

Duke Health Care Programs



Duke Health Care Programs

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

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

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

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

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

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Eligibility and Enrollment

Eligibility

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

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

Eligible Dependents

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

- Your legal spouse or same-sex spousal equivalent,
- Your unmarried dependent children (includes natural children, stepchildren, adopted children, foster children, or children for whom you are legal guardian up to age 19, or up to the 26th birthday if unmarried, full-time students. Dependent children does not include grandchildren, siblings, or other family members, or children of whom you have legal custody), and
- In order to continue coverage of a mentally or physically handicapped dependent child beyond the 19th birthday, all of the following criteria must be met:

- The parent must apply for the waiver on or prior to the child's 19th 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 19th birthday;
- The parent must remain eligible;
- The parent must provide annual evidence of continued incapacity;
- There must not be a break in coverage after the 19th birthday under the parental policy.

Collective Bargaining Agreements

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

- Local 77 of the American Federation of State, County, and Municipal Employees,
- Local 465 of the International Union of Operating Engineers, and
- Local 1328 Amalgamated Transit Union.

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

Employee/Labor Relations
112 Hanes House
Trent Drive
Durham, NC 27708

Enrolling

You have 60 days from your date of employment or eligibility to enroll in a Health Care Program.

If you do not enroll when you are first eligible (within 60 days of employment or eligibility), you can enroll during the annual Open Enrollment period, or within 30 days of a qualifying event.

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

- Employee Only (Individual),
- Employee and Spouse/Same-Sex Spousal Equivalent,
- Employee and Child,
- Employee and Children, or
- Family.

Effective Date of Coverage

New employees of Duke University and Duke University Health System are eligible for coverage effective on the:

- First day of employment/eligibility with Duke, or
- First day of the second full month of employment/eligibility.

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

When Coverage Ends

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

- Subsequent to an election made by the employee during open enrollment;
- At the end of the month in which an employee's work schedule drops below 20 hours;
- If premiums are not paid; or
- At the end of the month in which the employee transfers to an ineligible position.

Member Terminations

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

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

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

Spouse/Same Sex Spousal Equivalent

A spouse/same sex spousal equivalent must be removed from the Duke Health Plan at the time of divorce. At the time of legal separation the spouse may be removed, but may not be added back to the plan until Open Enrollment.

Dependent Children

Dependent children become ineligible for any of the following reasons:

- They marry;
- They are age 19 or over and are no longer a full-time student (12 or more credit hours at an accredited institution)*; or
- The day they turn age 26**.

*Unless the student is on an approved medical leave of absence. The medical leave will not extend past one year.

**Unless approved for handicapped status prior to the 19th birthday.

Eligibility and Enrollment

Termination of Coverage

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

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

PLEASE NOTE: If an enrolled employee dies, the Plan may determine that surviving members enrolled through that employee continue to meet the requirements to be eligible dependents, and that such members' coverage may continue in effect as if the employee were not deceased. The eligible dependent who is the deceased employee's spouse, or if there is no surviving spouse, the eldest eligible dependent (or his/her legal guardian if he/she is a minor or legally incapacitated) shall be responsible for taking any actions regarding the Plan which the employee would have been required to take. No additional dependents can be enrolled in the Plan subsequent to the death of the employee. Eligibility for continued coverage as a surviving spouse ends with remarriage. Eligibility for dependent children terminates at age 19, marriage, or age 26 as long as the dependent remains a full-time student and provides documentation (when requested) of student status. There is no waiver under this surviving dependent provision for continued enrollment of a handicapped dependent beyond the age of 26. Dependent children must be enrolled under the contract of the spouse if at the time of the employees' death, both parents are employed by Duke.

Refund of Premium

If you notify the HRIC of your dependent's change in eligibility within 30 days, you will be refunded any premium paid for coverage past the eligibility date (though not prorated for a partial month). If the HRIC is not notified within 30 days, the deduction going forward will be changed as soon as administratively possible, but you will not be eligible for a refund. Coverage will always be terminated retroactive to the end of eligibility regardless of when the HRIC is informed of the dependent's status. You will be responsible for any claims paid on your family member's behalf.

