Benefits Open Enrollment for 2026

Required Notices

This booklet contains the required notices listed below.

- Summary of Benefits and Coverage
- Designation of Primary Care Provider
- Newborns' and Mothers' Health Protection Act
- Women's Health and Cancer Rights Act
- Notice of Creditable Coverage
- HIPAA Special Enrollment Rights Notice
- Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)
- Notice of Privacy Practices
- Notice of Nondiscrimination
- Language Assistance Services

Duke University
Office of Human Resources
705 Broad Street, P.O. Box 90502, Durham, NC 27708
1-919-684-5600

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Women's Health and Cancer Rights Act

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Premium Assistance Under Medicaid and
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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $0 For mental health and substance abuse out-of-network providers: $650 individual/$1,950 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	Yes; $100 per person for retail brand prescription drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in-network providers: $3,000/individual or $6,000/family For mental health and substance abuse out-of-network providers: $6,000/individual or $12,000/family Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, Infertility treatment and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-440-DUKE (3853) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a Specialist?	No.	You can see the Specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	Not covered	Medically Necessary
	Specialist visit	$55 copay/visit	Not covered	Chiropractic care $55 copay/visit. Medically Necessary
	Preventive care/ screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge/x-ray No charge/blood work No charge/independent lab	Not covered	Medically Necessary
	Imaging (CT/PET scans, MRIs)	$150 copay per day Deductible does not apply	Not covered	Medically Necessary
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs (Tier 1)	$15 copay/prescription (retail up to 34 day supply), $25 copay/prescription (home delivery up to 90 day supply)	Your reimbursement will be the contracted rate less the copay. You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications 50% coinsurance with $15 or cost minimum and $30 maximum. Step therapy and/or pre-authorization may apply.
	Preferred brand drugs (Tier 2)	$50 copay/prescription after $100 deductible (retail up to 34 day supply), $130 copay/prescription (home delivery up to 90 day supply)	Your reimbursement will be the contracted rate less the copay. You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications 50% coinsurance with $70 minimum and $165 maximum. No deductible for Duke pharmacies for 90 day supply. Step therapy and/or pre-authorization may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand drugs (Tier 3)	$70 copay/prescription after $100 deductible (retail up to 34 day supply), $180 copay/prescription (home delivery up to 90 day supply)	Your reimbursement will be the contracted rate less the copay. You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications 50% coinsurance with $85 minimum and $180 maximum. No deductible for Duke pharmacies for 90 day supply. Step therapy and/or pre-authorization may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/visit	Not covered	Per visit copay is waived for non-surgical procedures.
	Physician/surgeon fees	No charge	Not covered	Medically Necessary
If you need immediate medical attention	Emergency room care	$250 copay/visit	$250 copay/visit	Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share.
	Emergency medical transportation	No charge	No charge	Out-of-network air ambulance services are paid at the in-network cost share. Services for MH/SA diagnoses will be payable according to Emergency room care benefits. Medically Necessary
	Urgent care	$35 copay/visit	$35 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$600 copay/admission	Not covered	Precertification required. WakeMed considered participating only for obstetrics, rehabilitation and most pediatric admissions.
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit No charge/all other services	30% coinsurance after deductible/office visit 30% coinsurance after deductible/all other services	Up to 20 visits per calendar year out of network for non-par providers, combined with substance use disorder.
	Inpatient services	$600 copay/admission	$900 deductible/admission, plus 30% coinsurance after deductible	Precertification required. Up to 20 days per calendar year for out of network non-par providers, combined with substance use disorder.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge $20 copay/PCP first visit $55 copay/ Specialist first visit	Not covered	Primary care or Specialist benefit levels apply for initial visit ($20 copay Primary care or $55 copay Specialist) to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$600 copay/admission	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Coverage is limited to 100 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	$20 copay/PCP visit	Not covered	Coverage is limited to annual max of: Unlimited days for Pulmonary rehab; Unlimited days for Chiropractic care services; 40 days for Cognitive therapy, Physical and Occupational therapies; 20 days for Speech therapy Medically Necessary Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	$20 copay/PCP visit	Not covered	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	No charge	Not covered	Coverage is limited to 60 days annual max. Precertification required
	Durable medical equipment	10% coinsurance after deductible	Not covered	Medically Necessary
	Hospice services	No charge/inpatient services No charge/outpatient services	Not covered	Must be authorized by doctor
If your child needs dental or eye care	Children's eye exam	$55 copay/visit	Not covered	Limited to one routine eye exam per calendar year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery - $2,500 copay only at Duke facilities for employees with two years of service; preauthorization required
- Chiropractic care
- Eye Care (Children)
- Routine eye care (Adult)
- Hearing aids (2 devices per 36 months, through age 22)
- Infertility treatment - Only at Duke Medical Center for employees with two years of service. Precertification required. Various limits on coverage apply. Infertility treatment does not count towards the plan's out of pocket maximum.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Cigna at 1-800-Cigna24, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: North Carolina Department of Insurance at (855) 408-1212.

Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$55
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$620

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$55
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$940

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$55
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$500

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: Duke Select **Ben Ver:** 33 **Plan ID:** 37355383

Discrimination is against the law.

Medical coverage

Cigna Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna Healthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna Healthcare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats) |

- Provides free language services to people whose primary language is not English, such as:
  - Qualified Interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to **ACAGrievance@Cigna.com** or by writing to the following address:

Cigna Healthcare
Nondiscrimination Complaint Coordinator
P.O. Box I88016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to **ACAGrievance@Cigna.com**. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.**or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F. HHH Building Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at
https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna Healthcare customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna Healthcare, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY debena llamar al 711).a

Chinese – 注意：我們可爲您免費提供語言協助服務。對於 Cigna Healthcare 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna Healthcare, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna Healthcare 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.a

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna Healthcare, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna Healthcare, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباة خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna Healthcare الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية.
او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna Healthcare yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna Healthcare, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna Healthcare atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna Healthcare mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCigna Healthcareのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna Healthcare attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna Healthcare-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می شود. برای مشتریان فعلی Cigna Healthcare، لطفاً با شماره‌ای که در پشت کارت شناسایی شما است تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شمار ه‌گیری کنید).

