit booklet.

In addition, the PLAN does not cover the following services, supplies, drugs or charges:

A

Acupuncture and acupressure

Administrative charges billed by a PROVIDER, including charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form, obtaining medical records, and telephone charges

Costs in excess of the ALLOWED AMOUNT for services usually provided by one DOCTOR, when those services are provided by multiple DOCTORS or medical care provided by more than one DOCTOR for treatment of the same condition

Augmentation communication devices and related instruction or therapy.

Alternative medicine services, which are unproven preventive or treatment modalities, also described as holistic, integrative, or complementary medicine, whether performed by a physician or any OTHER PROVIDER.

B

Collection and storage of blood and stem cells taken from the umbilical cord and placenta for future use in fighting a disease

C

Chelation therapy, except in the treatment of conditions which are considered MEDICALLY NECESSARY

Claims not submitted to BCBSNC within 18 months of the date the charge was INCURRED, except in the absence of legal capacity of the MEMBER

Side effects and complications of noncovered services, except for EMERGENCY SERVICES in the case of an EMERGENCY

Contraceptives, including oral and injectable contraceptives, contraceptive devices and long-term reversible contraceptives including, but not limited to, implanted hormonal contraceptives, solely prescribed for the purpose of contraception, except as specifically covered by the PLAN. These services are covered by your Pharmacy Benefits.

Convenience items such as, but not limited to, devices and equipment used for environmental control, urinary incontinence devices (including bed wetting devices) and equipment, heating pads, hot water bottles, ice packs and personal hygiene items
WHAT IS NOT COVERED? (cont.)

COSMETIC services and SURGERY for psychological or emotional reasons, except as specifically covered by the PLAN.

Services received either before or after the coverage period of the PLAN, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination.

Custodial care designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a DOCTOR. While some skilled services may be provided, the patient does not require continuing skilled services 24 hours daily. The individual is not under specific medical, surgical, or psychiatric treatment to reduce a physical or mental disability to the extent necessary to enable the patient to live outside either the institution or the home setting with substantial assistance and supervision, nor is there reasonable likelihood that the disability will be reduced to that level even with treatment. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over medications that could otherwise be self-administered. Such services and supplies are custodial as determined by BCBSNC without regard to the place of service or the PROVIDER prescribing or providing the services.

Charges for:
- Failure to keep an appointment
- Completion of a form
- Obtaining medical records
- Late payments
- Egg preservation and embryo storage charges, including, cryopreservation of oocytes, sperm, or embryos.

D

Dental care, dentures, dental implants, oral orthotic devices, palatal expanders and orthodontics except as specifically covered by the PLAN.

DENTAL SERVICES provided in a HOSPITAL, except as described in "Dental Treatment Covered Under Your Medical Benefit".

The following drugs:
- PRESCRIPTION DRUGS except as specifically covered by the PLAN.
- Injections by a health care professional of injectable PRESCRIPTION DRUGS which can be self-administered, unless medical supervision is required.
- Drugs associated with assisted reproductive technology.
- EXPERIMENTAL drugs or any drug not approved by the U.S. Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to PRESCRIPTION DRUGS used in covered phases II, III and IV clinical trials, or drugs approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the drug has been proven as effective and accepted in any one of the following:
  - The National Comprehensive Cancer Network Drugs & Biologics Compendium
  - The Thomson Micromedex DrugDex
  - The Elsevier Gold Standard's Clinical Pharmacology
  - Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

E

Services primarily for EDUCATIONAL TREATMENT including, but not limited to, books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction and counseling, except as specifically covered by the PLAN.

The following equipment:
- Air conditioners, furnaces, humidifiers, dehumidifiers, vacuum cleaners, electronic air filters and similar equipment.
- Devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, chair lifts, stair lifts, home elevators, and ramps.
- Physical fitness equipment, hot tubs, Jacuzzis, heated spas, pools or memberships to health clubs.
- Personal computers.
- Standing frames.

EXPERIMENTAL services including services whose efficacy has not been established by controlled clinical trials, or are not recommended as a preventive service by the U.S. Public Health Service, except as specifically covered by the PLAN.
Eyeglasses or contact lenses, except as specifically covered in "PROSTHETIC APPLIANCES"

F
ROUTINE FOOT CARE that is palliative or COSMETIC

G
Gastric bypass SURGERY, except for that provided as part of the Duke Bariatric Surgery benefit
Genetic testing, except for high risk patients when the therapeutic or diagnostic course would be determined by the outcome of the testing

H
Hair analysis
Hair pieces and hair implants for any reason
Routine hearing examinations and hearing aids or examinations for the fitting of hearing aids, except as specifically covered by the PLAN.
Home services to meet personal, family, domestic needs
Hypnosis except when used for control of acute or chronic pain

I
Immunizations required for occupational hazard or international travel, unless specifically covered by the PLAN
Inpatient admissions primarily for the purpose of receiving diagnostic services or a physical examination. Inpatient admissions primarily for the purpose of receiving therapy services, except when the admission is a continuation of treatment following care at an inpatient facility for an illness or accident requiring therapy.
Inpatient confinements that are primarily intended as a change of environment
Services that are INVESTIGATIONAL in nature or obsolete, including any service, drugs, procedure or treatment directly related to an INVESTIGATIONAL treatment, except as specifically covered by the PLAN

L
Services provided and billed by a lactation consultant

M
Maternity benefits for DEPENDENT CHILDREN
Services or supplies deemed not MEDICALLY NECESSARY
Services for mental health and substance abuse services - refer to Cigna Behavioral Health Information

N
Services that would not be necessary if a noncovered service had not been received, except for EMERGENCY SERVICES in the case of an EMERGENCY. This includes any services, procedures or supplies associated with COSMETIC services, INVESTIGATIONAL services, services deemed not MEDICALLY NECESSARY

O
Any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of a MEMBER or for treatment of obesity, except for surgical treatment of morbid obesity, or as specifically covered by the PLAN

P
Body piercing
Routine physical exams, well baby and well-child care, immunizations and **PREVENTIVE** screening services except as specifically covered by the PLAN

Care or services from a PROVIDER who:
- Cannot legally provide or legally charge for the services or services are outside the scope of the PROVIDER's license or certification
- Provides and bills for services from a licensed health care professional who is in training
- Is in a MEMBER’S immediate family
- Is not recognized by BCBSNC as an eligible PROVIDER

PROVIDER claims that contained billing for services or procedures that, based on national accepted claim billing rules, are considered inappropriate for reimbursement, such as not limited to services and/or procedures that are incidental or mutual exclusive with other services rendered; professional fees attached to a service that have no professional component indicated; services that are considered part of the global reimbursement; and, fees for after hours care billed by 24 hour facilities.

The PLAN does not limit a covered person's right to choose his or her own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a covered person still has the right and privilege to receive such medical service or supply at the covered person's own personal expense. Similarly, if the PROVIDER is OUT-OF-NETWORK, the covered person still has the right and privilege to utilize such PROVIDER at the PLAN'S reduced participating level, with the covered person being responsible for a larger percentage of the total medical expense.

**R**
The following **residential care** services:
- Care in a self-care unit, apartment or similar facility operated by or connected with a HOSPITAL
- Domiciliary care or rest cures, care provided and billed for by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility, home for the aged, infirmary, school infirmary, institution providing education in special environments, in RESIDENTIAL TREATMENT FACILITIES or any similar facility or institution

**RESPITE CARE**, whether in the home or in a facility or inpatient setting, except as specifically covered by the PLAN

**Reimbursement** of losses or damage caused by theft, negligence, acts of nature of any other reason.

**Removal** of excess skin from the abdomen, arms, thighs or any other areas of the body, except as specifically described in the Obesity Treatment/Weight Management Section of Covered Services.

**Removal** of tattoos

**Repatriation** of mortal remains.

**S**
**Services** or **supplies** that are:
- Not performed by or upon the direction of a DOCTOR or OTHER PROVIDER
- Available to a MEMBER without charge.
- SURGERY for psychological or emotional reasons
- Received prior to the MEMBER’S EFFECTIVE DATE or after the termination date.

**Shoe** lifts, and shoes of any type unless part of a brace

**Substance abuse** services except as specifically covered by the PLAN

**Surrogate** parenting - any cost related to surrogate parenting

**Sensory** integration therapy, reintegration therapy and kinetic therapy.

**T**
The following types of **therapy**:
- Music therapy, remedial reading, recreational or activity therapy, equestrian therapy, all forms of special education and supplies or equipment used similarly
- Massage therapy.
WHAT IS NOT COVERED? (cont.)

Travel, whether or not recommended or prescribed by a DOCTOR or other licensed health care professional, except when approved in advance for transplants

Topical hyperbaric oxygen therapy for open wounds.

Treatment, therapy and drugs for SEXUAL DYSFUNCTION.

V

The following vision services:
- Radial keratotomy and other refractive eye SURGERY, and related services to correct vision except for surgical correction of an eye injury. Also excluded are premium intraocular lenses or the services related to the insertion of premium lenses beyond what is required for insertion of conventional intraocular lenses, which are small, lightweight, clear disks that replace the distance-focusing power of the eye's natural crystalline lens.
- Eyeglasses or contact lenses, except as specifically covered in "PROSTHETIC APPLIANCES"
- Orthoptics, vision training, and low vision aids.

Vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind

Vocation or employment counseling
Commencement Of Coverage

The EFFECTIVE DATE of coverage under the PLAN depends on the circumstances under which the EMPLOYEE enrolls.

● **New EMPLOYEES.** Coverage for a new EMPLOYEE who enrolls in the PLAN may begin either the first day of employment, or the first day of the month following the first day of employment.

● ** Newly-Eligible EMPLOYEES.** Coverage for a newly-eligible EMPLOYEE who enrolls in the PLAN within 30 days of first becoming eligible, commences either the first day of eligibility or the first day of the month following eligibility.

● **Open Enrollment.** Coverage for EMPLOYEES who enroll during an open enrollment period commences on the date announced for that open enrollment period.

● **Leave of Absence.** Subject to the applicable provisions of the Family and Medical Leave Act, coverage for EMPLOYEES who enroll after returning from an approved leave of absence commences the first day of the first full month he or she resumes active employment after returning from the leave.

● **Loss of Other Coverage.** Coverage for EMPLOYEES who enroll after losing coverage under another health benefits plan commences on the first day of the first full month after electing coverage.

To be covered under this PLAN, you must be one of the following:

● Regular, full-time faculty EMPLOYEE holding a regular rank appointment who is receiving wages for Social Security purposes; or

● 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/week; or

● Regular, part-time non-faculty EMPLOYEE who is scheduled to work at least 20 hours per week;

● Visiting faculty member for whom Duke University is required to offer or provide medical benefits by any federal, immigration law or by the terms of an employment contract with Duke University;

● A graduate resident trainee of Duke University Health System, or

● A Duke post doctoral scholar previously eligible for coverage.

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 full-time EMPLOYEE for purposes of the Affordable Care Act (ACA) at your time of hire and each subsequent measurement period.

PLEASE NOTE: An EMPLOYEE who is enrolled in a Plan as the dependent of another Duke EMPLOYEE is not eligible to enroll as an EMPLOYEE under another Duke Health Plan.

For EMPLOYEE Enrollment:

Eligible EMPLOYEES may enroll in the PLAN:

● Within 30 days of beginning employment

● Within 30 days of first becoming eligible to enroll in the PLAN

● During open enrollment period

● Within 30 days after returning to work from an approved leave of absence, including a leave taken pursuant to the Family and Medical Leave Act of 1993

● Within 30 days of losing coverage under a spouse's EMPLOYER sponsored health benefit plan, if coverage was lost for one of the following reasons:
  ● Divorce or legal separation filed with the court
  ● Death of a spouse
  ● Termination of the spouse's employment
  ● Termination of the EMPLOYER sponsored health benefit plan to which the spouse belonged
  ● Within 30 days of giving birth or marriage

  Note: Under no circumstances may an EMPLOYEE enroll a sibling, cousin, parent, niece or nephew or other dependent relative as a DEPENDENT.