Continuation of Coverage

For information concerning COBRA continuation rights, please consult the Section, **Termination of Coverage and COBRA Continuation Coverage** in the *Summary Plan Description for the Duke Select Health Plan (SPD)*.

Cost of the Plan

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

Different contribution rates are applied for the different coverage categories. A copy of the current contribution schedules for the four health care plans is available from the HRIC or on the web at www.hr.duke.edu/benefits. Your contributions are paid on a before-tax basis, except contributions

for coverage of a same-sex spousal equivalent or dependants of a same-sex spousal equivalent, or postdoctoral scholars, which are made on an after-tax basis through payroll deduction. In certain other situations, federal tax laws require after-tax treatment.

Special Enrollment for Loss of Coverage or New Dependents

The Health Insurance Portability and Accountability Act (HIPAA) allows eligible employees and their dependents to request enrollment in the plans no later than 30 days after a loss of other coverage or a birth, marriage, adoption, or placement for adoption. Additional information may be found in the member documents.

Certificate of Group Health Plan Coverage

In compliance with HIPAA regulations, the plans will issue, per member request and automatically at termination of coverage, a “Certificate of Group Health Plan Coverage.” The certificate will attest to a period of continuous coverage up to 18 months with no break greater than 63 days. The certificate may be used to reduce or eliminate a pre-existing condition waiting period. None of the Duke Health Plans have a pre-existing condition waiting period.

Newborns’ and Mothers’ Health Protection Act

Under the federal legislation known as the Newborns’ and Mothers’ Health Protection Act, the plans may not restrict benefits for any hospital length of stay in connection with childbirth to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. Physicians are not required to obtain prior authorization from the plan before prescribing a length of stay that does not exceed these limits. However, all inpatient admissions do require notification by the facility.

Qualified Medical Child Support Orders

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

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

Subrogation and Reimbursement

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

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

Eligibility and Enrollment

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

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

- You, your covered dependent, and/or your attorney do not receive from the third party or organization (or any insurance company insuring such third person or organization) all of the damages you claim to have suffered,
- The payment you, your covered dependent, and/or your attorney receive is for, or described as for, your damages and/or expenses (such as for personal injuries, pain and suffering, or attorneys' fees) other than health care expenses, or
- The covered dependent recovering the money is a minor.

You, your covered dependent, and/or your attorney

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

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

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

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

Your Health Care Options

You can choose among four health care plan options to best suit the needs of you and your family:

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

Duke Select, Duke Basic, and Blue Care HMO

Duke offers three HMOs: Duke Select, Duke Basic, and Blue Care (administered by Blue Cross Blue Shield of NC). In these HMOs, you may, but are not required to, select a Primary Care Physician (PCP) from a plan's list of network providers. You will pay a flat charge — or co-pay — for most services when you visit a network provider. Routine, preventive services such as annual physicals, ob/gyn exams, immunizations, and well baby visits are covered under these plans.

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

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

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

- \$200 for Individual
- \$300 for Employee/Child
- \$400 for Employee/Children
- \$400 for Employee/Spouse or Employee/Same-Sex Spousal Equivalent
- \$600 for Family

PLEASE NOTE: Additional contributions will not be made if dependents are added during the plan year or if the same persons or portions of the family unit terminate and re-enroll under a separate contract during the same plan year.

Duke Options PPO

Duke offers you Duke Options PPO (administered by Blue Cross Blue Shield of NC). The plan also does not require that you select a PCP. Duke Options has a national network of physicians and hospitals and a network of international hospitals, so if you or a family member travels often or lives elsewhere, you may want to consider this plan. If you use a network provider, you will be responsible for a lower portion of the bill than you would if you used an out-of-network provider. Routine, preventive services such as annual physicals, ob/gyn exams, immunizations, and well baby visits are covered with network providers under this plan.

