

MEMBER SCHEDULE OF BENEFITS
including
PLAN ELIGIBILITY AND COVERAGE RULES
and
DESCRIPTION OF PLAN BENEFITS

Duke Basic

Administered by

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Outside the U.S. 1-800 US-AETNA (800-872-3862)

Duke Basic

Essential Phone Numbers and Addresses

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c/o Aetna

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El Paso, TX 79998

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(1-800-385-3636)

Out of Country: 1-800 – US-AETNA (1-800-873-3862)

aetna.com

Find a Duke Basic provider at aetna.com/dsepublic/#/dukeuniversity

Maternity Resources Program: 1-800-272-3531

Express Scripts Managed Pharmacy Program

(Prescription Drug Card Program)

1-800-717-6575

express-scripts.com

Cigna Behavioral Health

(Mental Health Referrals and Precertification)

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Duke Basic (the "Plan") is a benefit option of the Duke Basic Health Plan and is a self-funded plan providing the health benefits coverage described in this document to certain eligible employees of Duke University and Health System ("Duke") and their eligible dependents. Aetna Life Insurance Company (Aetna) provides certain administrative services to the Duke Basic Health Plan, including Precertification for Services, Member Appeals and Case Management.

This document, the *Member Schedule of Benefits*, describes the benefits available including limitations and exclusions, as well as the rules, conditions, and payment requirements a Plan member must satisfy in order to use his or her benefits. A list describing whether and under what circumstances coverage is provided for medical tests, devices and procedures is available to any member, by contacting Aetna Member Services Department at (800) 385-3636 (international callers please call (800) 872-3862. Duke Basic is only available to employees living in zipcodes beginning with 272, 273, 275, 276 and 277. This plan uses a health care provider network unique to Duke. Since this network is unique, we encourage careful review of the provider listing at aetna.com/dsepublic/#/dukeuniversity. Out-of-network care is only covered for emergency or urgent care.

Amendment and Termination of the Plan. The Duke Basic Health Plan is a welfare benefit plan. Duke expects to continue the Plan indefinitely, but reserves the right to terminate the Plan or to change terms and benefits of the Plan at any time in the future. Duke has the right to cancel your coverage.

PATIENT PROTECTION NOTICE

The Duke Basic Health Plan generally allows for the designation of a Primary Care Physician (PCP) (including OBGYNs and Pediatricians). You have the right to designate any PCP who participates in the Network and who is available to accept you or your family members. Until you make this designation Duke may make one for you. For information on how to select a PCP, and for a list of Participating Primary Care Physicians, contact Aetna at the Customer Service number printed on your ID card or visit their website at www.aetna.com and login to your Aetna Navigator or go directly to aetna.com/dsepublic/#/dukeuniversity.

NOTICE OF GRANDFATHERED HEALTH PLAN STATUS

This Employer Sponsored Health Plan believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the contact information listed under Essential Phone Numbers and Addresses. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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INTRODUCTION

What is in the *Member Schedule of Benefits*...

This document, known as the *Member Schedule of Benefits*, has three parts:

Part One, **Eligibility and Coverage Rules**, describes who is eligible to be a member of the Plan, what you must do to enroll, when Plan coverage takes effect and when it ends. It lists some circumstances under which you may lose your eligibility to be a Plan member. It also describes the procedures for filing claims and appealing the denial of claims; the procedures to be followed if a member has a complaint; and how benefits are coordinated for members who are covered under more than one health plan.

Part Two, **Description of Plan Benefits**, describes the health benefits coverage the Plan provides its members.

Part Three, **Definitions**, defines some of the terms used in Parts One and Two of this document. Please note that specific medical terms are not defined. If you have questions as to the meaning of terms used in this document, please call the Aetna Member Services Department at 1-800-DUKE-MEM (385-3636).