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $600/individual or $1,800/family For mental health and substance abuse out-of-network providers: $650 individual/$1,950 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations, office visits, diagnostic test, emergency room visits, urgent care facility visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes; $100 per person for retail brand prescription drugs.	You must pay all of these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in-network providers: $3,000/individual or $6,000/family For mental health and substance abuse out-of-network providers: $6,000/individual or $12,000/family Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-440-DUKE (3853) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a Specialist?	No.	You can see the Specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit Deductible does not apply	Not covered	Medically Necessary
	Specialist visit	$75 copay/visit Deductible does not apply	Not covered	Chiropractic care $75 copay/visit Medically Necessary
	Preventive care/ screening/ immunization	No charge Deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible/x-ray 10% coinsurance after deductible/blood work No charge/independent lab** **Deductible does not apply	Not covered	Medically Necessary
	Imaging (CT/PET scans, MRIs)	$150 copay per day	Not covered	Medically Necessary

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs (Tier 1)	$15 copay/prescription after $100 deductible (retail up to 34 day supply), $25 copay/prescription after $100 deductible (home delivery up to 90 day supply)	Your reimbursement will be the contracted rate less the copay. You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications the mail order program or Duke pharmacies must be used for coverage. Step therapy and/or pre-authorizationmay apply.
	Preferred brand drugs (Tier 2)	$50 copay/prescription after $100 deductible (retail up to 34 day supply), $130 copay/prescription after $100 deductible (home delivery up to 90 day supply)	Your reimbursement will be the contracted rate less the copay. You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications the mail order program or Duke pharmacies must be used for coverage. Step therapy and/or pre-authorizationmay apply.
	Non-preferred brand drugs (Tier 3)	$70 copay/prescription after $100 deductible (retail up to 34 day supply), $180 copay/prescription after $100 deductible (home delivery up to 90 day supply)	Your reimbursement will be the contracted rate less the copay. You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications the mail order program or Duke pharmacies must be used for coverage. Step therapy and/or pre-authorizationmay apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	Not covered	Medically Necessary
	Physician/surgeon fees	10% coinsurance after deductible	Not covered	Medically Necessary
If you need immediate medical attention	Emergency room care	$250 copay/visit Deductible does not apply	$250 copay/visit Deductible does not apply	Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share. Medically Necessary
	Emergency medical transportation	$250 per day Deductible does not apply	$250 per day Deductible does not apply	Out-of-network air ambulance services are paid at the in-network cost share and deductible. Services for MH/SA diagnoses will be payable according to Emergency room care benefits. Medically Necessary

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	$50 copay/visit Deductible does not apply	$50 copay/visit Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	Not covered	Precertification required. WakeMed considered participating only for obstetrics, rehabilitation and most pediatric admissions.
	Physician/surgeon fees	10% coinsurance after deductible	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit** 10% coinsurance/all other services** **Deductible does not apply	30% coinsurance after deductible/office visit 30% coinsurance after deductible/all other services	Up to 20 visits per calendar year for non-par providers, combined with substance use disorder. Includes medical services for MH/SA diagnoses.
	Inpatient services	10% coinsurance after deductible	$900 deductible/admission, plus 30% coinsurance after deductible	Precertification required. Up to 20 days per calendar year for non-par providers, combined with substance use disorder. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	No charge $25 copay/PCP first visit $75 copay/Specialist first visit	Not covered	Primary care or Specialist benefit levels apply for initial visit ($25 copay Primary care or $75 copay Specialist) to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	10% coinsurance after deductible	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$25 copay/visit** **Deductible does not apply	Not covered	Coverage is limited to 100 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	$75 copay/ Specialist visit** **Deductible does not apply	Not covered	Coverage is limited to annual max of: Unlimited days for Pulmonary rehab; 40 days for Cognitive therapy, Chiropractic care services, Physical and Occupational therapies; 20 days for Speech therapy Medically Necessary Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	$75 copay/ Specialist visit** **Deductible does not apply	Not covered	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	No charge	Not covered	Coverage is limited to 60 days annual max.
	Durable medical equipment	20% coinsurance after deductible	Not covered	Medically Necessary
	Hospice services	No charge/inpatient services No charge/outpatient services	Not covered	Must be authorized by doctor
If your child needs dental or eye care	Children's eye exam	$55 copay/visit	Not covered	Limited to one routine eye exam per calendar year
	Children's glasses	Not covered	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care (combined with Rehabilitation Services)
- Hearing aids (2 devices per 36 months, through age 22)
- Routine eye care (Adult)
- Eye care (Children)
- Infertility treatment - Diagnosis only. Patient copays apply. COH, IVF, and other types of artificial conception are excluded.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Cigna at 1-800-Cigna24, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: North Carolina Department of Insurance at (855) 408-1212.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$600**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$40
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$1,560

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$600**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$1,040

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$600**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$900

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: Duke Basic **Ben Ver:** 33 **Plan ID:** 37372130

Discrimination is against the law.

Medical coverage

Cigna Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna Healthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna Healthcare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats) |

- Provides free language services to people whose primary language is not English, such as:
  - Qualified Interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to **ACAGrievance@Cigna.com** or by writing to the following address:

Cigna Healthcare
Nondiscrimination Complaint Coordinator
P.O. Box I88016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to **ACAGrievance@Cigna.com**. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.**or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F. HHH Building Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at
https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna Healthcare customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna Healthcare, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY debena llamar al 711).a

Chinese – 注意：我們可爲您免費提供語言協助服務。對於 Cigna Healthcare 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna Healthcare, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna Healthcare 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.a

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna Healthcare, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna Healthcare, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباة خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna Healthcare الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية.
او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna Healthcare yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna Healthcare, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna Healthcare atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna Healthcare mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCigna Healthcareのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna Healthcare attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna Healthcare-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می شود. برای مشتریان فعلی Cigna Healthcare، لطفاً با شماره‌ای که در پشت کارت شناسایی شما است تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شمار ه‌گیری کنید).