Summary of Benefits

Benefits provided by the plans are described in detail in the member documents entitled “Duke Select – Member Schedule of Benefits,” “Duke Basic – Member Schedule of Benefits,” “Duke Options, Member Guide,” and “Blue Care, Member Guide.” A copy of the member document is available on the Duke HR web site (www.hr.duke.edu).

How to File a Claim

Claims and Claims Review Procedures for the Plan

The claims and claims review procedures for Duke Select, Duke Basic, Duke Options, and Blue Care are described in the member documents. In no event will any claim for benefits under the plans filed by any member or covered dependent be processed prior to the date the member signs an “Authorization for Release of Medical Information” form provided by the HRIC.

Authority of the Staff Fringe Benefits Committee and the Plan Administrator

Both the Staff Fringe Benefits Committee (the Committee) and the Plan Administrator have the duty and discretionary authority to interpret and construe the provisions of the Duke Select and Duke Basic plans, subject to the objective terms of the plans and the claims and claims review procedures described in the member document. Interpretations and determinations made by the Committee and the Plan Administrator will be applied uniformly to all persons similarly situated and will be binding and conclusive upon each eligible employee and dependent who is covered under the plans and any other interested person. Such interpretations and determinations made by the Committee and the Plan Administrator will be overruled by a court of law only if the Committee and the Plan Administrator are found to have acted arbitrarily and capriciously in interpreting and construing the provisions of the plans.

Other Information

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

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

Your prescription drug benefit program is administered by Medco and is available to Duke employees and retirees (and their eligible dependents) covered by Duke Select, Duke Basic, Duke Options, and Blue Care Health Care Plans, and the Duke Plus plan for those with medicare eligibility.

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

Injectable Fertility Drugs

Please note that injectable fertility drugs are not reimbursed according to the standard pharmacy benefit copayment. They are covered by Duke Select and Duke Options at 50% for those employees or their spouse with at least two years of service with Duke and only if treatment is received at the Duke University Department of Reproductive Endocrinology. Injectable fertility drugs are not covered by Duke Basic, Blue Care, or Duke Plus nor are they covered if fertility treatment is obtained at any provider other than Duke Reproductive Endocrinology.

Home Delivery Pharmacy Program

For your ongoing prescription drug needs.

Use the home delivery pharmacy if you're taking medication to treat any long-term health condition, such as high blood pressure, asthma, or diabetes.

With the home delivery pharmacy:

- Medco fills every prescription according to strict quality and safety controls,
- Licensed, highly-trained professionals staff the pharmacies,
- You can order your refills online at www.medco.com or phone in your order toll-free to (800) 717-6575,
- Telephone consultations with a registered pharmacist are available around the clock by calling (800) 717-6575, and
- You can use EasyRxSM to make ordering new or refill prescriptions simple. Just follow the steps on the next page.

EasyRxSM — the simple way to use the home delivery pharmacy.

1. Ordering new prescriptions

Ask your doctor to prescribe your medication for a 90-day supply plus refills, if appropriate. Mail your prescription, required co-pay, and order form in the envelope provided. Or ask your doctor to call (888) EASYRX1 (888-327-9791) for instructions on how to fax the prescription. You will need to give your doctor your member ID number. If you have any questions, please call Member Services at (800) 717-6575.

Pharmacy Benefits

2. Refilling your medication

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

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

Refills by phone: Call (800) 4REFILL (800-473-3455) to use the automated refill system. Have your member ID number, refill slip with the prescription number, and your credit card ready.

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

Medco Rx Services
P.O. Box 650322
Dallas, TX 75265-9946

3. Delivery of your medication

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

4. Paying for your medication

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

Please note: The pharmacist's judgment and state and federal laws govern the dispensing of certain controlled substances and other prescribed drugs and may, for instance, limit their allowed quantities. Federal law prohibits the return of dispensed controlled substances. Controlled substances are medications that are habit forming and are restricted to a six-month supply.