For DEPENDENTS to be covered under the PLAN, you must be covered and your DEPENDENT must be one of the following:

● Your spouse under an existing marriage that is legally recognized under any state law

● Your, your spouse's or your same sex domestic partner's DEPENDENT CHILDREN through the end of the month of their 26th birthday. Your EMPLOYER may require proof that your DEPENDENT CHILD meets the definition of DEPENDENT CHILD as outlined in the "Glossary."
A DEPENDENT CHILD who is either mentally or physically handicapped and incapable of self-support may continue to be covered under the PLAN regardless of age if the condition exists and coverage is in effect when the child reaches the end of eligibility for DEPENDENT CHILDREN. The handicap must be medically certified by the child's DOCTOR and may be verified annually by the PLAN.

Your same sex domestic partner, so long as you and your same sex domestic partner have attested to the PLAN ADMINISTRATOR, in writing to the following:

1. That you and your same sex domestic partner are both mentally competent
2. That you and your same sex domestic partner are both at least the age of consent for marriage in the state where you are a resident
3. That you and your same sex domestic partner are not related by blood to a degree of closeness that would prohibit legal marriage in the state where you are a resident
4. That you and your same sex domestic partner are not married to anyone else
5. That you and your same sex domestic partner are mutually responsible for the cost of basic living expenses as evidenced by joint home ownership, common investments, or some other similar evidence of financial interdependence
6. That you and your same sex domestic partner live together and intend to do so permanently
7. That you do not currently have a domestic partner covered under the PLAN

The conditions listed in 2-7 above must remain true and correct for your same sex domestic partner to remain an eligible DEPENDENT under the terms of this coverage.

Coverage of handicapped DEPENDENT CHILDREN:
In order to continue coverage of a mentally or physically handicapped DEPENDENT CHILD beyond the end of eligibility for DEPENDENT CHILDREN all of the following criteria must be met:

- The parent must apply for the waiver on or prior to the 26th birthday;
- The mental or physical handicap 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 end of eligibility for DEPENDENT CHILDREN;
- The parent must remain eligible;
- 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.

If both parents are EMPLOYEES of Duke University, each eligible person in the household may be covered only once. That is:

- Each spouse may elect Employee Only coverage
- One spouse may elect Employee and Spouse coverage

If there are children involved, each child can only be covered by one parent.

The EFFECTIVE DATE of coverage for a DEPENDENT depends on the circumstances under which he or she was enrolled in the PLAN.

- **Enrolled with New or Newly-eligible EMPLOYEE.** Coverage commences on the same date as the EMPLOYEE's coverage.
- **During Open Enrollment.** The EFFECTIVE DATE of coverage for any DEPENDENTS added during an annual open enrollment period commences on the date announced by Benefits Administration/Human Resources.
- **Loss of Other Coverage.** Coverage for a spouse who was enrolled within 30 days after involuntarily losing his or her own health benefits coverage, commences the first day of the first full month after he or she involuntarily lost his or her own EMPLOYER sponsored health benefits coverage or the first day of the month following the request for coverage.
- **New Spouse and Stepchildren.** If enrolled within 30 days of marriage, a new spouse and stepchildren (if any) will be covered as of the date of the marriage, or the first day of the first full month following the marriage, at the EMPLOYEE's selection.
- **Newborn Children.** If enrolled within 30 days of birth, a newborn child will be covered as of the date of birth.
- **Other New Children.** If enrolled within 30 days of placement, adopted children, FOSTER CHILDREN and children for whom the EMPLOYEE is a legal guardian will be covered as of the date of placement.
- **Qualified Medical Child Support Order (QMCSO).** A child for whom the PLAN receives a Qualified Medical Child Support Order may enroll as of the EFFECTIVE DATE of a valid QMCSO provided the EMPLOYEE is currently eligible for coverage. (If the EMPLOYEE is not a MEMBER he or she must enroll at the same time.) Appropriate written documentation is required to determine the qualified status of the Medical Child Support Order.
Removing Eligible Dependents From Coverage

DEPENDENTS who continue to be eligible to participate in the PLAN, may not be removed from PLAN coverage except during the annual open enrollment period unless there is a valid change in family status. Benefits Administration/Human Resources must be notified within 30 days of the change and documentation must be provided.

Enrolling in the PLAN

Timely Enrollees

Qualifying events:

You or your DEPENDENTS become eligible for coverage under the PLAN when:

- You or your DEPENDENTS become eligible for coverage under the PLAN
- You get married or obtain a DEPENDENT through birth, court order, adoption, placement in anticipation of adoption, or foster care placement of an eligible child
- You or your DEPENDENTS lose coverage under another health benefit plan, and each of the following conditions is met:
  - you and/or your DEPENDENTS are otherwise eligible for coverage under the PLAN, and
  - you and/or your DEPENDENTS were covered under another health benefit plan at the time this coverage was previously offered and declined enrollment due to the other coverage, and
  - you and/or your DEPENDENTS lose coverage under another health benefit plan due to i) the exhaustion of the COBRA continuation period, or ii) the loss of eligibility for that coverage for reasons including, but not limited to, legal separation, divorce, loss of DEPENDENT status, death of the EMPLOYEE, termination of employment, or reduction in the number of hours of employment, or iii) the termination of the other plan's coverage, or iv) the offered health benefit plan not providing benefits in your service area and no other health benefit plans are available, or v) the termination of EMPLOYER contributions toward the cost of the other plan's coverage, or vi) meeting or exceeding the lifetime benefit maximum, or vii) the discontinuance of the health benefit plan to similarly situated individuals.
- You or your DEPENDENTS lose coverage due to loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP) and apply for coverage under this PLAN within 60 days
- You or your DEPENDENTS become eligible for premium assistance with respect to coverage under this PLAN under Medicaid or Children's Health Insurance Program (CHIP) and apply for coverage under this PLAN within 60 days.

Late Enrollees

See also "Adding or Removing a DEPENDENT."

Adding or Removing a DEPENDENT

Do you want to add or remove a DEPENDENT? You must notify Duke Benefits and complete any required forms. Failure to notify Duke Benefits of the need to remove a DEPENDENT could result in loss of eligibility for continuation of coverage.

To add a DEPENDENT, due to a valid change in family status as defined by the Internal Revenue Service, you must notify the PLAN ADMINISTRATOR within 30 days of the DEPENDENTS becoming eligible. For instance, if you marry and want your spouse to be covered under the PLAN, your spouse's coverage will be effective on the date of your marriage so long as you complete the Enrollment Application and Change Form within 30 days after your marriage. Documentation is required.

You may only remove DEPENDENTS from your coverage within 30 days of a valid change in family status as defined by the IRS by contacting the Human Resources Information Center. DEPENDENTS must be removed from coverage when they are no longer eligible, such as when a child is no longer eligible due to age. The EFFECTIVE DATE of removal will be the end of the month in which the event occurs. If DEPENDENTS are removed due to divorce, legal separation or death, the EFFECTIVE DATE of removal will be the day of the event. Refer to "Eligibility Ends" for more information.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is any judgment, decree or order that is issued by an appropriate court or through an administrative process under state law that: (1) provides for coverage of the child of a MEMBER under the PLAN; and (2) is either issued according to state law or a law relating to medical child support described in Section 1908 of the Social Security Act. A QMCSO must be specific as to the participant whose child(ren) is (are) to be covered, the type
of coverage, the child(ren) to be covered and the applicable period of the QMCSO. A copy of the QMCSO procedures may be obtained free of charge from the PLAN ADMINISTRATOR.

Types of Coverage
These are the types of coverage available:

- **EMPLOYEE-only coverage** - The PLAN covers only you
- **EMPLOYEE-spouse coverage** - The PLAN covers you and your spouse or same sex domestic partner or domestic partner
- **EMPLOYEE-child coverage** - The PLAN covers you and one DEPENDENT CHILD
- **EMPLOYEE-children coverage** - The PLAN covers you and your DEPENDENT CHILDREN
- **Family coverage** - The PLAN covers you, your spouse or same sex domestic partner or domestic partner and your DEPENDENT CHILDREN.

Reporting Changes
Have you moved, added or changed other health coverage, changed your name or phone number? If so, contact the PLAN ADMINISTRATOR and fill out the proper form. It will help assure better service if BCBSNC is kept informed of these changes.

Continuing Coverage
Under certain circumstances, your eligibility for coverage under this PLAN may end.

You may have certain options such as enrolling in Medicare or continuing health insurance under this PLAN.

**Medicare**
When you reach age 65, you may be eligible for Medicare Part A HOSPITAL, Medicare Part B medical, and Medicare Part D prescription drug benefits. You may be eligible for Medicare benefits earlier if you become permanently disabled or develop end-stage renal disease. Just before either you or your spouse turns 65 or when disability or end-stage renal disease occurs, you should contact the nearest Social Security office and apply for Medicare benefits. They can tell you what Medicare benefits are available. If you are covered by this PLAN when you become eligible for Medicare and are not actively employed by Duke, **you are required to enroll in Medicare Parts A and B and your coverage will be transferred to another Duke sponsored plan, Duke Plus**.

**The PLAN As Your Primary Coverage - Active EMPLOYEES Age 65 Or Over**
If the PLAN is your primary coverage, you will continue to receive full benefits under the PLAN. Medicare will pay any differences between the payments made by the PLAN and what Medicare would have paid if you had no additional insurance.

**Medicare As Your Primary Coverage**
If you are over 65 and the spouse of an active EMPLOYEE and elect Medicare as your primary coverage, then you must terminate coverage under this plan.

If you are over 65 and you are an active employee and elect Medicare as your primary coverage, then your coverage and that of enrolled DEPENDENTS will end. Also see "Eligibility Ends" for information on continuation coverage.

**Medicare And Disability**
If you become disabled and eligible for Medicare due to your disability, you must enroll in both Medicare A and B.

If you or your spouse is retired and you are entitled to Medicare disability benefits, you must enroll in both Medicare A and B, then Medicare will pay primary benefits. Your coverage will be transferred to another Duke sponsored plan, Duke Plus.

**Medicare and Termination of Employment**
If you terminate employment with Duke and you and your covered spouse are age 65 or over you will need to obtain a document in the Benefits office which will allow you and or your spouse to enroll in Part B and D with no penalty.

**Medicare And End-Stage Renal Disease**
Medicare benefits are secondary for a period of 30 months for you if you are under age 65 and entitled to Medicare due to end-stage renal disease. Medicare will remain secondary for this 30-month period regardless of whether you or your Medicare-eligible spouse remains currently employed or continues coverage under the PLAN after termination of employment. After the expiration of the 30-month period, even if you are still currently employed with Duke, if you...
are eligible for Medicare due to end-stage renal disease, you must enroll in part A and B and Medicare will become primary to the PLAN.

Who To Contact About Medicare
Just before you or your spouse turns 65, when disability occurs, or when you are ready to leave employment or at age 65, you should contact the nearest Social Security office and apply for Medicare benefits. They can tell you what Medicare benefits are available for you at that time.

If you are covered by the PLAN, and you become eligible for Medicare, consult the Duke Benefits office. The Duke Benefits office will advise you about the continuation of coverage under the PLAN.

Retirement
To continue to receive the health insurance plan in retirement, you must meet the following criteria:
• At the time of retirement, you must be enrolled under the health plan as the subscriber.
  - Health insurance may also be continued for your spouse and eligible DEPENDENT CHILDREN who are covered at the time of your retirement.
  - If your spouse 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 and Medical Center Employees
You must meet the Rule of 75, which became effective July 1, 1990. It requires that 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.

Note: If a faculty member or staff member meets the retiree health eligibility requirements and retires (early or normal), the retiree may suspend health or dental coverage and contributions at any time while employed and receiving benefits elsewhere*. Re-enrollment in the health or dental plan must occur within 30 days of the termination of other employer sponsored coverage. Proof of continuous coverage through another employer plan will be required. If the individual re-enrolls after this 30 day period, the individual must pay the full premium (including the employer share) retroactive to the termination of the prior employer coverage and up to the time of re-enrollment. Thereafter, the individual shall pay the employee/retiree share. Also, if the former EMPLOYEE and/or spouse is eligible for Medicare, enrollment in Parts A and B are required immediately.