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $130/individual or $390/family For out-of-network providers: $650/individual or $1,950/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations, office visits, emergency room visits, urgent care facility visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes; $100 per person for retail brand prescription drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in-network providers: $3,000/individual or $6,000/family For out-of-network providers: $6,000/individual or $12,000/family Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, Infertility treatment and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-440 DUKE (3853) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a Specialist?	No.	You can see the Specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit Deductible does not apply	30% coinsurance after deductible	Medically necessary
	Specialist visit	$55 copay/visit Deductible does not apply	30% coinsurance after deductible	Chiropractic care $55 copay/visit. Medically Necessary
	Preventive care/ screening/ immunization	No charge Deductible does not apply	30% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	30% coinsurance after deductible	Medically Necessary
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	30% coinsurance after deductible	Medically Necessary
If you need drugs to treat your illness or condition More information about prescription drug coverage	Generic drugs (Tier 1)	$15 copay/prescription (retail up to 34 day supply), $25 copay/prescription (home delivery up to 90 day supply)	Your reimbursement will be the contracted rate less the copay. You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications 50% coinsurance with $15 or cost minimum and $30 maximum. Step therapy and/or pre-authorization may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
is available at www.express-scripts.com	Preferred brand drugs (Tier 2)	$50 copay/prescription after $100 deductible (retail up to 34 day supply), $130 copay/prescription (home delivery up to 90 day supply)	Your reimbursement will be the contracted rate less the copay. You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications 50% coinsurance with $70 minimum and $165 maximum. No deductible for Duke pharmacies. Step therapy and/or pre-authorization may apply.
	Non-preferred brand drugs (Tier 3)	$70 copay/prescription after $100 deductible (retail up to 34 day supply), $180 copay/prescription (home delivery up to 90 day supply)	Your reimbursement will be the contracted rate less the copay. You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications 50% coinsurance with $85 minimum and $180 maximum. No deductible for Duke pharmacies. Step therapy and/or pre-authorization may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	30% coinsurance after deductible	Medically Necessary
	Physician/surgeon fees	10% coinsurance after deductible	30% coinsurance after deductible	Medically Necessary
If you need immediate medical attention	Emergency room care	$250 copay/visit Deductible does not apply	$250 copay/visit Deductible does not apply	Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share.
	Emergency medical transportation	$250 deductible per day Deductible does not apply	$250 deductible per day Deductible does not apply	Out-of-network air ambulance services are paid at the in-network cost share and deductible. Services for MH/SA diagnoses will be payable according to Emergency room care benefits. Medically Necessary
	Urgent care	$35 copay/visit Deductible does not apply	$35 copay/visit Deductible does not apply	Medically Necessary

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Duke Facility $600 copay/admission, plus 10% coinsurance after deductible Non-Duke Facility $700 copay/admission, plus 10% coinsurance after deductible	$900 deductible/admission, plus 30% coinsurance after deductible	100% penalty for no out-of-network precertification.
	Physician/surgeon fees	10% coinsurance after deductible	30% coinsurance after deductible	100% penalty for no out-of-network precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit** 10% coinsurance/all other services** **Deductible does not apply	30% coinsurance after deductible/office visit 30% coinsurance after deductible/all other services	100% penalty if no precert of out-of-network non-routine services. Includes medical services for MH/SA diagnoses.
	Inpatient services	Duke Facility $600 copay/admission, plus 10% coinsurance after deductible Non-Duke Facility $700 copay/admission, plus 10% coinsurance after deductible	$900 deductible/admission, plus 30% coinsurance after deductible	100% penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	10% coinsurance after deductible $20 copay/PCP first visit $55 copay/Specialist first visit	30% coinsurance after deductible	Primary care or Specialist benefit levels apply for initial visit ($20 copay Primary care or $55 copay Specialist) to confirm pregnancy. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	10% coinsurance after deductible	30% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	Duke Facility $600 copay/admission, plus 10% coinsurance after deductible Non-Duke Facility $700 copay/admission, plus 10% coinsurance after deductible	$900 deductible/admission, plus 30% coinsurance after deductible	Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	30% coinsurance after deductible	Coverage is limited to 100 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	$55 copay/ Specialist visit** **Deductible does not apply	30% coinsurance/Specialist visit after deductible	Coverage is limited to annual max of: Unlimited days for Pulmonary rehab; 40 days Cognitive therapy, Chiropractic care services, Physical and Occupational therapies; 20 days for Speech therapy Medically Necessary Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	$55 copay/ Specialist visit** **Deductible does not apply	30% coinsurance/Specialist visit after deductible	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	$250 copay/admission, plus 10% coinsurance after deductible	$250 deductible/admission, plus 30% coinsurance after deductible	100% penalty for no out-of-network precertification. Coverage is limited to 60 days annual max.
	Durable medical equipment	10% coinsurance after deductible	30% coinsurance after deductible	Medically Necessary
	Hospice services	10% coinsurance after deductible/inpatient services 10% coinsurance after deductible/outpatient services	30% coinsurance after deductible/inpatient services 30% coinsurance after deductible/outpatient services	100% penalty for failure to precertify out-of-network inpatient hospice services.
If your child needs dental or eye care	Children's eye exam	$55 copay/visit	Not covered	Limited to one routine eye exam per calendar year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery (in-network only) - $2,500 copay. Two years of service and prior authorization required. North Carolina residents must use a Duke facility.
- Chiropractic care (combined Rehabilitation Services)
- Hearing aids (in-network only/2 devices per 36 months, through age 22)
- Routine eye care (Adult)
- Eye care (Children)
- Infertility treatment (in-network only) - Two years of service and prior authorization required. Various limits on coverage apply. North Carolina residents must use a Duke facility. Infertility treatment does not count towards the plan's out of pocket maximum.

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Cigna at 1-800-Cigna24, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: North Carolina Department of Insurance at (855) 408-1212.

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$130**
- **Specialist copayment** **$55**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$130
Copayments	$600
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$1,950

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$130**
- **Specialist copayment** **$55**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$1,060

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$130**
- **Specialist copayment** **$55**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$800

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: Duke Options **Ben Ver:** 33 **Plan ID:** 37367489

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $0 For mental health and substance abuse out-of-network providers: $650 individual/$1,950 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	Yes; $100 per person for retail brand prescription drugs.	You must pay all of these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in-network providers: $3,000/individual or $6,000/family For mental health and substance abuse out-of-network providers: $6,000/individual or $12,000/family Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-440-DUKE (3853) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a Specialist?	No.	You can see the Specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	Not covered	Medically Necessary
	Specialist visit	$55 copay/visit	Not covered	Medically Necessary
	Preventive care/ screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Medically Necessary
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Medically Necessary
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs (Tier 1)	$15 copay/prescription (retail up to 34 day supply), $25 copay/prescription (home delivery up to 90 day supply)	Your reimbursement will be the contracted rate less the copay. You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications 50% coinsurance with $15 or cost minimum and $30 maximum. Step therapy and/or pre-authorization may apply.
	Preferred brand drugs (Tier 2)	$50 copay/prescription after $100 deductible (retail up to 34 day supply), $130 copay/prescription (home delivery up to 90 day supply)	Your reimbursement will be the contracted rate less the copay. You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications 50% coinsurance with $70 minimum and $165 maximum. No deductible for Duke pharmacies for 90 day supply. Step therapy and/or pre-authorization may apply.
	Non-preferred brand drugs (Tier 3)	$70 copay/prescription after $100 deductible (retail up to 34 day supply), $180 copay/prescription (home delivery up to 90 day supply)	Your reimbursement will be the contracted rate less the copay. You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications 50% coinsurance with $85 minimum and $180 maximum. No deductible for Duke pharmacies for 90 day supply. Step therapy and/or pre-authorization may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/visit	Not covered	Per visit copay is waived for non-surgical procedures.
	Physician/surgeon fees	No charge	Not covered	Medically Necessary