Retail Network Pharmacy Program

For your immediate prescription drug needs.

If you use a participating retail network pharmacy:

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

Finding a participating retail network pharmacy:

To find the participating retail network pharmacies nearest you, visit the web site at www.medco.com and use the interactive pharmacy locator. Or, use the voice-activated Pharmacy Locator System by calling Member Services at (800) 717-6575.

If you use a non-participating pharmacy:

- You must pay 100% of the prescription price at the time of purchase.
- You will usually be reimbursed within 21 days of submitting your claim form. You will be reimbursed the discounted amount that would have been charged by a participating pharmacy, less the required co-pay.

What Drugs Are Covered?

- Legend drugs (federal law requires these drugs be dispensed by prescription only)
- Compounded drugs containing at least one legend ingredient
- Insulin
- Disposable insulin syringes/needles
- Blood glucose testing strips, glucometers
- Legend contraceptives; injectable contraceptives
- Any other drug which, under the applicable state law, may only be dispensed upon the written prescription of a physician or other lawful prescriber
- Growth hormone (limited to patients under age 18 who qualify under the Medco guidelines.)
- Retin A® (through age 35, over age 35 with approval through prior authorization)

What Drugs Are Not Covered?

- Anorexiant (drugs for weight reduction) Lonamin®, Pondimin®, Redux®, Meridia®, Xenical®, etc.
- Non-legend drugs other than those listed under “What Drugs Are Covered?”
- Viagra®, Muse®, Cavereject®, Levitra®, Cialis®, or other drugs approved for erectile dysfunction
- Renova®
- Growth hormone for short stature or for adult growth hormone deficiency (those age 18 and over)
- Rogaine®, Propecia® (for similar products whose sole purpose is to stimulate or promote hair growth)
- Drugs labeled “Caution — limited by federal law to investigational use,” or experimental drugs
- Infertility drugs unless authorized by a provider in the Duke Division of Reproductive Endocrinology when covered under Duke Options or Duke Select, and receiving services from Duke Reproductive Endocrinology
- Drugs which are purchased outside of the United States and do not have FDA approval
- Immunization agents, biological sera, blood or blood plasma, or products derived from blood or blood products
- Medical devices and appliances (except glucometers prescribed by your physician)
- Charges for the administration/injection or compounding of any drug that are in addition to negotiated fees
- Over-the-counter items
- Take-home drugs from an inpatient facility
- Replacement of drugs that have been lost, stolen, or destroyed
- Drugs prescribed by provider for himself/herself or his/her immediate family

Pharmacy Benefits

After you have paid for a prescription filled at a non-participating pharmacy, submit a completed claim form to Medco. The prescription receipt must be attached to the form. To obtain claim forms, visit www.medco.com or call Member Services at (800) 717-6575 to use the automated ordering system.

Other Important Features

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

Medco and your health plan may use the health and prescription information you provide solely to administer your benefit program. In addition, Medco Health may use this information and prescription data from claims submitted nationwide for reporting and analysis without identifying individual patients. Information may be shared with your health plan and your health plan's contractors as necessary to administer your health plan's benefit programs. Medco has a strong commitment to your privacy. Those are established effective administrative and technical safeguards to protect the confidentiality of your prescriptions and other information and to prevent unauthorized access to or disclosure of this information.

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

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

Drug Utilization Review: Safe and Appropriate Use of Medication

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

Education and Safety

You will receive information about critical topics like drug interactions and possible side effects with every new prescription through the mail. By visiting www.medco.com, you also can access other health-related information. Click on one of the links under "Health & Wellness" to browse health and wellness brochures, to get safety tips and answers to the most commonly-asked medication questions, or to just keep up with timely health issues. Written information cannot replace the expertise and advice of health care practitioners who have direct contact with a patient. All Medco health information is designed to educate you and help you communicate more effectively with your doctor.