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

Eligibility Requirements for Duke University Health Systems (DUHS) Employees
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
EMPLOYEES hired 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 services (but did not meet the Rule of 75) as of July 1, 2002, then the EMPLOYEE is grand-fathered 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 grand-fathered under the Rule of 75 eligibility provision
• All other EMPLOYEES employed by DUHS prior to July 1, 2002 are eligible for retiree health coverage at the time of retirement if they meet one of the following eligibility criteria:
  - Have 15 years of continuous service after age 45 — DUHS will pay a portion of the premium OR
  - Met the Rule of 75 — retiree pays 100% of the premium

Note: If a faculty or staff member meets the retiree health eligibility requirements and retires (early or normal), the retiree may suspend health or dental coverage and contributions at any time while employed and receiving benefits elsewhere*. Re-enrollment in the health or dental plan must occur within 30 days of the termination of other employer-sponsored coverage. Proof of continuous coverage through another employer plan will be required. If the individual attempts to re-enroll after this 30 day period, the individual must pay the full premium (including the employer share) retroactive to the termination of the prior employer coverage and up to the time of re-enrollment. Thereafter, the individual shall pay the employee/retiree share. If the former EMPLOYEE and/or spouse is eligible for Medicare, enrollment is required immediately.
Coverage under another plan available to the individual as a retiree of another employer, through a spouse's employer or retiree health plan, or from service with the military does not count as an employee under another employee sponsored plan.

Note about Transfers: Employees who have transferred to the University/Medical Center from the Health System will not immediately fall under the eligibility rules for the University/Medical Center. After working 5 continuous years for the University/Medical Center, the eligibility rules for the University/Medical Center in place at that time will apply.

Eligibility Ends
Under certain circumstances, your eligibility for coverage under the PLAN may end. You may be eligible to continue employer health coverage under the PLAN. Read this section to find out what your options are regarding eligibility for continuation of coverage.

Continuation Under Federal Law
Under a federal law known as COBRA, if your employer has 20 or more employees, you and your covered dependents can elect to continue coverage for up to 18 months by paying applicable fees to the employer in the following circumstances:

- Your employment is terminated (unless the termination is the result of gross misconduct)
- Your hours worked are reduced, causing you to be ineligible for coverage.

In addition to their rights above, dependents will be able to continue coverage for up to 36 months if their coverage is terminated due to:

- Your death
- Divorce or legal separation
- Your entitlement to Medicare
- A dependent child ceasing to be a dependent under the terms of this coverage.

Children born to or placed for adoption with you during the continuation coverage period are also eligible for the remainder of the continuation period.

Domestic partners and children of the same sex domestic partner are not eligible for COBRA benefits under federal law. All references to dependents in this section do not apply to a same sex domestic partner or their children.

If you are a retired employee and your employer allows coverage to extend to retirees under this plan, and you, your spouse and your dependents lose coverage resulting from a bankruptcy proceeding against your employer, you may qualify for continuation coverage under COBRA. Contact the plan administrator for conditions and duration of continuation coverage.

In addition, you and/or your dependents who are determined by the Social Security Administration to be disabled, may be eligible to extend their 18-month period of continuation coverage, for a total maximum of 29 months. The disability has to have started at some time before the 60th day of continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Notice must be provided to the plan administrator within 60 days of the determination of disability by the Social Security Administration and prior to the end of the original 18-month period of continuation coverage. In addition, notice must be provided to the plan administrator within 30 days after the later of the date of determination that the individual is no longer disabled or the date of the initial notification of this notice requirement.

You or your dependents must notify the plan administrator within 60 days of the following triggering events:

- Divorce
- Legal separation
- Ineligibility of a dependent child.

You and/or your dependents will be offered continuation coverage within 14 days of the date that the COBRA administrator is notified of one of these events resulting in the termination of your coverage. Eligible persons have 60 days to elect or reject continuation coverage. Following election, applicable fees must be paid to the COBRA administrator within 45 days.

Continuation coverage will end at the completion of the applicable continuation period or earlier if:

- Your employer ceases to provide a health benefit plan to employees
- The continuing person fails to pay the monthly fee on time
- The continuing person obtains coverage under another group plan
• The continuing person becomes entitled to Medicare after the election of continuation coverage.

If you are covered by the PLAN and called to the uniformed services, as defined in the Uniformed Services Employment and Reemployment Rights Act (USERRA), consult the PLAN ADMINISTRATOR. The PLAN ADMINISTRATOR will advise you about the continuation of coverage and reinstatement of coverage under this PLAN as required under USERRA.

If you have any questions about your COBRA rights or continuation of coverage, please contact the PLAN ADMINISTRATOR.

Health Insurance and Long Term Disability
Employees participating in a Duke Health Plan at the time of approval for Long Term Disability benefits may continue to participate in a Duke Health Plan with the following qualifications:

• The individual must be participating (in a fully paid-up status) in a Duke Health 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;
• 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 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;
• All persons participating in a Duke Health Plan during approved Long Term Disability 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.

Termination of MEMBER Coverage
BCBSNC will terminate coverage under the PLAN in accordance with eligibility information provided by the EMPLOYER. A MEMBER’S termination shall be effective at 11:59 p.m. on the date that eligibility ends.

Termination for Cause
A MEMBER’S coverage may be terminated upon 31 days prior written notice for the following reasons:

• The MEMBER fails to pay or to have paid on his or her behalf or to make arrangements to pay any copayments, deductible or coinsurance for services covered under the PLAN
• No IN-NETWORK PROVIDER is able to establish or maintain a satisfactory DOCTOR-patient relationship with a MEMBER, as determined by the PLAN
• A MEMBER exhibits disruptive, abusive, or fraudulent behavior toward an IN-NETWORK PROVIDER.

As an alternative to termination as stated above, the PLAN, in its sole discretion, may limit or revoke a MEMBER’S access to certain IN-NETWORK PROVIDERS.

A MEMBER’S coverage under the PLAN will be terminated immediately for the following reasons:

• Fraud or intentional misrepresentation of a material fact by a MEMBER or DEPENDENT. However, if such termination is made retroactively, including back to the EFFECTIVE DATE of your policy (called a rescission), you will be given 30 days advance written notice of this rescission and may submit an appeal; see “What if You Disagree With a Decision?” If your policy is rescinded, any premiums paid will be returned unless BCBSNC deducts the amount for any claims paid.
• A MEMBER has been convicted of (or a restraining order has been issued for) communicating threats of harm to BCBSNC personnel or property
• A MEMBER permits the use of his or her or any other MEMBER’S ID CARD by any other person not enrolled under this PLAN, or uses another person’s ID CARD.
To make sure you have access to high quality, cost-effective health care, BCBSNC has a UTILIZATION MANAGEMENT (UM) program. The UM program requires that certain health care services be reviewed and approved by BCBSNC in order to receive benefits. As part of this process, BCBSNC looks at whether health care services are MEDICALLY NECESSARY, provided in the proper setting and provided for a reasonable length of time. BCBSNC will honor a CERTIFICATION to cover medical services or supplies under the PLAN unless the CERTIFICATION was based on a material misrepresentation about your health condition or you were not eligible for these services under the PLAN due to termination of coverage (including your voluntary termination of coverage) or nonpayment of premiums.

**Rights and Responsibilities Under the UM Program**

**Your MEMBER Rights**

Under the UM program, you have the right to:

- A UM decision that is timely, meeting applicable state and federal time frames
- The reasons for BCBSNC’s ADVERSE BENEFIT DETERMINATION of a requested treatment or health care service, including an explanation of the UM criteria and treatment protocol used to reach the decision
- Have a medical director from BCBSNC make a final determination of all ADVERSE BENEFIT DETERMINATIONS that were based upon MEDICAL NECESSITY
- Request a review of an ADVERSE BENEFIT DETERMINATION through the appeals process (see "What if You Disagree With a Decision?")
- Have an authorized representative pursue payment of a claim or make an appeal on your behalf.

An authorized representative may act on the MEMBER’s behalf with the MEMBER’s written consent. In the event you appoint an authorized representative, references to "you" under the "UTILIZATION MANAGEMENT" section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

**BCBSNC’s Responsibilities**

As part of all UM decisions, BCBSNC will:

- Provide you and your PROVIDER with a toll-free telephone number to call UM review staff when CERTIFICATION of a health care service is needed. See "Who to Contact?"
- Limit what BCBSNC requests from you or your PROVIDER to information that is needed to review the service in question
- Request all information necessary to make the UM decision, including pertinent clinical information
- Provide you and your PROVIDER prompt notification of the UM decision consistent with applicable state and federal law and the PLAN.

In the event that BCBSNC does not receive sufficient information to approve coverage for a health care service within specified time frames, BCBSNC will notify you of an ADVERSE BENEFIT DETERMINATION in writing. The notice will explain how you may appeal the ADVERSE BENEFIT DETERMINATION.

**PRIOR REVIEW (Pre-Service)**

The PLAN requires that certain health care services receive PRIOR REVIEW and CERTIFICATION as noted in "COVERED SERVICES.” These types of reviews are called pre-service reviews.

Certain services require PRIOR REVIEW and CERTIFICATION by the PLAN in order to receive benefits. IN-NETWORK PROVIDERS in North Carolina will request PRIOR REVIEW when necessary. IN-NETWORK inpatient FACILITIES outside of North Carolina will also request PRIOR REVIEW for you, except for Veterans’ Affairs (VA) and military providers. If you go to any other PROVIDER outside of North Carolina or to an OUT-OF-NETWORK PROVIDER in North Carolina, you are responsible for ensuring that you or your PROVIDER requests PRIOR REVIEW by BCBSNC. The PLAN delegates administration of your mental health and substance abuse benefits to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. **Failure to request PRIOR REVIEW and receive CERTIFICATION may result in allowed charges being reduced or a full denial of benefits**

If PRIOR REVIEW is required by the PLAN, you or your PROVIDER must request PRIOR REVIEW regardless of whether this health benefit plan is your primary or secondary coverage (see "Coordination of Benefits (OVERLAPPING COVERAGE)"). Also, the PLAN requires notification for MEMBERS who have Medicare as their primary coverage and who are admitted to a Medicare-certified HOSPITAL or NONHOSPITAL FACILITY. If neither you nor your PROVIDER requests PRIOR REVIEW and receives CERTIFICATION, this may result in an ADVERSE BENEFIT DETERMINATION.

To request PRIOR REVIEW, please call the numbers in "Who to Contact?"
General categories of services with this requirement are noted in "COVERED SERVICES." You may also visit the BCBSNC website at mybcbsnc.com or call BCBSNC Customer Service at the number listed in "Who to Contact?" for a detailed list of these services. The list of services that require PRIOR REVIEW may change from time to time.

If you fail to follow the procedures for filing a request for CERTIFICATION, BCBSNC will notify you of the failure and the proper procedures to be followed in filing your request within five days of receiving the request.

BCBSNC will make a decision on your request for CERTIFICATION within a reasonable amount of time taking into account the medical circumstances. The decision will be made and communicated to you and your PROVIDER within three business days after BCBSNC receives all necessary information but no later than 15 days from the date BCBSNC received the request. BCBSNC may extend this period one time for up to 15 days if additional information is required and will notify you and your PROVIDER before the end of the initial 15-day period of the information needed and the date by which BCBSNC expects to make a decision. You will have 45 days to provide the requested information. As soon as BCBSNC receives all the requested information, or at the end of the 45 days, whichever is earlier, BCBSNC will make a decision within three business days. BCBSNC will notify you and the PROVIDER of an ADVERSE BENEFIT DETERMINATION electronically or in writing.

**Urgent PRIOR REVIEW**
You have a right to an urgent review when the regular time frames for a decision: (i) could seriously jeopardize your or your DEPENDENT’s life, health, or ability to regain maximum function; or (ii) in the opinion of your PROVIDER, would subject you or your DEPENDENT to severe pain that cannot be adequately managed without the requested care or treatment. BCBSNC will notify you and your PROVIDER of its decision as soon as possible, taking into account the medical circumstances. BCBSNC will notify you and your PROVIDER of its decision within 72 hours after receiving the request. Your PROVIDER will be notified of the decision, and if the decision results in an ADVERSE BENEFIT DETERMINATION, written notification will be provided to you and your PROVIDER. If BCBSNC needs more information to process your urgent review, BCBSNC will notify you and your PROVIDER of the information needed as soon as possible but no later than 24 hours following the receipt of your request. You will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the time period specified for you to provide the information, whichever is earlier, BCBSNC will make a decision on your request within a reasonable time but no later than 48 hours after receipt of requested information or the end of the time period given to the PROVIDER to submit necessary clinical information.