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$250 copay/visit	$250 copay/visit	Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share. Medically Necessary
	Emergency medical transportation	No charge	No charge	Out-of-network air ambulance services are paid at the in-network cost share. Services for MH/SA diagnoses will be payable according to Emergency room care benefits. Medically Necessary
	Urgent care	$35 copay/visit	$35 copay/visit	Medically Necessary
If you have a hospital stay	Facility fee (e.g., hospital room)	Duke Facility $600 copay/admission Non-Duke Facility $700 copay/admission	Not covered	Precertification required.
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit No charge/all other services	30% coinsurance after deductible/office visit 30% coinsurance after deductible/all other services	Up to 20 visits per calendar year for out of network non-Duke providers, combined with substance use disorder.
	Inpatient services	$600 copay/admission	$900 deductible/admission, plus 30% coinsurance after deductible	Precertification required. Up to 20 days per calendar year for out of network non-par providers, combined with substance use disorder.
If you are pregnant	Office visits	No charge $20 copay/PCP first visit $55 copay/Specialist first visit	Not covered	Primary care or Specialist benefit levels apply for initial visit ($20 copay Primary care or $55 copay Specialist) to confirm pregnancy. Cost sharing does not apply for
	Childbirth/delivery professional services	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	Duke Facility $600 copay/admission Non-Duke Facility $700 copay/admission	Not covered	preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Must be authorized by doctor. Coverage is limited to 100 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	$55 copay/ Specialist visit	Not covered	Coverage is limited to annual max of: Unlimited days for Pulmonary rehab; Unlimited days for Chiropractic care services; 40 days for Cognitive therapy, Physical and Occupational therapies; 20 days for Speech therapy Medically Necessary Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	$55 copay/ Specialist visit	Not covered	Combined with Rehabilitation visits above. Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	No charge	Not covered	Coverage is limited to 60 days annual max. Precertification required
	Durable medical equipment	No charge	Not covered	Medically Necessary
	Hospice services	No charge/inpatient services No charge/outpatient services	Not covered	Must be authorized by doctor
If your child needs dental or eye care	Children's eye exam	$55 copay/visit	Not covered	Limited to one routine eye exam per calendar year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery - $2,500 copay only at Duke facilities for employees with two years of service; preauthorization required.
- Chiropractic care (combined with Rehabilitation Services)
- Infertility treatment - Diagnosis only. Patient copays apply. COH, IVF, and other types of artificial conception are excluded.
- Routine eye care (Adult)
- Eye care (Children)
- Hearing aids (2 devices per 36 months, through age 22)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Cigna at 1-800-Cigna24, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: North Carolina Department of Insurance at (855) 408-1212.

Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$55
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$620

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$55
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$940

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$55
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$500

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: Cigna Care Plan **Ben Ver:** 33 **Plan ID:** 37372558

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $2,000/individual or $6,000/family For out-of-network providers: $6,000/individual or $12,000/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations, office visits, emergency room visits, urgent care facility visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes; $100 per person for retail brand prescription drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in-network providers: $6,800/individual or $13,600/family For out-of-network providers: $13,600/individual or $27,200/family Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-440-DUKE (3853) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a Specialist?	No.	You can see the Specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit Deductible does not apply	40% coinsurance after deductible	Medically Necessary
	Specialist visit	$55 copay/visit Deductible does not apply	40% coinsurance after deductible	Medically Necessary
	Preventive care/ screening/ immunization	No charge Deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	Medically Necessary
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	Medically Necessary
If you need drugs to treat your illness or condition More information about prescription drug coverage	Generic drugs (Tier 1)	$15 copay/prescription (retail up to 34 day supply), $25 copay/prescription (home delivery up to 90 days)	Your reimbursement will be the contracted rate less the copay. You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications 50% coinsurance with $15 or cost minimum and $30 maximum. Step therapy and/or pre-authorization may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
is available at www.express-scripts.com	Preferred brand drugs (Tier 2)	$50 copay/prescription after $100 deductible (retail up to 34 day supply), $130 copay/prescription (home delivery up to 90 day supply)	Your reimbursement will be the contracted rate less the copay. You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications 50% coinsurance with $70 minimum and $165 maximum. No deductible for Duke pharmacies. Step therapy and/or pre-authorization may apply.
	Non-preferred brand drugs (Tier 3)	$70 copay/prescription after $100 deductible (retail up to 34 day supply), $180 copay/prescription (home delivery up to 90 day supply)	Your reimbursement will be the contracted rate less the copay. You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications 50% coinsurance with $85 minimum and $180 maximum. No deductible for Duke pharmacies. Step therapy and/or pre-authorization may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	Medically Necessary
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	Medically Necessary
If you need immediate medical attention	Emergency room care	$250 copay/visit Deductible does not apply	$250 copay/visit Deductible does not apply	Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share. Medically Necessary
	Emergency medical transportation	$250 per day deductible	$250 per day deductible	Out-of-network air ambulance services are paid at the in-network cost share and deductible. Services for MH/SA diagnoses will be payable according to Emergency room care benefits.
	Urgent care	$50 copay/visit Deductible does not apply	$50 copay/visit Deductible does not apply	Medically Necessary