Health Management

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

Generic Drugs

The brand name of a drug is the product name under which the drug is advertised and sold, and many brand-name medications have become well known through advertising. Generic medications are sold under often unfamiliar names, yet they must have the same active ingredients and are subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength, and purity as their brand-name counterparts. Generic drugs usually cost less than brand-name drugs, so please ask your doctor to prescribe generic drugs whenever appropriate.

Sometimes your doctor may prescribe a medication to be dispensed as written when a preferred brand-name or generic drug is available. As part of your prescription drug program, the pharmacist may discuss with your doctor whether a generic drug might be appropriate for you. Although your doctor always makes the final decision on your medication, you may request to keep the original prescription. If a generic drug is available but you receive the brand-name drug, you will pay the generic co-pay plus the difference between the costs of the two drugs, unless you utilize the mail service, which requires non formulary co-pay for brand drugs when a generic is available.

The Rx Selections™ Formulary

Your prescription drug program includes a formulary feature. A formulary is a list of commonly prescribed medications that are preferred based on their clinical effectiveness and lower plan cost. The list includes medications from most major pharmaceutical manufacturers.

Visit our web site at www.medco.com to view the formulary. Use of a formulary drug is voluntary. However, you will pay less if you need a brand-name drug and use a drug on the formulary.

Sometimes your doctor may prescribe a non-formulary medication when a formulary brand-name drug is available. In such cases, your doctor may specify that the prescription be dispensed as written.

As part of your prescription drug program, the pharmacist may ask your doctor whether an alternative formulary drug might be appropriate for you. If your physician agrees, your prescription will be filled with the alternative drug. **Your doctor always makes the final decision on your medication.** Ask your doctor if you have any questions about a change in prescription. Only the medication authorized by your doctor can be dispensed.

Managed Rx Coverage/ Prior Authorization

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

Pharmacy Benefits Comparison Chart

	Duke Select (HMO)	Duke Basic (HMO)	Duke Options (Blue Cross Blue Shield PPO)	Blue Care (Blue Cross Blue Shield HMO)
Pharmacy Benefits	MEDCO HEALTH			
	<i>34-day supply</i>		<i>90-day supply</i>	
Retail				
■ Generic	■ \$10 co-pay		■ \$30 co-pay	
■ Formulary	■ \$35 co-pay		■ \$105 co-pay	
■ Non-Formulary	■ \$50 co-pay		■ \$150 co-pay	
Home Delivery^{1,2}				
<i>90-day supply</i>				
■ Generic	■ N/A		■ \$20 co-pay	
■ Formulary	■ N/A		■ \$87 co-pay	
■ Non-Formulary	■ N/A		■ \$125 co-pay	
Deductible for Duke Basic	\$100 per person			

- 1 With Duke Basic, home delivery is required after the first three months on a maintenance prescription medication.
- 2 With home delivery, your prescription should be written for a 90-day supply because a prescription written for less than 90 days is still charged the 90-day co-payment.

Please note: Injectable fertility drugs are not reimbursed according to the standard pharmacy co-payment. These drugs are only covered by Duke Select and Duke Options at 50% for those employees or their spouse with at least two years of service with Duke and only if treatment is received from providers at Duke Reproductive Endocrinology.

Q. Why should I use the home delivery pharmacy?

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

Q. How soon will I receive my home delivery prescription?

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

Q. I sent in a prescription to the home delivery pharmacy for a 30-day supply with 11 refills and I was charged the 90-day co-pay. Why is this the case?

- A. The home delivery pharmacy only charges three different co-pays — so review your prescription prior to sending it in and make sure it is for a 90-day supply with three refills. Medco must dispense the quantity listed on the prescription.

Q. How do I order additional home delivery order forms or claim forms?

- A. Order online at www.medco.com or call Member Services at (800) 717-6575 to use the automated system. We mail your requested materials to you right away.

Q. What if I send the wrong co-pay amount?

- A. If there is a balance due, an invoice will be included with your prescription order. If you overpaid, your account will be credited.