The Summary Plan Description (“SPD”) for the Duke Basic Health Plan is comprised of this document, the *Member Schedule of Benefits*, and a second document titled *Summary Plan Description for the Duke Basic Health Plan*. To understand the terms and conditions of your coverage, please read both of these SPD documents carefully. Subjects addressed in the other document include, but are not limited to, information about Plan eligibility, commencement and termination of Plan coverage, COBRA continuation coverage, subrogation and reimbursement, amendment and termination of the Plan and a statement of your ERISA rights.

The two documents that comprise the SPD are intended only to summarize your coverage under the Plan. In the event of a conflict between the terms or provisions of the SPD and the Plan document, the terms of the Plan document shall prevail. A copy of the Plan document may be obtained from the Human Resources Information Center (HRIC). In addition, you may be provided with supplements that describe changes in your benefits or the terms of your coverage under the Plan.

Member Rights & Responsibilities

With Duke Basic...

You have the right to:

- Be treated in a manner reflecting respect for your privacy and dignity as a person.
- Not be discriminated against because of age, disability, race, color, religion, sex, or national origin.
- Be informed regarding diagnosis, treatment and prognosis in terms that you can be expected to understand.
- Receive sufficient information to enable you to give informed consent before the initiation of any procedure and/or treatment.
- Refuse treatment to the extent permitted by law, and to be made aware of the potential medical consequences of such action. Refusal of treatment may result in termination of membership if it precludes the establishment of a sound physician-patient relationship and/or jeopardizes the ability of the physician to care for you properly.
- Have reasonable access to necessary medical services.
- Express a complaint, as outlined in the Member Grievance Procedure, and to expect an answer within a reasonable period.
- Call Aetna whenever you have a question about your benefits. We are here to serve you.

You have the responsibility to:

- **Read your Schedule of Benefits.** You are subject to all of the terms, conditions, limitations and exclusions in the Duke Basic Plan.
- Always seek care through a participating provider.
- Always identify yourself as a Duke Basic member when calling for an appointment and when obtaining health care services.
- Always present your Duke Basic identification card when obtaining health care services.
- Keep scheduled appointments or, if necessary, call to cancel appointments as early as possible. Remember, your participating provider may bill you if you fail to keep a scheduled appointment.
- Inform us of any additional health insurance your family may have so that payments can be properly coordinated between us and the other insurer.
- Cooperate with your health care professionals and follow their advice for treatment of injuries or illnesses.
- Know how to recognize an Urgent Care condition versus a Medical Emergency and what to do if one should occur.
- Pay your Copayments and Deductibles at the time of your office visit.

PLEASE READ THIS DOCUMENT CAREFULLY.

Throughout this document, “Plan” refers to the Duke Basic Plan. “Benefits” and “coverage” refer to the benefits and coverage provided by the Plan. “You” and “your” refer to a member or members of the Plan. Aetna” refers to Aetna Life Insurance Company, the company that administers the Plan.

PART ONE

ELIGIBILITY AND COVERAGE RULES

Section I - General Rules

A. ELIGIBILITY; ENROLLMENT; COMMENCEMENT OF COVERAGE.

(Documentation is required for enrollment, additions and changes in coverage.)

1. Employee Coverage.

a. Eligibility. To be eligible to enroll in the Plan an employee must be:

- i. Living in an area in which the zip code begins with one of the following prefixes: 272, 273, 275, 276, 277; and
- ii. A faculty employee holding a regular rank appointment who is receiving wages for Social Security purposes; or
- iii. A faculty employee holding other than a regular rank appointment and classified as a full-time or part-time member of the faculty, who is receiving wages for Social Security purposes; or
- iv. A regular, full-time non-faculty employee scheduled to work at least 30 hours per week; or
- v. A regular, part-time non-faculty employee scheduled to work at least 20 hours per week; or
- vi. A visiting faculty member required to be provided medical benefits by an federal immigration law or pursuant to an employment contract with Duke; or
- vii. A graduate resident trainee of Duke University Health System; or
- viii. A postdoctoral scholar previously eligible for coverage.