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Duke Facility $600 copay/admission, plus 20% coinsurance after deductible Non-Duke Facility $700 copay/admission, plus 20% coinsurance after deductible	$900 deductible/admission, plus 40% coinsurance after deductible	100% penalty for no out-of-network precertification.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	100% penalty for no out-of-network precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit** 20% coinsurance/all other services** **Deductible does not apply	40% coinsurance after deductible/office visit 40% coinsurance after deductible/all other services	100% penalty if no precert of out-of-network non-routine services. Includes medical services for MH/SA diagnoses.
	Inpatient services	Duke Facility $600 copay/admission, plus 20% coinsurance after deductible Non-Duke Facility $700 copay/admission, plus 20% coinsurance after deductible	$900 deductible/admission, plus 40% coinsurance after deductible	100% penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	20% coinsurance after deductible $25 copay/PCP first visit $75 copay/Specialist first visit	40% coinsurance after deductible	Primary care or Specialist benefit levels apply for initial visit ($25 copay Primary care or $75 copay Specialist) to confirm pregnancy. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	Duke Facility $600 copay/admission, plus 20% coinsurance after deductible Non-Duke Facility $700 copay/admission, plus 20% coinsurance after deductible	$900 deductible/admission, plus 40% coinsurance after deductible	Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Coverage is limited to 100 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	$55 copay/ Specialist visit** **Deductible does not apply	40% coinsurance after deductible/Specialist visit	Coverage is limited to annual max of: 40 days for Pulmonary rehab, Cognitive therapy and Chiropractic care services; 40 days for Physical and Occupational therapies; 20 days for Speech therapy Medically Necessary Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	$55 copay/ Specialist visit** **Deductible does not apply	40% coinsurance after deductible/Specialist visit	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	$250 copay/admission, plus 20% coinsurance after deductible	$250 deductible/admission, plus 40% coinsurance after deductible	100% penalty for no out-of-network precertification. Coverage is limited to 60 days annual max.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	Medically Necessary
	Hospice services	20% coinsurance after deductible/inpatient services 20% coinsurance after deductible/outpatient services	40% coinsurance after deductible/inpatient services 40% coinsurance after deductible/outpatient services	100% penalty for failure to precertify out-of-network inpatient hospice services.
If your child needs dental or eye care	Children's eye exam	$55 copay/visit	Not covered	Limited to one routine eye exam per calendar year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care (combined with Rehabilitation Services)
- Hearing aids (2 devices per 36 months, through age 22)
- Routine eye care (Adult)
- Eye care (Children)
- Infertility treatment – Diagnosis only. Patient copay applies. COH, IVF, and other types of artificial conception are excluded.

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Cigna at 1-800-Cigna24, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: North Carolina Department of Insurance at (855) 408-1212.

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist copayment	$55
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$600
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$4,620

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist copayment	$55
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$1,060

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist copayment	$55
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$980
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,480

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: Duke USA PPO **Ben Ver:** 33 **Plan ID:** 37345349

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Nondiscrimination Complaint Coordinator
P.O. Box I88016
Chattanooga, TN 37422

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U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F. HHH Building Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at
https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

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Room 509F. HHH Building Washington, DC 20201
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Cigna Healthcare
Nondiscrimination Complaint Coordinator
P.O. Box I88016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to **ACAGrievance@Cigna.com**. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.**or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F. HHH Building Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at
https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna Healthcare customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna Healthcare, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY debena llamar al 711).a

Chinese – 注意：我們可爲您免費提供語言協助服務。對於 Cigna Healthcare 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna Healthcare, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna Healthcare 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.a

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Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna Healthcare, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباة خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna Healthcare الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية.
او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna Healthcare yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna Healthcare, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna Healthcare atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna Healthcare mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCigna Healthcareのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna Healthcare attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna Healthcare-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می شود. برای مشتریان فعلی Cigna Healthcare، لطفاً با شماره‌ای که در پشت کارت شناسایی شما است تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شمار ه‌گیری کنید).

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $3,000/individual - employee only or $6,000/family maximum For out-of-network providers: $6,000/individual - employee only or $12,000/family maximum Combined medical/behavioral and pharmacy deductible Deductible per individual applies when the employee is the only individual covered under the plan.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: $7,500/individual - employee only or $15,000/family maximum (no more than $7,500 per individual - within a family) For out-of-network providers: $15,000/individual - employee only or $30,000/family maximum (no more than $15,000 per individual - within a family) Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-440-DUKE (3853) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a Specialist?	No.	You can see the Specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	25% coinsurance after deductible/visit	45% coinsurance after deductible	Medically Necessary
	Specialist visit	25% coinsurance after deductible/visit	45% coinsurance after deductible	Medically Necessary
	Preventive care/ screening/ immunization	No charge Deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance after deductible	45% coinsurance after deductible	Medically Necessary
	Imaging (CT/PET scans, MRIs)	25% coinsurance after deductible	45% coinsurance after deductible	Medically Necessary

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs (Tier 1)	25% coinsurance after deductible/prescription (retail up to 34 day supply), 25% coinsurance after deductible/prescription (home delivery up to 90 day supply)	25% coinsurance after deductible/prescription (retail up to 34 day supply), 25% coinsurance after deductible/prescription (home delivery up to 90 day supply)	After 3rd retail fill of maintenance medication, member must fill at Duke pharmacies or home delivery or a penalty will be applied. Step therapy and/or pre-authorization may apply.
	Preferred brand drugs (Tier 2)	25% coinsurance after deductible/prescription (retail up to 34 day supply), 25% coinsurance after deductible/prescription (home delivery up to 90 day supply)	25% coinsurance after deductible/prescription (retail up to 34 day supply), 25% coinsurance after deductible/prescription (home delivery up to 90 day supply)	After 3rd retail fill of maintenance medication, member must fill at Duke pharmacies or home delivery or a penalty will be applied. Step therapy and/or pre-authorization may apply.
	Non-preferred brand drugs (Tier 3)	25% coinsurance after deductible/prescription (retail up to 34 day supply), 25% coinsurance after deductible/prescription (home delivery up to 90 day supply)	25% coinsurance after deductible/prescription (retail up to 34 day supply), 25% coinsurance after deductible/prescription (home delivery up to 90 day supply)	After 3rd retail fill of maintenance medication, member must fill at Duke pharmacies or home delivery or a penalty will be applied. Step therapy and/or pre-authorization may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance after deductible	45% coinsurance after deductible	Medically Necessary
	Physician/surgeon fees	25% coinsurance after deductible	45% coinsurance after deductible	Medically Necessary
If you need immediate medical attention	Emergency room care	25% coinsurance after deductible	25% coinsurance after deductible	Out-of-network services are paid at the in-network cost share and deductible. Medically Necessary