Q. How do I find a participating retail network pharmacy?

- A. Visit www.medco.com or call Member Services toll-free at (800) 717-6575. You will be asked for your member ID number and the area in which you want to find a pharmacy.

Q. Does Medco sell my individually identifiable information to people outside Medco?

- A. Medco does not sell individually identifiable information or lists of their members and their covered dependents to outside companies.

Q. Do I have to participate in the health management programs?

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

Q. Will I get an identification card?

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

If you are a Duke employee with family coverage, only your name will appear on the identification card, but your covered family members may use that card as well.

Q. Who do I call if I have questions?

- A. If you have questions about your eligibility or your dependents' eligibility for this plan, you can call Duke University's Human Resource Information Center (HRIC) at (919) 684-5600 or send an e-mail to www.benefits@mc.duke.edu.

If you have questions about specific drugs, claims you have filed, co-pays, the Rx Selections™ Formulary, or home delivery orders, call Medco at (800) 717-6575 (TTY 800-759-1089).

Pharmacy Benefits

Contacts

Medco

www.medco.com

Member Services at (800) 717-6575
(TTY 800-759-1089).

24 hours a day, seven days a week.

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

Special Services

We continually strive to meet people's special needs;

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

Mental Health and Substance Abuse Benefits

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

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

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

Amendment and Termination of the Plan

Duke Select, Duke Basic, Duke Options, and Blue Care are welfare benefit plans. Duke expects to continue the plans indefinitely, but reserves the right to terminate the plans or to change terms and benefits of the plans at any time in the future. Duke has the right to cancel your coverage.

Mental Health and Substance Abuse Comparison Chart

	Duke Select (HMO)	Duke Basic (HMO)	Duke Options (Blue Cross Blue Shield PPO)	Blue Care (Blue Cross Blue Shield HMO)
	CIGNA Behavioral Health			
	In-Network		Out-of-Network	
Outpatient	<ul style="list-style-type: none"> Covered in full after \$35 co-pay per visit for individual/family therapy 		<ul style="list-style-type: none"> \$100 annual deductible Plan pays 50% of the prevailing^{1,4} costs 	
	<ul style="list-style-type: none"> Group Therapy visits at \$17.50 co-pay 			
	<ul style="list-style-type: none"> Medication management visits (CPT 90862) covered in full after \$35 co-pay; limit of 12 visits per calendar year 		<ul style="list-style-type: none"> In-network and out-of-network combined maximum of 12 visits 	
	<ul style="list-style-type: none"> Limit of 20 unmanaged^{1,2} visits per calendar year 		<ul style="list-style-type: none"> Limit of 20 visits per calendar year² 	
	<ul style="list-style-type: none"> Precertification required for psychological testing, electroshock therapy, hypnosis 		<ul style="list-style-type: none"> Precertification required for psychological testing, electroshock therapy, hypnosis 	
	<ul style="list-style-type: none"> Lab and outpatient charges and ECT, you pay 20%⁴ 		<ul style="list-style-type: none"> Lab and outpatient charges and ECT, you pay 50% after deductible^{1,4} 	
Inpatient	<ul style="list-style-type: none"> You pay 20% after \$250 annual deductible 		<ul style="list-style-type: none"> Plan pays 50% of the prevailing^{1,4} cost after \$250 per admission co-pay 	
	<ul style="list-style-type: none"> \$1,000 annual out-of-pocket maximum 		<ul style="list-style-type: none"> Alternative care limited to non-residential programs 	
	<ul style="list-style-type: none"> Limit of 30 days per calendar year³ 		<ul style="list-style-type: none"> Limit of 20 days per calendar year³ 	
	<ul style="list-style-type: none"> Must be precertified prior to admission 		<ul style="list-style-type: none"> Must be precertified prior to admission 	

1 "Unmanaged" means that no precertification is required. However, precertification is required for psychological testing, electroshock therapy, and hypnosis.