An urgent review may be requested by calling BCBSNC Customer Service at the number given in "Who to Contact?"

**Concurrent Reviews**
BCBSNC will also review health care services at the time you receive them. These types of reviews are concurrent reviews.

If a request for an extension of treatment is non-urgent, a decision will be made and communicated to the requesting HOSPITAL or other facility within three business days after receipt of all necessary clinical information, but no later than 15 days after we receive the request. In the event of an ADVERSE BENEFIT DETERMINATION, BCBSNC will notify you, your HOSPITAL’s or other facility’s UM department and your PROVIDER within three business days after receipt of all necessary clinical information, but no later than 15 days after BCBSNC receives the request. Written confirmation of the decision will also be sent to your home by U.S. mail. For concurrent reviews, BCBSNC will remain responsible for COVERED SERVICES you are receiving until you or your representatives have been notified of the ADVERSE BENEFIT DETERMINATION.

**Urgent Concurrent Review**
If a request for an extension of treatment is urgent, and the request is received at least 24 hours before the expiration of a previously approved inpatient stay or course of treatment at the requesting HOSPITAL or other facility, a decision will be made and communicated to the requesting HOSPITAL or other facility as soon as possible, but no later than 24 hours after we receive the request.

If a request for extension of treatment is urgent, and the request is not received at least 24 hours before the expiration of a previously approved inpatient stay or course of treatment at the requesting HOSPITAL or other facility, a decision will
be made and communicated as soon as possible, but no later than 72 hours after we receive the request. If BCBSNC needs more information to process your urgent review, BCBSNC will notify the requesting HOSPITAL or other facility of the information needed as soon as possible but no later than 24 hours after we receive the request. The requesting HOSPITAL or other facility will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. BCBSNC will make a decision within 48 hours of the earlier of receipt of the requested information, or the end of the time period given to the requesting HOSPITAL or other facility to provide the information.

Retrospective Reviews (Post-Service)

BCBSNC also reviews the coverage of health care services after you receive them (retrospective/post-service reviews). Retrospective review may include a review to determine if services received in an EMERGENCY setting qualify as an EMERGENCY. BCBSNC will make all retrospective review decisions and notify you and your PROVIDER of its decision within a reasonable time but no later than 30 days from the date BCBSNC received the request. In the event of an ADVERSE BENEFIT DETERMINATION, BCBSNC will notify you and your PROVIDER in writing within five business days of the decision. All decisions will be based on MEDICAL NECESSITY and whether the service received was a benefit under this PLAN. If more information is needed before the end of the initial 30-day period, BCBSNC will notify you of the information needed. You will then have 90 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 days. Services that were approved in advance by BCBSNC will not be subject to denial for MEDICAL NECESSITY once the claim is received, unless the CERTIFICATION was based on a material misrepresentation about your health condition or you were not eligible for these services under the PLAN due to termination of coverage or nonpayment of premiums. All other services may be subject to retrospective review and could be denied for MEDICAL NECESSITY or for a benefit limitation or exclusion.

Care Management

MEMBERS with complicated and/or chronic medical needs may be eligible for care management services.

Care management (or case management) encourages MEMBERS with complicated or chronic medical needs, their PROVIDERS, and the PLAN to work together to meet the individual's health needs and promote quality outcomes.

To accomplish this, MEMBERS enrolled in or eligible for care management programs may be contacted by BCBSNC or by a representative of BCBSNC. The PLAN is not obligated to provide the same benefits or services to a MEMBER at a later date or to any other MEMBER. Information about these services can be obtained by contacting an IN-NETWORK PCP or IN-NETWORK SPECIALIST or by calling BCBSNC Customer Service.

In addition to our care management programs for MEMBERS with complicated and/or chronic medical needs, MEMBERS may receive a reduced or waived copayment and/or coinsurance in connection with programs and/or promotions designed to encourage members to seek appropriate, high quality, efficient care based on BCBSNC criteria.

Continuity of Care

Continuity of care is a process that allows you to continue receiving care from an OUT-OF-NETWORK PROVIDER for ongoing special conditions at the IN-NETWORK benefit level when the MEMBER or EMPLOYER changes plans or when your PROVIDER is no longer in the PPO network.

If your PCP or SPECIALIST leaves the BCBSNC PROVIDER network and they are currently treating you for an ongoing special condition that meets BCBSNC continuity of care criteria, BCBSNC will notify you 30 days before the PROVIDER's termination, as long as BCBSNC receives timely notification from the PROVIDER. To be eligible for continuity of care, the MEMBER must be actively being seen by the OUT-OF-NETWORK PROVIDER for an ongoing special condition and the PROVIDER must agree to abide by the BCBSNC requirements for continuity of care.

An ongoing special condition means:

- in the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm;
- in the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time;
- in the case of pregnancy, the second and third trimesters of pregnancy;
- in the case of a terminal illness, an individual has a medical prognosis that the MEMBER's life expectancy is six months or less.

The allowed transitional period shall extend up to 90 days, as determined by the PROVIDER, except in the cases of:
● scheduled SURGERY, organ transplantation, or inpatient care which shall extend through the date of discharge and post-
  discharge follow-up care or other inpatient care occurring within 90 days of the date of discharge; and
● second trimester pregnancy which shall extend through the provision of postpartum care; and
● terminal illness which shall extend through the remainder of the individual’s life with respect to care directly related to
  the treatment of the terminal illness.

Continuity of care requests will be reviewed by a medical professional based on the information provided about specific
medical conditions. Claims for approved continuity of care services will be subject to the IN-NETWORK benefit. In these
situations, benefits are based on the billed amount. However, you may be responsible for charges billed separately by
the PROVIDER which are not eligible for additional reimbursement. Continuity of care will not be provided when the
PROVIDER'S contract was terminated for reasons relating to quality of care or fraud. Such a decision may not be reviewed
on appeal.

Please call BCBSNC Customer Service at the number listed in "Who to Contact?" for more information.

Evaluating New Technology
In an effort to allow for continuous quality improvement, BCBSNC has processes in place to evaluate new medical
technology, procedures and equipment. These policies allow BCBSNC to determine the best services and products to offer
MEMBERS. They also help BCBSNC keep pace with the ever-advancing medical field. Before implementing any new or
revised policies, BCBSNC reviews professionally supported scientific literature as well as state and federal guidelines,
regulations, recommendations, and requirements. BCBSNC then seeks additional input from PROVIDERS who know the
needs of the patients they serve.
WHAT IF YOU DISAGREE WITH A DECISION?

In addition to the UM program, BCBSNC offers an appeals process for MEMBERS.

If you want to appeal an ADVERSE BENEFIT DETERMINATION, you have the right to request that BCBSNC review the decision through the appeals process. The appeals process is voluntary and may be requested by the MEMBER or an authorized representative acting on the MEMBER’s behalf with the MEMBER’s written consent. In the event you appoint an authorized representative, references to "you" under this section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

You may request, at no charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Steps to Follow in the Appeals Process

For each step in this process, there are specified time frames for filing an appeal and for notifying you or your PROVIDER of the decision. The type of ADVERSE BENEFIT DETERMINATION will determine the steps that you will need to follow in the appeals process. For all appeals, the review must be requested in writing, within 180 days of an ADVERSE BENEFIT DETERMINATION or by the date indicated on your Explanation of Benefits.

Any request for review should include:

- MEMBER’S ID number
- MEMBER’S name
- Patient's name
- The nature of the appeal
- Any other information that may be helpful for the review.

To request a form to submit a request for review, visit the BCBSNC website at mybcbsnc.com or call BCBSNC Customer Service at the number given in "Who to Contact?"

All correspondence related to a request for a review through BCBSNC’s appeals process should be sent to:

BCBSNC
Appeals Department
PO Box 30055
Durham, NC 27702-3055

You may also receive assistance from the Employee Benefits Security Administration at 1-866-444-3272.

Following such request for review, a review will be conducted by BCBSNC, by someone who is neither the individual who made the original claims denial that is the subject of the appeal, nor the subordinate of such individual. The denial of the initial claim will not have an effect on the review. If a claims denial is based on medical judgment, including determinations with respect to whether a particular treatment, drug or other item is EXPERIMENTAL, INVESTIGATIONAL, or not MEDICALLY NECESSARY or appropriate, BCBSNC shall consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved (as determined by BCBSNC) who was not involved in the initial claims denial and who is not a subordinate of any such individual.

You will have exhausted the PLAN'S internal appeal process after pursuing a first level appeal. Unless otherwise noted below, upon completion of the first level appeal you may: pursue a second level appeal; or pursue a civil action under 502(a) of ERISA.

Quality of Care Complaints

For quality of care complaints, an acknowledgement will be sent by BCBSNC within ten business days.

First Level Appeal

BCBSNC will provide you with the name, address and phone number of the appeals coordinator within three business days after receipt of a review request. BCBSNC will also give you instructions on how to submit written materials.

Although you are not allowed to attend a first level appeal, you may provide and/or present written evidence and testimony. BCBSNC asks that you send all of the written material you feel is necessary to make a decision. BCBSNC will use the material provided in the request for review, along with other available information, to reach a decision. If your appeal is due to a NONCERTIFICATION, your appeal will be evaluated by a licensed medical DOCTOR who was not involved in the initial NONCERTIFICATION decision. You may receive, in advance, any new information that BCBSNC
may use in making a decision or any new or additional rationale so that you have an opportunity to respond prior to the notice of an ADVERSE BENEFIT DETERMINATION.

You will be notified in clear written terms of the decision, within a reasonable time but no later than 30 days from the date BCBSNC received the request. You may then request all information that was relevant to the review.

Second Level Appeal
If you are dissatisfied with the first level appeal decision, you have the right to a second level appeal. Second level appeals are not allowed for benefits or services that are clearly excluded by this benefit booklet, or quality of care complaints. Within ten business days after BCBSNC receives your request for a second level appeal, BCBSNC will send you an acknowledgement letter which will include the following:

- Name, address and telephone number of the appeals coordinator
- A statement of your rights, including the right to:
  - request and receive all information that applies to your appeal from BCBSNC
  - participate in the second level appeal meeting
  - present your case to the review panel
  - submit supporting material before and during the review meeting
  - ask questions of any member of the review panel
  - be assisted or represented by a person of your choosing, including a family member, an EMPLOYER representative, or an attorney
  - pursue other voluntary alternative dispute resolution options as applicable.

The second level appeal meeting, which will be conducted by a review panel coordinated by BCBSNC using external physicians and/or benefit experts, will be held within 45 days after BCBSNC receives a second level appeal request. You will receive notice of the meeting date and time at least 15 days before the meeting, which will be held by teleconference. You have the right to a full review of your appeal even if you do not participate in the meeting. A written decision will be issued to you within seven business days of the review meeting.

Notice of Decision
If any claim (whether expedited or nonexpedited) shall be wholly or partially denied at either the first level appeal or the second level appeal, a written notice shall be provided to the MEMBER worded in an understandable manner and shall set forth:

- The specific reason(s) for the denial
- Reference to the specific health benefit plan provisions on which the decision is based
- A statement that the MEMBER is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information relevant to the MEMBER'S claim for benefits
- If applicable, a statement describing any voluntary appeals procedures and the MEMBER'S right to receive information about the procedures as well as the MEMBER'S right to bring a civil action under Section 502(a) of ERISA following an adverse determination upon review
- A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the decision or a statement that such specific rule, guideline, protocol, or other similar criteria was relied upon in making the decision and that this will be provided without charge upon request
- The right to pursue other voluntary alternative dispute resolution options as applicable
- If the decision is based on MEDICAL NECESSITY or EXPERIMENTAL treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the PLAN to the MEMBER'S medical circumstances, or a statement that such explanation will be provided without charge upon request; and
- The following statement: "You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Expedited Appeals (Available only for NONCERTIFICATIONS)
You have the right to a more rapid or expedited review of a NONCERTIFICATION if a delay: (i) would reasonably appear to seriously jeopardize your or your DEPENDENT'S life, health or ability to regain maximum function; or (ii) in the opinion of your PROVIDER, would subject you or your DEPENDENT to severe pain that cannot be adequately managed without the requested care or treatment. You can request an expedited second level review even if you did not request that the initial review be expedited. An expedited review may be initiated by calling BCBSNC Customer Service at the number given in "Who to Contact?" An expedited review will take place in consultation with a medical DOCTOR. All of the same conditions for a first level or second level appeal apply to an expedited review. BCBSNC will communicate the decision by phone to you and your PROVIDER as soon as possible, taking into account the medical circumstances, but no later than 72 hours
after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited appeal. Information initially given by telephone must also be given in writing.