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	25% coinsurance after deductible	25% coinsurance after deductible	Out-of-network air ambulance services are paid at the in-network cost share and deductible. Medically Necessary
	Urgent care	25% coinsurance after deductible	25% coinsurance after deductible	Medically Necessary
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance after deductible	45% coinsurance after deductible	100% penalty for no out-of-network precertification.
	Physician/surgeon fees	25% coinsurance after deductible	45% coinsurance after deductible	100% penalty for no out-of-network precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance/office visit after deductible 25% coinsurance/all other services after deductible	45% coinsurance/office visit after deductible 45% coinsurance/all other services after deductible	100% penalty if no precert of out-of-network non-routine services. Includes medical services for MH/SA diagnoses.
	Inpatient services	25% coinsurance after deductible	45% coinsurance after deductible	100% penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	25% coinsurance after deductible	45% coinsurance after deductible	Primary care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	25% coinsurance after deductible	45% coinsurance after deductible	
	Childbirth/delivery facility services	25% coinsurance after deductible	45% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	25% coinsurance after deductible	45% coinsurance after deductible	Coverage is limited to 100 days annual max combined for In-network and Out-of-Network services. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	25% coinsurance after deductible/PCP visit 25% coinsurance after deductible/ Specialist visit	45% coinsurance after deductible/PCP visit 45% coinsurance after deductible/ Specialist visit	Coverage is limited to annual max of: Unlimited days for Pulmonary rehab; 40 days for Chiropractic care services, Physical and Occupational therapies; 20 days for Speech therapy combined for In-network and Out-of-Network services. Medically Necessary Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	25% coinsurance after deductible/PCP visit 25% coinsurance after deductible/ Specialist visit	45% coinsurance after deductible/PCP visit 45% coinsurance after deductible/ Specialist visit	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	25% coinsurance after deductible	45% coinsurance after deductible	100% penalty for no out-of-network precertification. Coverage is limited to 60 days annual max.
	Durable medical equipment	25% coinsurance after deductible	45% coinsurance after deductible	Medically Necessary

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	25% coinsurance after deductible/inpatient services 25% coinsurance after deductible/outpatient services	45% coinsurance after deductible/inpatient services 45% coinsurance after deductible/outpatient services	100% penalty for failure to precertify out-of-network inpatient hospice services.
If your child needs dental or eye care	Children's eye exam	25% coinsurance after deductible	Not covered	Limited to one exam per calendar year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care (combined with Rehabilitation Services)
- Eye care (Children)
- Hearing aids (2 devices per 36 months, through age 22)
- Routine eye care (Adult)
- Infertility treatment – Diagnosis only. Patient coinsurance applies. COH, IVF, and other types of artificial conception are excluded.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Cigna at 1-800-Cigna24, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: North Carolina Department of Insurance at (855) 408-1212.

Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,000
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost **$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$5,430

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,000
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost **$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,240
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$1,880

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,000
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost **$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,800

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: Duke Advantage HDHPQ **Ben Ver:** 33 **Plan ID:** 37353574

Discrimination is against the law.

Medical coverage

Cigna Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna Healthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna Healthcare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats) |

- Provides free language services to people whose primary language is not English, such as:
  - Qualified Interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

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U.S. Department of Health and Human Services
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Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna Healthcare, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna Healthcare 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.a

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna Healthcare, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna Healthcare, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباة خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna Healthcare الحاليين برجاء الاتصال بالرقم المهون علي ظهر بطاقتكم الشخصية.
او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna Healthcare yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna Healthcare, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna Healthcare atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna Healthcare mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCigna Healthcareのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Perai clienti Cigna Healthcare attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna Healthcare-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می شود. برای مشتریان فعلی Cigna Healthcare، لطفاً با شماره‌ای که در پشت کارت شناسایی شما است تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شمار هگیری کنید).

Other Required Notices

1. Designation of Primary Care Provider
2. Newborns' and Mothers' Health Protection Act
3. Women's Health and Cancer Rights Act
4. Notice of Creditable Coverage
5. HIPAA Special Enrollment Rights
6. Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
7. Notice of Privacy Practices
8. Notice of Nondiscrimination
9. Language Assistance Services

1. Designation of Primary Care Provider

You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Duke Human Resources at 1-919-684-5600. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Duke Health Plans or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Duke Human Resources at 1-919-684-5600.

2. 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..

3. Women's Health and Cancer Rights Act

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

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the nondiseased breastto produce a symmetrical appearance without regardto the lapse of time between the mastectomy and thereconstructive surgery
- Prostheses and treatment of physical complications of allstages of the mastectomy, including lymphedemas.

The benefits described above are subject to the same deductibles co-payments, coinsurance and limitations applicable to other medical and surgical benefits provided by Duke Health Plans. If you would like more information on WHCRA benefits, call Duke Human Resources at (919) 684-5600.

4. Notice of Creditable Coverage from the Centers for Medicare and Medicaid Services

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Duke University and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage::

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Duke University has determined that the prescription drug coverage offered by Duke Plus is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Duke University coverage will be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will not still be eligible to receive all of your current health and prescription drug benefits. If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may not enroll back into the Duke Plus benefit plan during an open enrollment period.

If you do decide to join a Medicare drug plan and drop your current Duke University coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Duke University and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact our office for further information at 1-919-684-5600. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Duke University changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit **medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

5. HIPAA Special Enrollment Rights

If you decline Duke University's medical plan coverage for yourself or your dependents (including your spouse) because you have other medical coverage, you may be able to enroll yourself or your dependents in a Duke University medical plan if you or your dependents lose eligibility for the other coverage, or if the employer stops contributing to the other coverage.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be eligible to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights may also exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends, or
- If you or your dependents become eligible for state premium assistance subsidy through Medicaid or state CHIP with respect to coverage under the plan and you request enrollment within 60 days after the determination of eligibility of such assistance.

If you have any questions, please contact Duke Human Resources at 919-684-5600.

6. Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer

plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility .

ALABAMA – Medicaid
myalhipp.com
1-855-692-5447

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

ARKANSAS – Medicaid
myarhipp.com
1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
dhcs.ca.gov/hipp
916-445-8322
Fax: 916-440-5676
hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado
healthfirstcolorado.com
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: **hcpf.colorado.gov/child-health-plan-plus**
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI):
mycohibi.com
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
flmedicaidtplrecovery.comflmedicaidtplrecover y.comhipp/ index.html
1-877-357-3268

GEORGIA – Medicaid
GA HIPP: **medicaid.georgia.gov/health- insurance-premium-payment-program-hipp**
678-564-1162, Press 1
GA CHIPRA: **medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra**
678-564-1162, Press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program All other Medicaid
in.gov/medicaid
in.gov/fssa/dfr
Family and Social Services Administration
1-800-403-0864
Member Services: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid: **hhs.iowa.gov/programs/welcome-iowa-medicaid**
1-800-338-8366
Hawki: **hhs.iowa.gov/programs/welcome-iowa-medicaid/ iowa-health-link/hawki**
Hawki: 1-800-257-8563
hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/ hipp
HIPP: 1-888-346-9562

KANSAS – Medicaid
kancare.ks.gov
1-800-792-4884
HIPP: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
1-855-459-6328
KIHIPP.PROGRAM@ky.gov KCHIP
kynect.ky.gov
1-877-524-4718
Kentucky Medicaid: **chfs.ky.gov/agencies/dms**

LOUISIANA – Medicaid
medicaid.la.gov or ldh.la.gov/lahipp
1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment: **mymaineconnection.gov/benefits/ s/?language=en_US**
1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
maine.gov/dhhs/ofi/applications-forms
1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
mass.gov/masshealth/pa
1-800-862-4840
TTY: 711
masspremassistance@accenture.com

MINNESOTA – Medicaid
mn.gov/dhs/health-care-coverage
1-800-657-3672

MISSOURI – Medicaid
dss.mo.gov/mhd/participants/pages/hipp.htm
573-751-2005

MONTANA – Medicaid
dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
1-800-694-3084
HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
ACCESSNebraska.ne.gov
1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid
dhcfp.nv.gov Medicaid
1-800-992-0900

NEW HAMPSHIRE – Medicaid
dhhs.nh.gov/programs- services/medicaid/health-insurance-premium-program
603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid: **state.nj.us/humanservices/dmahs/clients/medicaid**
1-800-356-1561
CHIP Premium Assistance
609-631-2392
CHIP: **njfamilycare.org/index.html CHIP**
1-800-701-0710 (TTY: 711)

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

NORTH CAROLINA – Medicaid
medicaid.ncdhhs.gov
919-855-4100

NORTH DAKOTA – Medicaid
hhs.nd.gov/healthcare
1-844-854-4825

OKLAHOMA – Medicaid and CHIP
insureoklahoma.org
1-888-365-3742

OREGON – Medicaid and CHIP
healthcare.oregon.gov/Pages/index.aspx
1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
www.pa.gov/en.html
1-800-692-7462
CHIP: **www.pa.gov/en/agencies/dhs/resources/chip.html** (pa.gov)
CHIP: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
eohhs.ri.gov
1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
scdhhs.gov
1-888-549-0820

SOUTH DAKOTA - Medicaid
dss.sd.gov
1-888-828-0059

TEXAS – Medicaid
www.hhs.texas.gov
1-800-440-0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
medicaid.utah.gov/upp
upp@utah.gov
1-888-222-2542
Adult Expansion; **medicaid.utah.gov/expansion**
Utah Medicaid Buyout Program: **medicaid.utah.gov/buyout-program**
CHIP: **chip.utah.gov**

VERMONT– Medicaid
dvha.vermont.gov/members/medicaid/hipp-program
1-800-250-8427

VIRGINIA – Medicaid and CHIP
coverva.dmas.virginia.gov/learn/premium- assistance/famis-select
coverva.dmas.virginia.gov/learn/premium- assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP: 1-800-432-5924

WASHINGTON – Medicaid
hca.wa.gov
1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
dhhr.wv.gov/bms
mywvhipp.com
Medicaid: 304-558-1700
CHIP Toll-free: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
dhs.wisconsin.gov/badgercareplus/p-10095.htm
1-800-362-3002

WYOMING – Medicaid
health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility
1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
1-877-267-2323, menu option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.
OMB Control Number 1210-0137 (expires 1/31/2026)

7. Notice of Privacy Practices

Revised September 20, 2013

This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information. Please review it carefully.

USE AND DISCLOSURE OF HEALTH INFORMATION

The provisions of the Duke University Health Plan ("the Health Plan") are designed to protect the privacy of health information that it creates or receives about you that can identify you, called "protected health information". Protected health information includes information about your past, present or future health, the provision of health care to you, or your past, present, or future payment for the provision of health care. The Health Plan has established policies to protect the privacy of your protected health information. The Health Plan consists of Duke Select, Duke Basic, Duke Options, Blue Care, and Duke Plus medical benefits programs, the Health Care Reimbursement Account program, the Personal Assistance Service (PAS) program and the Employee Assistance Plans.

The Health Plan's privacy practices concerning your protected health information are as follows:

- The Health Plan will safeguard the privacy of protected health information that it has created or received.
- The Health Plan will explain how, when and why it may use and/or disclose your protected health information.
- The Health Plan will only use and/or disclose your protected health information as described in this Notice.

The following categories describe different ways that the Health Plan may use and disclose health information. For each category of uses or disclosure we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways the Health Plan is permitted to use and disclose information will fall within at least one of the categories.

To Make or Obtain Payment.

The Health Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Health Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations.

The Health Plan may use or disclose health information for its own operations to facilitate the administration of the Health Plan and as necessary to provide coverage and services to all of the Health Plan's participants. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. Health Care Operations includes such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination, and utilization review.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.

- Business management and general administrative activities of the Health Plan, including customer service and resolution of internal grievances.

For Treatment Alternatives.
The Health Plan may use or disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services.

The Health Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

For Disclosure to the Plan Sponsor.

The Health Plan may disclose your health information to the Plan Sponsor for Plan Administration functions performed by the Plan Sponsor on behalf of the Health Plan. In addition, the Health Plan may provide health information to the Plan Sponsor so that the Plan Sponsor may solicit premium bids from health insurers or modify, amend or terminate the plan. The Health Plan also may disclose to the Plan Sponsor information on whether you are participating in the health plan.

SPECIAL SITUATIONS

The Health Plan may use and/or disclose protected health information about you for a number of circumstances in which you do not have to consent, give authorization or otherwise have an opportunity to agree or object. Those circumstances include:

When Legally Required.

The Health Plan will disclose your health information when it is required to do so by any federal, state or local law.

To Conduct Health Oversight Activities.

The Health Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Health Plan, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

Research.

We use and disclose PHI in connection with research performed by faculty members of Duke University, as well as researchers outside the institution. This research is subject to the oversight of the Duke University Institutional Review Board. In most cases, while PHI may be used to help prepare a research project or to contact you to ask whether you want to participate in a study, it will not be further disclosed for research without your authorization. Sometimes, however, where permitted under federal law and institutional policy, and approved by an Institutional Review Board or a privacy board, PHI may be used or disclosed. In addition, PHI may be used or disclosed to compile "limited or de-identified data sets" that do not include your name, address, social security number or other direct identifiers. These data sets may, in turn, be used for research purposes.