You are eligible to participate in a Duke Health Plan if you meet the payroll/benefit classifications for eligible employees, and you are a full-time employee for purposes of the Affordable Care Act (ACA) at your time of hire and each subsequent measurement period. The employee must also be in a payroll classification that Duke has designated as eligible for health care benefits coverage under the Plan. Employees at a \$0 rate of pay or scheduled too few weeks per year (Example: where weeks scheduled per year multiplied by hours scheduled is below 1,000) are generally not in a payroll/benefits eligible classification.



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

b. Enrollment. Eligible employees may enroll in the Plan:

- i. the first of the month following hire/eligibility date; or
- ii. During the annual open enrollment period; or
- iii. Within 30 days after returning to work from an approved leave of absence, including a leave taken pursuant to the Family and Medical Leave Act of 1993 (“FMLA leave”); or
- iv. Within 30 days of aging off a parental health policy; or
- v. Within 30 days of marriage or birth of a child; or
- v. Within 30 days of losing coverage under a spouse’s health benefits plan, if coverage was lost for one of the following reasons:
 - Divorce or legal separation filed with the court;
 - Death of the spouse;
 - Termination of the spouse’s employment;
 - Termination of the health benefits plan to which the spouse belonged.

c. Commencement of Coverage. The effective date of coverage under the Plan depends on the circumstances under which the employee enrolls.

- i. **New Employees**. Coverage for a new employee who enrolls in the Plan may begin either the first day of employment, or the first day of the month following the first day of employment.

- ii. **Newly-Eligible Employees.** Coverage for a newly-eligible employee, who enrolls in the Plan within 30 days of first becoming eligible, commences either the first day of eligibility or the first day of the month following eligibility.
- iii. **Open Enrollment.** Coverage for employees who enroll during an open enrollment period commences on the date announced for that open enrollment period.
- iv. **Leave of Absence.** Subject to the applicable provisions of the Family and Medical Leave Act, coverage for employees who enroll after returning from an approved leave of absence commences the first day of the first full month he or she resumes active employment after returning from the leave.
- v. **Loss of Other Coverage.** Coverage for employees who enroll after losing coverage under another health benefits plan commences on the first day of the first full month after electing coverage. See Section I.A.3 in this Part One.

2. Dependent Coverage.

Please Note: Under no circumstances may an employee enroll a sibling, cousin, parent or other dependent relative as a dependent. The University requires a birth certificate, marriage certificate and proof of joint residency or the first two pages of your tax return and proof of joint residency be submitted online within 30 days of the health plan effective date.

- a. Eligible Dependents. An employee enrolled in the Plan may also enroll a dependent that is:
 - i. The employee's spouse (marriage certificate + proof of joint residency required); or
 - ii. The employee's Registered Same-Sex Spousal Equivalent if registered with Duke HR prior to 1/1/2016.
 - iii. The employee's child ("child" includes biological children, foster and legally adopted children, children placed for adoption with the employee, stepchildren, children for whom the employee is legal guardian, children for whom the employee has been ordered by a court or administrative agency to provide health benefits under the Plan, and, if the employee has a Registered Same-Sex Spousal Equivalent who is enrolled in the Plan as an eligible dependent of the employee, the children of the employee's Registered Same-Sex Spousal Equivalent), who are under 26 years of age.

Please Note: Legal custody is insufficient. To cover a child you must be the legal guardian* of the child.

***Legal guardianship if obtained outside of NC must be consistent with NC requirements (i.e. a permanent surrender of parental rights of the birth parents).**

Coverage of disabled dependent children:

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

- The child must be covered under a Duke policy on the 26th birthday;
- The parent must apply for the waiver on or prior to the child's 26th birthday
- The mental or physical disability must be significant and render the child incapable of independent living and self-sustaining employment, and must be supported by medical records;
- The condition must exist on or prior to the 26th birthday;
- The parent must remain eligible and enrolled;
- The parent must provide annual evidence of continued incapacity;
- There must not be a break in coverage after the 26th birthday under the parental policy.