2 The limit of 20 visits for outpatient in-network and out-of-network benefits is combined.

3 The limits for inpatient in-network and out-of-network benefits are combined, and are not mutually exclusive.

4 All payments are based on the prevailing charge. You are liable for charges over the prevailing cost when receiving out-of-network services.

CIGNA Behavioral Health Benefits

In-Network Benefits

Before Treatment Takes Place

To access in-network benefits, you can call CIGNA Behavioral Health for network provider referrals before receiving any type of psychiatric or substance abuse treatment. Network referrals also can be obtained from Duke's Personal Assistance Service (PAS).

If you face a life-threatening situation, call your local emergency number or go to a hospital emergency room. Then call CIGNA Behavioral Health within 48 hours or on the next business day. The hospital usually will make this call for you.

1. Before beginning treatment, call CIGNA Behavioral Health at (888) 253-8552 to locate an appropriate provider.
2. Use a CIGNA Behavioral Health authorized provider or you may obtain a referral from PAS.
3. Before beginning inpatient or outpatient treatment that requires a precertification such as psychological testing, electroshock therapy, biofeedback, and hypnosis call CIGNA Behavioral Health at (888) 253-8552.
4. CIGNA Behavioral Health network providers may charge you only the amount of your co-pay and are required to submit the claims for you.

In-Network Benefit Limits

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

- Inpatient treatment programs for psychiatric and/or substance abuse treatment limited to 30 days per calendar year;
- Outpatient treatment limited to 20 unmanaged visits per year, including visits for psychological testing and out-of-network benefits.
- Outpatient medication management visits (CPT 90862) are limited to 12 per calendar year.

In-Network Substance Abuse Treatment

The plan approves a substance abuse rehabilitation and recovery program which:

- Is a CIGNA Behavioral Health-approved substance abuse program with physician supervision;
- Involves individual and group therapy, as well as attendance at meetings of organizations specializing in the therapeutic treatment of alcohol or substance abuse/dependency. The patient must attend these meetings as prescribed in the patient's aftercare treatment plan; and
- Is provided by a CIGNA Behavioral Health-approved facility or provider.

The following types of substance abuse treatment are not covered and benefits won't be paid:

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

Mental Health and Substance Abuse Benefits

Out-of-Network Benefits

Before Treatment Takes Place

To access out-of-network benefits, you can schedule a visit with any eligible provider for any type of psychiatric or substance abuse treatment. (See the section for eligible provider information on page 23.) Referrals also can be obtained from Duke's Personal Assistance Service (PAS).

If you face a life-threatening situation, call your local emergency number or go to a hospital emergency room. Then call CIGNA Behavioral Health within 48 hours or on the next business day. The hospital will usually make this call for you.

1. Before beginning inpatient treatment or outpatient services requiring precertification, call CIGNA Behavioral Health at (888) 253-8552.
2. Use any eligible provider, or you may obtain a referral from PAS.

For Your Information

For Duke Select, Duke Basic, Duke Options, and Blue Care, behavioral health benefits are administered by CIGNA Behavioral Health. The same behavioral health benefits are available whether you are enrolled in the Duke Select, Duke Basic, Duke Options, or Blue Care health care plans. When you need any type of behavioral health care — inpatient or outpatient — you can call a CIGNA Behavioral Health clinical care manager at (888) 253-8552, 24 hours a day, seven days a week. Your clinical care manager will provide assessment, referral, and precertification services. All treatment must be provided by a mental health provider, licensed at the highest level available in North Carolina, and who has malpractice insurance, or at accredited treatment facilities. You also may obtain treatment from licensed mental health providers outside of the CIGNA Behavioral Health network. Please see this section on out-of-network benefits for details.

3. Submit your claim to CIGNA Behavioral Health. Claims for all services for which you are required to pay must be submitted within 180 days from the date services were rendered. Claim submissions beyond the 180 days will not be considered.

Send claims forms to:

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

Claims questions should be directed to:

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

Out-of-Network Benefit Limits

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

- Inpatient treatment programs for psychiatric and/or substance abuse treatment limited to 20 days per calendar year; and
- Outpatient treatment limited to 20 visits per year, including visits for psychological testing.