In Connection with Judicial and Administrative Proceedings.
As permitted or required by law, the Health Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Health Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes.

As permitted or required by state law, the Health Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Health Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

Lawsuits and Disputes.

If you are involved in a lawsuit or a dispute, we may disclose your health information in response to a court or administrative order. We may also disclose your health information in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

In the Event of a Serious Threat to Health or Safety.

The Health Plan may, consistent with applicable law, disclose your health information if the Health Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions.

In certain circumstances, federal regulations require the Health Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

To Respond to Organ and Tissue Donation Requests and work with a medical examiner or funeral director.

For Workers' Compensation.

The Health Plan may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Health Plan will not disclose your health information other than with your written permission. In addition, we will not use your PHI for marketing and fundraising purposes without your permission. We will not sell your PHI without your permission. If you authorize the Health Plan to use or disclose your health information, you may revoke that permission in writing at any time. If you revoke your permission, the Health Plan will no longer use or disclose your health information for the reasons covered by your written authorization. The Health Plan is unable to take back any disclosures it has already made with your permission.

North Carolina Law.

In the event that North Carolina Law requires the Health Plan to give more protection to your health information than stated in this notice or as required by Federal Law, the Health Plan will give that additional protection to your health information.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Health Plan maintains:

Right to Request Restrictions.

You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Health Plan's disclosure of your health information to someone involved in the payment of your care. However, the Health Plan is not required to agree to your request. If you wish to make a request for restrictions, please call (919) 684-5600 for the appropriate request form.

Right to Request Alternative Ways of Communications.

You have the right to request that the Health Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Health Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please call (919) 684-5600 for the appropriate request form. The Health Plan will attempt to honor your reasonable requests for confidential communications, but when appropriate, may condition the accommodation on your providing the Health Plan with information regarding your alternative address or other method of contact.

Right to Inspect and Copy Your Health Information.

You have the right to inspect and copy your health information. To inspect and copy your health information, please call (919) 684-5600 for the appropriate request form. If you request a copy of your health information, the Health Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information.

If you believe that your health information records are inaccurate or incomplete, you may request that the Health Plan amend the records. That request may be made as long as the information is maintained by the Health Plan. To request an amendment to your health information, please call (919) 684-5600 for the appropriate form. The Health Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Health Plan, if the health information you are requesting to amend is not part of the Health Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Health Plan determines the records containing your health information are accurate and complete.

Right to an Accounting.

You have the right to request a list of certain disclosures of your health information that the Health Plan is required to keep a record of under the Privacy Rule, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law. To request an accounting of disclosure, contact (919) 684-5600 for the appropriate form. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Health Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Health Plan will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice.

You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. You may also obtain a copy of this Notice at any time from our website at hr.duke.edu or by calling (919) 684-5600 and requesting a paper copy.

Right to Choose Someone to Act for You.

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will verify that the person has this authority and can act for you before we take any action.

Right to File a Complaint if you Feel Your Rights Have Been Violated.

You can complain if you feel we have violated your rights by contacting us using the information listed for the privacy official. In addition, you can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave., S.W., Washington, D.C. 20201. Calling 1-877-696-6775, or visiting hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

DUTIES OF THE HEALTH PLAN

The Health Plan is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Health Plan is required to abide by the terms of this Notice, which may be amended from time to time, and to promptly notify you if a breach occurs that may have compromised the privacy or security of your information. The Health Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If Health Plan changes its policies and procedures, the Health Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Health Plan and to the Secretary of the Department of Health and Human Services if you believe

that your privacy rights have been violated. Any complaints to the Health Plan should be made in writing to the Health Plan's Privacy Official. The Health Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

If you have any questions regarding this Notice or if you believe your privacy rights have been violated or you wish to file a complaint about the Health Plan's privacy practices, you may contact:

Privacy Official
Duke University
Benefits Administration
705 Broad St.
Durham, NC 27705
(919) 684-5600

8. Notice of Nondiscrimination

Duke University complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Duke University does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Duke University:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Benjamin Reese.

If you believe that Duke University has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Benjamin Reese, 705 Broad St., Durham, NC 27705, 919-684-8222 (p), 919-684-8580 (f), ben.reese@duke.edu. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Benjamin Reese, VP for Institutional Equity & Chief Diversity Officer is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
hhs.gov/ocr/office/file/index.html.

9. Language Assistance Services

English: If you speak English, language assistance services, free of charge, are available to you. Call 1-919-684-5600.

Español (Spanish): si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-919-684-5600.

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-919-684-5600. ◦

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-919-684-5600.

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-919-684-5600. 번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-919-684-5600.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-919-684-5600.

العربية (Arabic): ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-919-684-5600 (رقم.)

Français (French): Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-919-684-5600.

Deutsch (German): Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-919-684-5600.

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-919-684-5600.まで、お電話にてご連絡ください。

हिंदी (Hindi): ध्यान द: यद आप हदी बोलते ह तो आपके लए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-919-684-5600. पर कॉल कर।

ગુજરાતી (Gujarati): ચના: જો તમે જરાતી બોલતા હો, તો ન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો 1-919-684-5600.

Hmoob (Hmong): Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-919-684-5600.

ខ្មែរ (Cambodian): ប្រយ័ត្ន៖ បើសិនអ្កនិយ ែខ្មរ, សវំនួយែផ្ក ែយមិនគិតឈលៃ ថ្លៃចនសំប់បំែរអ្ក។ ចូរ ទូរស័ព 1-919-684-5600.។

ພາສາລາວ (Lao): ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-919-684-5600. ।

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA Medicaid	ALASKA Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS Medicaid	**CALIFORNIA Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA Medicaid	INDIANA Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA Medicaid and CHIP (Hawki)	**KANSAS Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY Medicaid	**LOUISIANA Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE Medicaid	**MASSACHUSETTS Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA Medicaid	**MISSOURI Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA Medicaid	NEBRASKA Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA Medicaid	**NEW HAMPSHIRE Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY Medicaid and CHIP	**NEW YORK Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA Medicaid	**NORTH DAKOTA Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA Medicaid and CHIP	**OREGON Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA Medicaid and CHIP	**RHODE ISLAND Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA Medicaid	**SOUTH DAKOTA Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS Medicaid	UTAH Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT Medicaid	**VIRGINIA Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON Medicaid	**WEST VIRGINIA Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN Medicaid and CHIP	**WYOMING Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.