After requesting an expedited review, BCBSNC will remain responsible for covered health care services you are receiving until you have been notified of the review decision.
Benefits to which MEMBERS are Entitled

The benefits described in this benefit booklet are provided only for MEMBERS. These benefits and the right to receive payment under this health benefit plan cannot be transferred or assigned to any other person or entity, including PROVIDERS. Under the PLAN, BCBSNC may pay a PROVIDER directly. For example, BCBSNC pays IN-NETWORK PROVIDERS directly under applicable contracts with those PROVIDERS. However, any PROVIDER’S right to be paid directly is through such contract with BCBSNC, and not through the PLAN. Under the PLAN, BCBSNC has the sole right to determine whether payment for services is made to the PROVIDER, to the SUBSCRIBER, or allocated among both. BCBSNC’s decision to pay a PROVIDER directly in no way reflects or creates any rights of the PROVIDER under the PLAN, including but not limited to benefits, payments or procedures.

If a MEMBER resides with a custodial parent or legal guardian who is not the EMPLOYEE, the PLAN will, at its option, make payment to either the PROVIDER of the services or to the custodial parent or legal guardian for services provided to the MEMBER. If the EMPLOYEE or custodial parent or legal guardian receives payment, it is his or her responsibility to pay the PROVIDER.

Benefits for COVERED SERVICES specified in the PLAN will be provided only for services and supplies that are performed by a PROVIDER as specified in the PLAN and regularly included in the ALLOWED AMOUNT. BCBSNC establishes coverage determination guidelines that specify how services and supplies must be billed in order for payment to be made under the PLAN.

Any amounts paid by the PLAN for noncovered services or that are in excess of the benefit provided under your Blue Options coverage may be recovered by BCBSNC. BCBSNC may recover the amounts by deducting from a MEMBER’S future claims payments. This can result in a reduction or elimination of future claims payments. In addition, under certain circumstances, if BCBSNC pays the PROVIDER amounts that are your responsibility, such as deductible, copayments or coinsurance, BCBSNC may collect such amounts directly from you.

Amounts paid by the PLAN for work-related accidents, injuries, or illnesses covered under state workers’ compensation laws will be recovered upon final adjudication of the claim or an order of the applicable state agency approving a settlement agreement. It is the legal obligation of the MEMBER, the EMPLOYER or the workers’ compensation insurer (whoever is responsible for payment of the medical expenses) to notify BCBSNC in writing that there has been a final adjudication or settlement.

PROVIDERS are independent contractors, and they are solely responsible for injuries and damages to MEMBERS resulting from misconduct or negligence.

Grandfathered Health Plan Disclosure

The PLAN ADMINISTRATOR believes this health benefit plan is 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.

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 your PLAN ADMINISTRATOR at Duke University and Duke University Health Systems.

You may also contact the 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.

BCBSNC’S Disclosure of Protected Health Information (PHI)

The privacy of your protected health information is very important. BCBSNC will only use or disclose your protected health information in accordance with applicable privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA).

Administrative Discretion

BCBSNC has the authority to use its discretion to make reasonable determinations in the administration of coverage. These determinations will be final. Such determinations include decisions concerning coverage of services, care, treatment or supplies, and reasonableness of charges. BCBSNC medical policies are guides considered when making coverage determinations.

North Carolina PROVIDER Reimbursement
BCBSNC has contracts with certain PROVIDERS of health care services for the provision of, and payment for, health care services provided to all MEMBERS entitled to health care benefits. BCBSNC’s payment to PROVIDERS may be based on an amount other than the billed charges, including without limitation, an amount per confinement or episode of care, agreed upon schedule of fees, or other methodology as agreed upon by BCBSNC and the PROVIDER. Under certain circumstances, a contracting PROVIDER may receive payments from BCBSNC greater than the charges for services provided to an eligible MEMBER, or BCBSNC may pay less than charges for services, due to negotiated contracts. The MEMBER is not entitled to receive any portion of the payments made under the terms of contracts with PROVIDERS. The MEMBER’s liability when defined as a percent of charge shall be calculated based on the lesser of the ALLOWED AMOUNT or the PROVIDER’s billed charge for COVERED SERVICES provided to a MEMBER.

Some OUT-OF-NETWORK PROVIDERS have other agreements with BCBSNC that affect their reimbursement for COVERED SERVICES provided to Blue Options MEMBERS. These PROVIDERS agree not to bill MEMBERS for any charges higher than their agreed upon, contracted amount. In these situations, MEMBERS will be responsible for the difference between the Blue Options ALLOWED AMOUNT and the contracted amount. OUT-OF-NETWORK PROVIDERS may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim with BCBSNC.

**Services Received Outside of North Carolina**

BCBSNC has a variety of relationships with other Blue Cross and/or Blue Shield licensees, generally referred to as "Inter-Plan Programs." As a MEMBER of the PLAN, you have access to PROVIDERS outside the state of North Carolina. Your ID CARD tells PROVIDERS that you are a MEMBER of the PLAN. While the PLAN maintains its contractual obligation to provide benefits to MEMBERS for COVERED SERVICES, the Blue Cross and/or Blue Shield licensee in the state where you receive services ("Host Blue") is responsible for contracting with and generally handling all interactions with its participating PROVIDERS.

Whenever you obtain health care services outside the area in which the BCBSNC network operates, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include Negotiated National Account Arrangements available between BCBSNC and other Blue Cross and/or Blue Shield licensees.

Under the BlueCard Program, the amount you pay toward such COVERED SERVICES, such as deductibles, copayments or coinsurance, is usually based on the lesser of:

- The billed charges for your COVERED SERVICES, or
- The negotiated price that the "Host Blue" passes on to BCBSNC.

This "negotiated price" can be:

- A simple discount that reflects the actual price paid by the Host Blue to your PROVIDER
- An estimated price that factors in special arrangements with your PROVIDER or with a group of PROVIDERS that may include types of settlements, incentive payments, and/or other credits or charges
- An average price, based on a discount that reflects the expected average savings for similar types of health care PROVIDERS after taking into account the same types of special arrangements as with an estimated price.

The estimated or average price may be adjusted in the future to correct for over- or underestimation of past prices. However, such adjustments will not affect the price that BCBSNC uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered health care services according to applicable law.

As an alternative to the BlueCard Program and depending on your geographic location, your claim may be processed through a Negotiated National Account Arrangement with a Host Blue. In these situations, the amount you pay for COVERED SERVICES will be calculated based on the negotiated price made available to BCBSNC by the Host Blue.

If you receive COVERED SERVICES from a nonparticipating PROVIDER outside the state of North Carolina, the amount you pay will generally be based on either the Host Blue’s nonparticipating PROVIDER local payment or the pricing arrangements required by applicable state law. However, in certain situations, the PLAN may use other payment bases, such as billed charges, to determine the amount the PLAN will pay for COVERED SERVICES from a nonparticipating PROVIDER. In any of these situations, you may be liable for the difference between the nonparticipating PROVIDER’S billed amount and any payment the PLAN would make for the COVERED SERVICES.

**Right of Recovery Provision**
Immediately upon paying or providing any benefit under the PLAN, the PLAN shall be subrogated to all rights of recovery a MEMBER has against any party potentially responsible for making any payment to a MEMBER due to a MEMBER’S injuries, illness or condition, to the full extent of benefits provided or to be provided by the PLAN.

In addition, if a MEMBER receives any payment from any potentially responsible party as a result of an injury, illness or condition, the PLAN has the right to recover from, and be reimbursed by, the MEMBER for all amounts the PLAN has paid and will pay as a result of that injury or illness, up to and including the full amount the MEMBER receives from all potentially responsible parties. The MEMBER agrees that if the MEMBER receives any payment from any potentially responsible party as a result of an injury or illness, the MEMBER will serve as a constructive trustee over the funds for the benefit of the PLAN. Failure to hold such funds in trust will be deemed a breach of the MEMBER’S fiduciary duty to the PLAN.

Further, the PLAN will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a MEMBER receives from the third party, the third party’s insurer or any other source as a result of the MEMBER’S injuries. The lien is in the amount of benefits paid by the PLAN for the treatment of the illness, injury or condition for which another party is responsible.

As used throughout this provision, the term responsible party means any party possibly responsible for making any payment to a MEMBER due to a MEMBER’S injuries or illness or any insurance coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers’ compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The lien can be filed with or enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the PLAN including, but not limited to, the MEMBER; the MEMBER’S representative or agent; responsible party; responsible party’s insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the PLAN.

The MEMBER acknowledges that the PLAN’S recovery rights are a first priority claim against all potentially responsible parties and are to be paid to the PLAN before any other claim for the MEMBER’S damages. The PLAN shall be entitled to full reimbursement first from any potentially responsible party payments, even if such payment to the PLAN will result in a recovery to the MEMBER which is insufficient to make the MEMBER whole or to compensate the MEMBER in part or in whole for the damages sustained. It is further understood that the PLAN will pay all fees associated with counsel it hires to represent its interests related to any recovery it may be entitled to, but it is agreed that the PLAN is not required to participate in or pay court costs or attorney fees to any attorney hired by the MEMBER.

The terms of this entire right of recovery provision shall apply and the PLAN is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the MEMBER identifies the medical benefits the PLAN provided. The PLAN is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The MEMBER acknowledges that BCBSNC has been delegated authority by the PLAN ADMINISTRATOR to assert and pursue the right of subrogation and/or reimbursement on behalf of the PLAN. The MEMBER shall fully cooperate with BCBSNC’s efforts to recover benefits paid by the PLAN. It is the duty of the MEMBER to notify BCBSNC in writing of the MEMBER’S intent to pursue a claim against any potentially responsible party, within 30 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the MEMBER. The MEMBER shall provide all information requested by BCBSNC or its representative including, but not limited to, completing and submitting any applications or other forms or statements as BCBSNC may reasonably request.

The MEMBER shall do nothing to prejudice the PLAN’S recovery rights as herein set forth. This includes, but is not limited to, refraining from entering into any settlement or recovery that attempts to reduce, waive, bar or exclude the full cost of all benefits provided by the PLAN.

In the event that any claim is made that any part of this right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the MEMBER and the PLAN agree that the PLAN ADMINISTRATOR shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

The MEMBER agrees that any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction as BCBSNC may elect. Upon receiving benefits under the PLAN, the MEMBER hereby submits to each such jurisdiction, waiving whatever rights may correspond to the MEMBER by reason of the MEMBER’S present or future domicile.

**Notice of Claim**
ADDITIONAL TERMS OF YOUR COVERAGE (cont.)

The PLAN will not be liable for payment of benefits unless proper notice is furnished to BCBSNC that COVERED SERVICES have been provided to a MEMBER. If the MEMBER files the claim, written notice must be given to BCBSNC within 18 months after the MEMBER INCURS the COVERED SERVICE, except in the absence of legal capacity of the MEMBER. The notice must be on an approved claim form and include the data necessary for BCBSNC to determine benefits.

**Notice of Benefit Determination**

BCBSNC will provide an explanation of benefits determination to the MEMBER or the MEMBER's authorized representative within 30 days of receipt of a notice of claim if the MEMBER has financial liability on the claim other than a copayment or other services where payment was made at the point of service (unless the PLAN has chosen to provide an explanation of benefits for additional claims where the MEMBER does not have a financial liability other than a copayment).

BCBSNC may take an extension of up to 15 more days to complete the benefits determination if additional information is needed. If BCBSNC takes an extension, BCBSNC will notify the MEMBER or the MEMBER's authorized representative of the extension and of the information needed. You will then have 90 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 days.

Such notice will be worded in an understandable manner and will include:

- The specific reason(s) for the denial of benefits
- Reference to the benefit booklet section on which the denial of benefits is based
- A description of any additional information needed for you to perfect the claim and an explanation of why such information is needed
- A description of the review procedures and the time limits applicable to such procedures, including the MEMBER's right to bring a civil action under Section 502(a) of ERISA following a denial of benefits
- A copy of any internal rule, guideline, protocol or other similar criteria relied on, if any, in making the benefit determination or a statement that it will be provided without charge upon request
- If the denial of benefits is based on MEDICAL NECESSITY or EXPERIMENTAL treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the PLAN to the MEMBER's medical circumstances, or a statement that this will be provided without charge upon request; and
- In the case of a denial of benefits involving URGENT CARE, a description of the expedited review process available to such claims.