Out-of-Network Substance Abuse Treatment

The plan approves substance abuse treatment which:

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

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

- Substance abuse detoxification treatments that are not followed by a completed clinically appropriate and CIGNA Behavioral Health-approved program of therapy directed toward rehabilitation; and
- Maintenance care, which provides an environment without access to alcohol or drugs but does not include a rehabilitation component.
- Residential treatment is not covered under out-of-network benefits.

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

- call: (888) 253-8552, or
- log on to: www.hr.duke.edu/benefits/health/mental.html to download claim forms.

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

Medical/Behavioral Health Care Overlap

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

Behavioral Health Providers

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

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

Alternatives to Inpatient Care

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

Claims and Appeals Procedures For CIGNA Behavioral Health

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

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

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

Clinical Appeals Process

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

1

First Step

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

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

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

Response Timeframe:

Varies according to level of appeal. See the following steps.

2

Peer-to-Peer Review

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

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

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

Response Timeframe:

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

3

1st Level Appeal

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

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

Response Timeframe:

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

4

2nd Level Appeal

CIGNA Behavioral Health's Formal Appeals Committee reviews all **2nd level appeals** at your written request only. The Committee reviews for medical necessity and coverage under your benefit

plan. This committee is comprised of medical management, risk management, account management, claims/customer service and your appeals advocate—a CIGNA employee who assures that you have access to all your legal rights of appeal. At this level of appeal, you and your provider have the right to participate by phone in the review process.

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

Response Timeframe:

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

5

For CIGNA Behavioral Health Administrative Appeals

1. Filing the Appeal.

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

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

2. Appeal Process.

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

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

PLEASE NOTE: Neither you nor your representative has the right to be present during the consideration of any appeal from the initial denial.

3. Time Table for Committee's Decisions.

Generally, the Committee will reach its decision within 60 days following receipt of an appeal, but in some cases special circumstances may exist which necessitate extending the time for the appeal decision. If additional time is required, you will be sent a notice before the 60-day period is up, explaining why more time is needed ("extension notice"). In cases where you receive a notice that more time is needed, the decision in most cases will be made within 60 additional days — that is, within a total of 120 days.

Limited Right to Representation

Any action required or permitted to be taken by you regarding the claims process, requests for review of eligibility determinations, or appeals to the Committee may be taken by a representative acting on your behalf. You may be required to provide evidence to verify the authority of any such representative to act on your behalf.

Authority of Committee and Plan Administrator

Both the Committee and the Plan Administrator have the duty and discretionary authority to interpret and construe the provisions of the plan, subject to the terms of the plan and the procedures described on the previous page. Interpretations and determinations made by the Committee and the Plan Administrator will be applied consistently to all members similarly situated (with due regard for individual differences in circumstances) and will be binding and conclusive upon each member and any other interested person. Such interpretations and determinations made by the Committee or the Plan Administrator will be overruled only by a court of law if the Committee or the Plan Administrator, as the case may be, is found to have acted arbitrarily and capriciously in interpreting and construing the provisions of the plan.

Services That Are Not Covered

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

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

Mental Health and Substance Abuse Benefits

It is intended that the Duke Health Care Programs qualify as “accident and health plans” and as “self-insured medical expense reimbursement plans” under the federal tax laws. This Benefit Program Description, which is a part of the Duke University Welfare and Fringe Benefit Plan along with the applicable Member Guides, shall constitute the written plan document for the Duke Health Care Programs. It is further intended that benefits payable under the Duke Health Care Programs be eligible for exclusion from gross income. Duke reserves the right to amend or terminate these benefits or your eligibility for benefits (including an amendment to reduce benefits or eliminate benefits or any changes to the premium or contribution rates) for all participants or for a specific class of participants, including current or former employees, under the Duke Health Care Programs. The written plan documents for the Duke Health Care Programs are not employment contracts or any type of employment guarantee.

Notes

Notes