

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.