Upon receipt of a denial of benefits, you have the right to file an appeal with BCBSNC. See "What if You Disagree with a Decision?" for more information.

**Limitation of Actions**

No legal action may be taken to recover benefits for 60 days after the Notice of Claim has been given as specified above and until you have exhausted all administrative remedies, including following the appeals process. If the PLAN is subject to ERISA, you must only exhaust the first level appeal process following the Notice of Claim requirement.

Please see "What if You Disagree with a Decision?" for details regarding the appeals process.

No legal action may be taken later than three years from the date services are INCURRED. However, if you are authorized to pursue an action in federal court under ERISA, and you choose to pursue a second level appeal, the three-year limitation is temporarily suspended until that review has been resolved.

**Coordination of Benefits (Overlapping Coverage)**

If a MEMBER is also enrolled in another group health plan, the PLAN may take into account benefits paid by the other plan.

Coordination of benefits (COB) means that if a MEMBER is covered by more than one group insurance plan, benefits under one group insurance plan are determined before the benefits are determined under the second group insurance plan. The group insurance plan that determines benefits first is called the primary group insurance plan. The other group insurance plan is called the secondary group insurance plan.

Benefits paid by the secondary group insurance plan may be reduced to avoid paying benefits between the two plans that are greater than the cost of the health care service. Most group health insurance plans include a COB provision. Payment by BCBSNC under the PLAN takes into account whether or not the PROVIDER is a participating PROVIDER. If the PLAN is the secondary plan, and the MEMBER uses a participating PROVIDER, the PLAN will coordinate up to the ALLOWED AMOUNT. The participating PROVIDER has agreed to accept the ALLOWED AMOUNT as payment in full.
If you receive services from an OUT-OF-NETWORK PROVIDER, you are responsible for any charges not paid by either group insurance plan. You may wish to check with the primary group insurance plan to find out if an OUT-OF-NETWORK PROVIDER participates in the primary group insurance plan’s network and whether this affects your responsibility for paying up to the PROVIDER’S charges.

If either the primary or the secondary health benefit plan covers a particular service, where the PLAN is the secondary plan, the PLAN will coordinate benefits for that service based on the benefits of the secondary coverage. However, if neither the primary nor secondary plan covers a particular service, the MEMBER will be responsible for payment for that service.

BCBSNC, on behalf of the PLAN may request information about the other plan from the MEMBER. A prompt reply will help BCBSNC process payments quickly. There will be no payment until primary coverage is determined. It is important to remember that even when benefits from other group health plans are taken into account, benefits for COVERED SERVICES under this PLAN are still subject to program requirements, such as PRIOR REVIEW and CERTIFICATION procedures.

The rules by which a plan is determined primary or secondary are listed in the following chart. The "participant" is the person who is signing up for group health insurance coverage.
### When a person is covered by 2 group health plans, and

<table>
<thead>
<tr>
<th>When a person is covered by 2 group health plans, and</th>
<th>Then</th>
<th>Primary</th>
<th>Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>One plan does not have a COB provision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The plan without the provision is</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The plan with the provision is</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>The person is the participant under one plan and a DEPENDENT under the other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The plan covering the person as the participant is</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The plan covering the person as a DEPENDENT is</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>The person is covered as a DEPENDENT CHILD under both plans and parents are either:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) married or living together; or</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2) divorced/separated or not living together and a court decree* states that they have joint custody without specifying which parent is responsible for the DEPENDENT CHILD’s health care coverage; or</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3) divorced/separated or not living together and a court decree* states that both parents have responsibility for the DEPENDENT CHILD’S health care coverage</td>
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</tr>
<tr>
<td></td>
<td>The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The plan of the parent whose birthday is later in the calendar year is</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Note: When the parents have the same birthday, the plan that covered the parent longer is</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>The person is covered as a DEPENDENT CHILD under both plans and parents are divorced/separated or not living together with no court decree* for coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The custodial parent’s plan is</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The plan of the spouse of the custodial parent is</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Or, if the custodial parent covers the child through their spouse’s plan, the plan of the spouse is</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>The non-custodial parent’s plan is</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Note: The custodial parent is considered to be the parent awarded custody of a child by a court decree*; or in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The person is covered as a DEPENDENT CHILD under both plans and parents are divorced/separated or not living together, and coverage is stipulated in a court decree*</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>The plan of the parent primarily responsible for health coverage under the court decree is</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The plan of the other parent is</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Note: If there is a court decree that requires a parent to assume financial responsibility for the child’s health care coverage, and BCBSNC has actual knowledge of those terms of the court decree, benefits under that parent’s plan are</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### ADDITIONAL TERMS OF YOUR COVERAGE (cont.)

<table>
<thead>
<tr>
<th>When a person is covered by 2 group health plans, and</th>
<th>Then</th>
<th>Primary</th>
<th>Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>The person is covered as a laid-off or retired MEMBER or that MEMBER’S DEPENDENT on one of the plans, including coverage under COBRA</td>
<td>The plan that covers a person other than as a laid-off or retired MEMBER or as that MEMBER’S DEPENDENT is</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>The plan that covers a person as a laid-off or retired MEMBER or the DEPENDENT of a laid-off or retired MEMBER is</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Note: This rule does not apply if it results in a conflict with any of the other rules for determining order of benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The person is the participant in two active group health plans and none of the rules above apply</td>
<td>The plan that has been in effect longer is</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The plan that has been in effect the shorter amount of time is</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

*Note: You may be required to submit a copy of the court order or legal documentation in these instances.*
Programs Outside Your Regular Benefits

The PLAN ADMINISTRATOR and BCBSNC may add programs that are outside your regular benefits. These programs may be changed from time to time. Following are examples of programs that may be included outside your regular benefits:

- Health and wellness programs, including discounts on goods and services from other companies including certain types of PROVIDERS
- Service programs for MEMBERS identified with complex health care needs, including a dedicated administrative contact, consolidated claims data information, and supportive gift items
- Clinical Opportunities Notification Program involves the analysis of claims and subsequent notification to PROVIDERS suggesting consideration of certain patient-specific treatment options along with medical literature addressing these treatment options
- Rewards or drawings for gifts based on activities related to online tools found on BCBSNC’s website
- Quarterly, semi-annual, and/or annual drawings for gifts, which may include club memberships and trips to special events, based on submitting activity diaries
- Charitable donations made on your behalf by BCBSNC
- Discounts or other savings on retail goods and services.

These discounts on goods and services may not be provided directly by the PLAN or BCBSNC, but may instead be arranged for your convenience. These discounts are outside the PLAN benefits. Neither the PLAN nor BCBSNC is liable for problems resulting from goods and services it does not provide directly, such as goods and services not being provided or being provided negligently. The gifts and charitable donations are also outside the PLAN benefits. Neither the PLAN nor BCBSNC is liable for third party PROVIDERS’ negligent provision of the gifts. The PLAN ADMINISTRATOR or BCBSNC may stop or change these programs at any time.

Healthy Outcomes

BCBSNC offers health and wellness programs at no additional cost to MEMBERS. These confidential programs are designed to provide MEMBERS with targeted information and support services, which can help them improve their health as well as manage specific health care needs.

MEMBERS may receive comprehensive educational materials, tools and other resources. These programs also provide the opportunity to work one-on-one with a specially trained nurse, and offer benefits for MEMBERS with certain conditions who agree to engage. The Healthy Outcomes program includes the following components:

Healthy Outcomes Case Management – provides support to MEMBERS with various high-risk health conditions to better manage the daily challenges of those conditions. MEMBERS are able to work one-on-one with a nurse coach.

Healthy Outcomes Condition Care – provides disease management assistance to MEMBERS 18 years of age and older who are at risk and diagnosed with chronic health conditions through education, empowerment and support. MEMBERS enrolled in the program receive personalized support through telephonic coaching and targeted educational materials. Conditions supported include:

- Chronic obstructive pulmonary disease (COPD)
- Asthma
- Diabetes
- Congestive Heart Failure
- Coronary Artery Disease

Healthy Outcomes Maternity – provides support to female MEMBERS 18 years of age and older who are currently pregnant. This program offers initial and mid-pregnancy assessments through a health coach, and additional nurse support via a 24/7 BabyLine®, which is available through 6 weeks post delivery.

Healthy Outcomes Wellness – provides robust, integrated wellness offerings through a variety of media – on-line, telephonic and mail – to help MEMBERS improve their health. This program includes a health assessment, virtual coaching programs, a personal health record, as well as a variety of tools, trackers, and newsletter articles.

Health Line Blue – provides a toll-free, nurse-driven telephonic support program that empowers MEMBERS to better manage their health and make informed healthcare decisions. Highly trained registered nurses are available 24/7 to provide cost-effective solutions for MEMBERS coping with chronic and acute illnesses, episodic or injury-related events and other healthcare issues.
Full details on these programs, including a description of what's available and how to get started, are located on the website at bcbsnc.com. Programs are available at the discretion of your EMPLOYER. To determine which programs are available to you, log into mybcbsnc.com. You can also call 1-800-260-0091 to learn more about these programs and find out which ones are included in the PLAN.

**Health Information Services**
If you have certain health conditions, BCBSNC or a representative of BCBSNC may contact you to provide information about your condition, answer questions and tell you about resources that may be available to you. Your participation is voluntary, and your medical information will be kept confidential.
These definitions will help you understand the PLAN. Please note that some of these terms may not apply to the PLAN.

**ADVERSE BENEFIT DETERMINATION**
A denial, reduction, or termination of, or failure to provide or make full or partial payment for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be EXPERIMENTAL or INVESTIGATIONAL or not MEDICALLY NECESSARY or appropriate. Rescission of coverage and initial eligibility determinations are also included as adverse benefit determinations.

**ALLOWED AMOUNT**
The maximum amount that BCBSNC determines is reasonable for COVERED SERVICES provided to a MEMBER. The allowed amount includes any BCBSNC payment to the PROVIDER, plus any deductible, coinsurance or copayment. For PROVIDERS that have entered into an agreement with BCBSNC, the allowed amount is the negotiated amount that the PROVIDER has agreed to accept as payment in full. Except as otherwise specified in "EMERGENCY Care," for PROVIDERS that have not entered into an agreement with BCBSNC, the allowed amount will be the lesser of the PROVIDER'S billed charge or an amount based on an OUT-OF-NETWORK fee schedule established by BCBSNC that is applied to comparable PROVIDERS for similar services under a similar health benefit plan. Where BCBSNC has not established an OUT-OF-NETWORK fee schedule amount for the billed service, the allowed amount will be the lesser of the PROVIDER'S billed charge or a charge established by BCBSNC using a methodology that is applied to comparable PROVIDERS who may have entered into an agreement with BCBSNC for similar services under a similar health benefit plan. Calculation of the allowed amount is based on several factors including BCBSNC's medical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the PROVIDER may be combined into one procedure for reimbursement purposes.

**AMBULATORY SURGICAL CENTER**
A NONHOSPITAL FACILITY with an organized staff of DOCTORS, which is licensed or certified in the state where located, and which:

a) Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis
b) Provides nursing services and treatment by or under the supervision of DOCTORS whenever the patient is in the facility
c) Does not provide inpatient accommodations
d) Is not other than incidentally, a facility used as an office or clinic for the private practice of a DOCTOR or OTHER PROVIDER.

**ANCILLARY PROVIDER**
Independent clinical laboratories, durable/home medical equipment and supply providers, or specialty pharmacies. Ancillary providers are considered IN-NETWORK if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, based on the following criteria:

a) For independent clinical laboratories, services are received in the state where the specimen is drawn
b) For durable/home equipment and supply PROVIDERS, services are received in the state where the equipment or supply is shipped (receiving address) or if purchased at a retail store the vendor must be contracted with the plan in the state where the retail store is located
c) For specialty pharmacies, services are received in the state where the ordering physician is located.

**BENEFIT PERIOD**
The period of time, as stated in the "Summary of Benefits," during which charges for COVERED SERVICES, provided to a MEMBER, must be INCURRED in order to be eligible for payment by the PLAN. A charge shall be considered INCURRED on the date the service or supply was provided to a MEMBER.

**BENEFIT PERIOD MAXIMUM**
The maximum amount of charges or number of visits in a BENEFIT PERIOD that will be covered on behalf of a MEMBER. Services in excess of a benefit period maximum are not COVERED SERVICES and MEMBERS may be responsible for the entire amount of the PROVIDER'S billed charge.

**CERTIFICATION**
The determination by BCBSNC that an admission, availability of care, continued stay, or other services, supplies or drugs have been reviewed and, based on the information provided, satisfy BCBSNC's requirements for MEDICALLY NECESSARY services and supplies, appropriateness, health care setting, level of care and effectiveness.

**COMPLICATIONS OF PREGNANCY**
Medical conditions whose diagnoses are distinct from pregnancy, but are adversely affected or caused by pregnancy, resulting in the mother's life being in jeopardy or making the birth of a viable infant impossible and which require the mother to be treated prior to the full term of the pregnancy (except as otherwise stated below), including, but not limited to: abruption of placenta; acute nephritis; cardiac decompensation; documented hydramnios; eclampsia; ectopic pregnancy; insulin dependent diabetes mellitus; missed abortion; nephrosis; placenta previa; Rh sensitization; severe pre-eclampsia; trophoblastic disease; toxemia; immediate postpartum hemorrhage due to uterine atony; retained placenta or uterine rupture occurring within 72 hours of delivery; or, the following conditions occurring within ten days of delivery: urinary tract infection, mastitis, thrombophlebitis, and endometritis. EMERGENCY cesarean section will be considered eligible for benefit application only when provided in the course of treatment for those conditions listed above as a complication of pregnancy. Common side effects of an otherwise normal pregnancy, conditions not specifically included in this definition, episiotomy repair and birth injuries are not considered complications of pregnancy.

CONGENITAL
Existing at, and usually before, birth referring to conditions that are apparent at birth regardless of their causation.

COSMETIC
To improve appearance. This does not include restoration of physiological function resulting from accidental injury, trauma or previous treatment that would be considered a COVERED SERVICE. This also does not include reconstructive SURGERY to correct CONGENITAL or developmental anomalies that have resulted in functional impairment.

COVERED SERVICE(S)
A service, drug, supply or equipment specified in this benefit booklet for which MEMBERS are entitled to benefits in accordance with the terms and conditions of the PLAN. Any services in excess of a BENEFIT PERIOD MAXIMUM or LIFETIME MAXIMUM are not covered services.

CREDITABLE COVERAGE
Accepted health insurance coverage carried prior to BCBSNC coverage can be group health insurance, an employee welfare benefit plan to the extent that the plan provides medical care to employees and/or their dependents directly or through insurance, reimbursement, or otherwise, individual health insurance, short-term limited duration health insurance coverage, public health plan, Children's Health Insurance Program (CHIP), Medicare, Medicaid, and any other coverage defined as creditable coverage under state or federal law. Creditable coverage does not include coverage consisting solely of excepted benefits.

DENTAL SERVICE(S)
Dental care or treatment provided by a DENTIST or OTHER PROFESSIONAL PROVIDER in the DENTIST'S office to a covered MEMBER while the policy is in effect, provided such care or treatment is recognized by BCBSNC as a generally accepted form of care or treatment according to prevailing standards of dental practice.

DENTIST
A dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to provide DENTAL SERVICES, perform dental SURGERY or administer anesthetics for dental SURGERY. All services performed must be within the scope of license or certification to be eligible for reimbursement.

DEPENDENT
A MEMBER other than the EMPLOYEE as specified in "When Coverage Begins and Ends."

DEPENDENT CHILD(REN)
A child until the end of the month of their 26th birthday who is either: 1) the EMPLOYEE’S biological child, stepchild, legally adopted child (or child placed with the EMPLOYEE and/or spouse for adoption), FOSTER CHILD, or 2) a child for whom legal guardianship has been awarded to the EMPLOYEE and/or spouse, or 3) a child for whom the EMPLOYEE and/or spouse has been court-ordered to provide coverage. The spouse or children of a dependent child are not considered DEPENDENTS.

DOCTOR
Includes the following: a doctor of medicine, a doctor of osteopathy, licensed to practice medicine or SURGERY by the Board of Medical Examiners in the state of practice, a doctor of dentistry, a doctor of podiatry, a doctor of chiropractic, a doctor of optometry, or a doctor of psychology who must be licensed or certified in the state of practice and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting or has met the standards of the National Register of Health Service Providers in Psychology. All of the above must be duly licensed to practice by the state in which any service covered by the contract is performed, regularly charge and collect fees as a personal right,
subject to any licensure or regulatory limitation as to location, manner or scope of practice. All services performed must be within the scope of license or certification to be eligible for reimbursement.

**DURABLE MEDICAL EQUIPMENT**
Items designated by BCBSNC which can withstand repeated use, are used primarily to serve a medical purpose, are not useful to a person in the absence of illness, injury or disease, and are appropriate for use in the patient's home.

**EDUCATIONAL TREATMENT**
Services provided to foster acquisition of skills and knowledge to assist development of an individual’s cognitive independence and personal responsibility. These services include academic learning, socialization, adaptive skills, communication, amelioration of interfering behaviors, and generalization of abilities across multiple environments.

**EFFECTIVE DATE**
The date on which coverage for a MEMBER begins, according to "When Coverage Begins and Ends."

**EMERGENCY(IES)**
The sudden or unexpected onset of a condition of such severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of an individual or with respect to a pregnant woman, the health of the pregnant woman or her unborn child in serious jeopardy, serious physical impairment to bodily functions, serious dysfunction of any bodily organ or part, or death. Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock, and other severe, acute conditions are examples of emergencies.

**EMERGENCY SERVICES**
Health care items and services furnished or required to screen for or treat an EMERGENCY medical condition until the condition is STABILIZED, including pre-hospital care and ancillary services routinely available in the EMERGENCY department.

**EMPLOYEE**
The person who is eligible for coverage under the PLAN due to employment with the EMPLOYER and who is enrolled for coverage.

**EMPLOYER**
Duke University and Duke University Health Systems

**ERISA**

**ESSENTIAL HEALTH BENEFITS**
The core set of services as defined by federal law that includes the following ten categories: (1) ambulatory patient services, (2) EMERGENCY SERVICES, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance abuse services, including behavioral health treatment, (6) PRESCRIPTION DRUGS, (7) REHABILITATIVE and HABILITATIVE SERVICES and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care. No annual or lifetime dollar limits can apply to essential health benefits.

**EXPERIMENTAL**
See INVESTIGATIONAL.

**FACILITY SERVICES**
Covered services provided and billed by a HOSPITAL or NONHOSPITAL FACILITY. All services performed must be within the scope of license or certification to be eligible for reimbursement.

**FOSTER CHILD(REN)**
Children under age 18 i) for whom a Guardian has been appointed by any clerk of superior court, or ii) whose primary or sole custody has been assigned by order of a court with proper jurisdiction and who are residing with a person appointed as guardian or custodian for so long as the guardian or custodian has assumed the legal obligation for total or partial support of the children with the intent that the children reside with the guardian or custodian on more than a temporary or short-term basis.

**HABILITATIVE SERVICES**
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational
therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

**HOMEBOUND**
A MEMBER who cannot leave their home or temporary residence due to a medical condition which requires both the assistance of another person and the aid of supportive devices or the use of special transportation. To be homebound means that leaving home takes considerable and taxing effort. A MEMBER is not considered homebound solely because the assistance of another person is required to leave the home.

**HOME HEALTH AGENCY**
A NONHOSPITAL FACILITY which is primarily engaged in providing home health care services, medical or therapeutic in nature, and which:

a) Provides skilled nursing and other services on a visiting basis in the MEMBER'S home,
b) Is responsible for supervising the delivery of such services under a plan prescribed by a DOCTOR,
c) Is accredited and licensed or certified in the state where located,
d) Is certified for participation in the Medicare program, and
e) Is acceptable to BCBSNC.

**HOSPICE**
A NONHOSPITAL FACILITY that provides medically related services to persons who are terminally ill, and which:

a) Is accredited, licensed or certified in the state where located,
b) Is certified for participation in the Medicare program, and
c) Is acceptable to BCBSNC.

**HOSPITAL**
An accredited institution for the treatment of the sick that is licensed as a hospital by the appropriate state agency in the state where located. All services performed must be within the scope of license or certification to be eligible for reimbursement.

**IDENTIFICATION CARD (ID CARD)**
The card issued to MEMBERS upon enrollment which provides EMPLOYER/MEMBER identification numbers, names of the MEMBERS, and key benefit information, phone numbers and addresses.

**INCURRED**
The date on which a MEMBER receives the service, drug, equipment or supply for which a charge is made.

**INFERTILITY**
The inability to conceive a child.

**IN-NETWORK**
Designated as participating in the PPO network. BCBSNC's payment for in-network COVERED SERVICES is described in this benefit booklet as in-network benefits or in-network benefit levels.

**IN-NETWORK PROVIDER**
A HOSPITAL, DOCTOR, other medical practitioner or PROVIDER of medical services and supplies that has been designated as a Blue Options PROVIDER by BCBSNC or a PROVIDER participating in the BlueCard program. ANCILLARY PROVIDERS outside North Carolina are considered IN-NETWORK only if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, even if they participate in the BlueCard program.

**INVESTIGATIONAL (EXPERIMENTAL)**
The use of a service or supply including, but not limited to, treatment, procedure, facility, equipment, drug, or device that BCBSNC does not recognize as standard medical care of the condition, disease, illness, or injury being treated. The following criteria are the basis for BCBSNC's determination that a service or supply is investigational:

a) Services or supplies requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the U.S. Food and Drug Administration (FDA) or final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.
b) There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to permit BCBSNC's evaluation of the therapeutic value of the service or supply
c) There is inconclusive evidence that the service or supply has a beneficial effect on health outcomes
d) The service or supply under consideration is not as beneficial as any established alternatives
e) There is insufficient information or inconclusive scientific evidence that, when utilized in a non-investigational setting, the service or supply has a beneficial effect on health outcomes and is as beneficial as any established alternatives. If a service or supply meets one or more of the criteria, it is deemed investigational except for clinical trials as described under the PLAN. Determinations are made solely by BCBSNC after independent review of scientific data. Opinions of experts in a particular field and/or opinions and assessments of nationally recognized review organizations may also be considered by BCBSNC but are not determinative or conclusive.

LICENSED PRACTICAL NURSE (LPN)
A nurse who has graduated from a formal practical nursing education program and is licensed by the appropriate state authority.

LIFETIME MAXIMUM
The benefit maximum of certain COVERED SERVICES that will be reimbursed on behalf of a MEMBER while covered under the PLAN. Services in excess of any lifetime maximum are not COVERED SERVICES, and MEMBERS may be responsible for the entire amount of the PROVIDER’S billed charge. See "Summary of Benefits" for any limits that may apply.

MEDICAL SUPPLIES
Health care materials that include ostomy supplies, catheters, oxygen and diabetic supplies.

MEDICALLY NECESSARY (or MEDICAL NECESSITY)
Those COVERED SERVICES or supplies that are:
a) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except for clinical trials as described under the PLAN, not for EXPERIMENTAL, INVESTIGATIONAL, or COSMETIC purposes,
b) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms,
c) Within generally accepted standards of medical care in the community, and
d) Not solely for the convenience of the insured, the insured’s family, or the PROVIDER.
For medically necessary services, BCBSNC may compare the cost-effectiveness of alternative services, settings or supplies when determining which of the services or supplies will be covered and in what setting medically necessary services are eligible for coverage.

MEMBER
An EMPLOYEE or DEPENDENT, who is currently enrolled in the PLAN and for whom premium is paid.

MENTAL ILLNESS
(1) When applied to an adult MEMBER, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his/her affairs and social relations as to make it necessary or advisable for him/her to be under treatment, care, supervision, guidance, or control; and (2) when applied to a DEPENDENT CHILD, a mental condition, other than mental retardation alone, that so impairs the DEPENDENT CHILD’S capacity to exercise age adequate self-control or judgment in the conduct of his/her activities and social relationships so that he/she is in need of treatment; and a mental disorder defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, DC (“DSM-V”). Mental illness does not include substance-related disorders, SEXUAL DYSFUNCTIONS, and disorders coded as “V” codes in the DSM-V.

NONCERTIFICATION
An ADVERSE BENEFIT DETERMINATION by BCBSNC that a service covered under the PLAN has been reviewed and does not meet BCBSNC’s requirements for MEDICAL NECESSITY /CLINICAL NECESSITY, appropriateness, health care setting, level of care or effectiveness or the prudent layperson standard for coverage of EMERGENCY SERVICES and, as a result, the requested service is denied, reduced or terminated. The determination that a requested service is EXPERIMENTAL, INVESTIGATIONAL or COSMETIC is considered a noncertification. A noncertification is not a decision based solely on the fact that the requested service is specifically excluded under your benefits.

NONHOSPITAL FACILITY
An institution or entity other than a HOSPITAL that is accredited and licensed or certified in the state where located to provide COVERED SERVICES, and is acceptable to BCBSNC. All services performed must be within the scope of license or certification to be eligible for reimbursement.

OFFICE VISIT
Medical care, SURGERY, diagnostic services, REHABILITATIVE and HABILITATIVE THERAPY services and MEDICAL SUPPLIES provided in a PROVIDER’S office.

OTHER PROFESSIONAL PROVIDER
GLOSSARY (cont.)

A person or entity other than a DOCTOR who is accredited and licensed or certified in the state where located to provide COVERED SERVICES, and which is acceptable to BCBSNC. Examples may include physician assistants (PAs), nurse practitioners (NPs), or certified registered nurse anesthetists (CRNAs). All services performed must be within the scope of license or certification to be eligible for reimbursement.

OTHER PROVIDER
An institution or entity other than a HOSPITAL, which is accredited and licensed or certified in the state where located to provide COVERED SERVICES, and which is acceptable to BCBSNC. All services performed must be within the scope of license or certification to be eligible for reimbursement.

OTHER THERAPY(IES)
The following services and supplies, both inpatient and outpatient, ordered by a DOCTOR or OTHER PROVIDER to promote recovery from an illness, disease or injury when provided by a DOCTOR, OTHER PROVIDER or professional employed by a PROVIDER licensed in the state of practice.
   a) Cardiac rehabilitative therapy - reconditioning the cardiovascular system through exercise, education, counseling and behavioral change
   b) Chemotherapy (including intravenous chemotherapy) - the treatment of malignant disease by chemical or biological antineoplastic agents which have received full, unrestricted market approval from the U.S. Food and Drug Administration (FDA)
   c) Dialysis treatments - the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis
   d) Pulmonary therapy - programs that combine exercise, training, psychological support and education in order to improve the patient's functioning and quality of life
   e) Radiation therapy - the treatment of disease by x-ray, radium, or radioactive isotopes
   f) Respiratory therapy - introduction of dry or moist gases into the lungs for treatment purposes.

OUT-OF-NETWORK
Not designated as participating in the PPO network, and not certified in advance by BCBSNC to be considered as IN-NETWORK. Payment for out-of-network COVERED SERVICES is described in this benefit booklet as out-of-network benefits or out-of-network benefit levels.

OUT-OF-NETWORK PROVIDER
A PROVIDER that has not been designated as a Blue Options PROVIDER by BCBSNC.

OUT-OF-POCKET LIMIT
The maximum amount of coinsurance listed in “Summary of Benefits” that is payable by the MEMBER in a BENEFIT PERIOD before the PLAN pays 100% of COVERED SERVICES.

OUTPATIENT CLINIC(S)
An accredited institution/facility associated with or owned by a HOSPITAL. An outpatient clinic may bill for outpatient visits, including professional services and ancillary services, such as diagnostic tests. These services may be subject to the Outpatient Services benefit. All services performed must be within the scope of the professional or facility license or certification to be eligible for reimbursement.

PLAN
The EMPLOYER health benefit plan established by Duke University and Duke University Health Systems to provide health benefits for participants.

PLAN ADMINISTRATOR
Duke University and Duke University Health Systems

PLAN SPONSOR
Duke University and Duke University Health Systems

POSITIONAL PLAGIOCEPHALY
The asymmetrical shape of an infant's head due to uneven external pressures on the skull in either the prenatal or postnatal environment. This does not include asymmetry of an infant's head due to premature closure of the sutures of the skull.

PREVENTIVE CARE
Medical services provided by or upon the direction of a DOCTOR or OTHER PROVIDER that detect disease early in patients who do not show any signs or symptoms of a disease. Preventive care services include immunizations, medications that
delay or prevent a disease, and screening and counseling services. Screening services are specific procedures and tests that identify disease and/or risk factors before the beginning of any signs and symptoms.

**PRIMARY CARE PROVIDER (PCP)**
An IN-NETWORK PROVIDER who has been designated by BCBSNC as a PCP.

**PRIOR REVIEW**
The consideration of benefits for an admission, availability of care, continued stay, or other services, supplies or drugs, based on the information provided and requirements for a determination of MEDICAL NECESSITY of services and supplies, appropriateness, health care setting, or level of care and effectiveness. Prior review results in CERTIFICATION or NONCERTIFICATION of benefits.

**PROSTHETIC APPLIANCES**
Fixed or removable artificial limbs or other body parts, which replace absent natural ones following permanent loss of the body part.

**PROVIDER**
A HOSPITAL, NONHOSPITAL FACILITY, DOCTOR, or OTHER PROVIDER, accredited, licensed or certified where required in the state of practice, performing within the scope of license or certification. All services performed must be within the scope of license or certification to be eligible for reimbursement.

**REGISTERED NURSE (RN)**
A nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program), and is licensed by the appropriate state authority in the state of practice.

**REHABILITATIVE THERAPY**
Services and supplies both inpatient and outpatient, ordered by a DOCTOR or OTHER PROVIDER to promote the recovery of the MEMBER from an illness, disease or injury when provided by a DOCTOR, OTHER PROVIDER or professional employed by a PROVIDER licensed by the appropriate state authority in the state of practice and subject to any licensure or regulatory limitation as to location, manner or scope of practice.

a) Occupational therapy - treatment by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role after such ability has been impaired by disease, injury or loss of a body part

b) Physical therapy - treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles and devices to relieve pain, restore maximum function and prevent disability following disease, injury or loss of a body part

c) Speech therapy - treatment for the restoration of speech impaired by disease, SURGERY, or injury; certain significant physical CONGENITAL conditions such as cleft lip and palate; or swallowing disorders related to a specific illness or injury.

**RESIDENTIAL TREATMENT FACILITY**
A residential treatment facility is a facility that either: (1) offers treatment for patients that require close monitoring of their behavioral and clinical activities related to their chemical dependency or addiction to drugs or alcohol, or (2) offers treatment for patients that require psychiatric services for the diagnosis and treatment of MENTAL ILLNESS. All services performed must be within the scope of license or certification to be eligible for reimbursement.

**RESPITE CARE**
Services provided by an alternate caregiver or facility to allow the primary caregiver time away from those activities. Respite care is provided in-home or at an alternative location for a short stay. Services include support of activities of daily living such as feeding, dressing, bathing, routine administration of medicines, and can also include intermittent skilled nursing services that the caregiver has been trained to provide.

**ROUTINE FOOT CARE**
Hygiene and preventive maintenance of feet such as trimming of corns, calluses or nails that do not usually require the skills of a qualified PROVIDER of foot care services.

**SEXUAL DYSFUNCTION**
Any of a group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder.

**SKILLED NURSING FACILITY**
A NONHOSPITAL FACILITY licensed under state law that provides skilled nursing, rehabilitative and related care where professional MEDICAL SERVICES are administered by a registered or LICENSED PRACTICAL NURSE. All services performed must be within the scope of license or certification to be eligible for reimbursement.

SPECIALIST
A DOCTOR who is recognized by BCBSNC as specializing in an area of medical practice.

STABILIZE
To provide medical care that is appropriate to prevent a material deterioration of the MEMBER’S condition, within reasonable medical certainty.

SURGERY
The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures, such as:
   a) The correction of fractures and dislocations
   b) Usual and related pre-operative and post-operative care
   c) Other procedures as reasonable and approved by BCBSNC.

URGENT CARE
Services provided for a condition that occurs suddenly and unexpectedly, requiring prompt diagnosis or treatment, such that in the absence of immediate care the individual could reasonably be expected to suffer chronic illness, prolonged impairment, or require a more hazardous treatment. Fever over 101 degrees Fahrenheit, ear infection, sprains, some lacerations and dizziness are examples of conditions that would be considered urgent.

UTILIZATION MANAGEMENT (UM)
A set of formal processes that are used to evaluate the MEDICAL NECESSITY, quality of care, cost-effectiveness and appropriateness of many health care services, including procedures, treatments, medical devices, PROVIDERS and facilities.

WAITING PERIOD
The amount of time that must pass before a MEMBER is eligible to be covered for benefits under the terms of the PLAN.
ERISA Rights Statement

As a participant in the PLAN, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all MEMBERS shall be entitled to:

- Examine, without charge, at the PLAN ADMINISTRATOR’S office and at other specified locations, such as worksites, all PLAN documents, including insurance contracts, 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.
- 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. The PLAN ADMINISTRATOR may make a reasonable charge for the copies.
- Receive a summary of the PLAN’S financial report. The PLAN ADMINISTRATOR is required by law to furnish each MEMBER with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or DEPENDENTS if there is a loss of coverage under the PLAN as a result of a qualifying event. You or your DEPENDENTS may have to pay for such coverage. Review this Summary Plan Description and the documents governing the PLAN on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for MEMBERS, ERISA imposes duties upon the people who are responsible for the operation of the PLAN. The people who operate the PLAN, called “fiduciaries” of the PLAN, have a duty to do so prudently and in the interest of you and other PLAN MEMBERS and beneficiaries. No one, including your EMPLOYER or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 medical child support order, you may file suit in Federal court. If it should happen that the 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.

If you have any questions about the PLAN, you should contact the PLAN ADMINISTRATOR. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
BCBSNC MEMBER RIGHTS AND RESPONSIBILITIES

As a Blue Cross and Blue Shield of North Carolina (BCBSNC) member, you have the right to:

● Receive information about your coverage and your rights and responsibilities as a member
● Receive, upon request, facts about your plan, including a list of doctors and health care services covered
● Receive polite service and respect from BCBSNC
● Receive polite service and respect from the doctors who are part of the BCBSNC networks
● Receive the reasons why BCBSNC denied a request for treatment or health care service, and the rules used to reach those results
● Receive, upon request, details on the rules used by BCBSNC to decide whether a procedure, treatment, site, equipment, drug or device needs prior approval
● Receive clear and correct facts to help you make your own health care choices
● Play an active part in your health care and discuss treatment options with your doctor without regard to cost or benefit coverage
● Participate with practitioners in making decisions about your health care
● Expect that BCBSNC will take measures to keep your health information private and protect your health care records
● Voice complaints and expect a fair and quick appeals process for addressing any concerns you may have with BCBSNC
● Make recommendations regarding BCBSNC’s member rights and responsibilities policies
● Receive information about BCBSNC, its services, its practitioners and providers and members’ rights and responsibilities
● Be treated with respect and recognition of your dignity and right to privacy.

As a BCBSNC member, you should:

● Present your BCBSNC ID card each time you receive a service
● Read your BCBSNC benefit booklet and all other BCBSNC member materials
● Call BCBSNC when you have a question or if the material given to you by BCBSNC is not clear
● Follow the course of treatment prescribed by your doctor. If you choose not to comply, advise your doctor.
● Provide BCBSNC and your doctors with complete information about your illness, accident or health care issues, which may be needed in order to provide care
● Understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
● Make appointments for non-emergency medical care and keep your appointments. If it is necessary to cancel an appointment, give the doctor’s office at least 24-hours’ notice.
● Play an active part in your health care
● Be polite to network doctors, their staff and BCBSNC staff
● Tell your place of work and BCBSNC if you have any other group coverage
● Tell your place of work about new children under your care or other family changes as soon as you can
● Protect your BCBSNC ID card from improper use
● Comply with the rules outlined in your member benefit guide.
Duke University and Duke University Health Systems
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Blue Options™

Duke University and Duke University Health Systems

Group Effective Date:
January 1, 2015

Blue Cross Blue Shield of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association