PLEASE NOTE: A person who is enrolled in the Plan as an employee cannot also enroll as the dependent of another employee. A person who is enrolled in the Plan as the dependent of one employee cannot also enroll as the dependent of another employee.

- b. Enrolling Dependents. An employee may enroll any of his or her eligible dependents at the same time the employee enrolls in the Plan, or add them during an annual open enrollment period see notes above for documentation requirements. In addition, certain eligible dependents may be enrolled outside the annual open enrollment period, as follows:
 - i. **New Spouse.** A new spouse and stepchildren, but they must be enrolled within 30 days of the marriage. (Marriage certificate is required.)

- ii. **A Registered Same-Sex Spousal Equivalent Registered prior to 1/1/2016.** A Registered Same-Sex Spousal Equivalent, and his or her children, but they must be enrolled within 30 days of the date on which the Human Resources Information Center (HRIC) verifies the Qualifying Life Event.
- iii. **Newborn Children.** To be covered at birth, a newborn child must be enrolled with the Human Resources Information Center (HRIC) within 30 days of birth.
- iv. **Other New Children.** An adopted child, foster child or child for whom the employee is a legal guardian must be enrolled within 30 days of placement with the family. (Documentation is required.) Coverage is effective on the date of placement.
- v. **Loss of Other Coverage.** A spouse or Registered Same-Sex Spousal Equivalent who involuntarily loses his or her own health benefits coverage due to termination of employment or termination of the employer sponsored group health benefits plan to which he or she belonged may elect enrollment within 30 days of the loss of such coverage. A letter must be provided to the Human Resources Information Center (HRIC) by the employer or former employer documenting the loss of such other coverage.
- vi. **Qualified Medical Child Support Order (QMCSO).** A child for whom the Plan receives a Qualified Medical Child Support Order may enroll as of the effective date of a valid QMCSO provided the employee is currently eligible for coverage. (If the employee is not a member he or she must enroll at the same time.) Appropriate written documentation is required to determine the qualified status of the Qualified Medical Child Support Order.



PLEASE NOTE: All changes in an employee's coverage, including the addition or deletion of dependents from Plan coverage, must be requested in writing and submitted with appropriate documentation through the HR website www.hr.duke.edu to the Human Resources Information Center (HRIC). The Human Resources Information Center (HRIC) will advise you of the date on which an eligible dependent's coverage becomes effective. The requested change must occur within 30 days of the qualifying event.

- c. Commencement of Dependent Coverage. The effective date of coverage for a dependent depends on the circumstances under which he or she was enrolled in the Plan.
 - i. **Enrolled with New or Newly-Eligible Employee.** Coverage commences on the same date as the employee's coverage.
 - ii. **During Open Enrollment.** The effective date of coverage for any dependents added during an annual open enrollment period commences on the date announced by the Human Resources Information Center (HRIC).
 - iii. **Loss of Other Coverage.** Coverage for a spouse or Registered Same-Sex Spousal Equivalent who was enrolled within 30 days after involuntarily losing his or her own health benefits coverage, as described in Part One, Section I.A.2.b.v, commences on the first day of the first full month after he or she involuntarily lost his or her own health benefits coverage or the first day of the month following the request for coverage.
 - iv. **New Spouse and Stepchildren.** If enrolled within 30 days of marriage, a new spouse and stepchildren (if any) will be covered as of the date of the marriage, or the first day of the first full month following the marriage, at the employee's selection.
 - v. **Newborn Children.** If enrolled within 30 days of birth, a newborn child will be covered as of the date of birth.
 - vi. **Other New Children.** If enrolled within 30 days of placement, adopted children, foster children and children for whom the employee is a legal guardian will be covered as of the date of placement.
 - vii. **Qualified Medical Child Support Order (QMCSO).** A child for whom the Plan receives a Qualified Medical Child Support Order may enroll as of the effective date of a valid QMCSO provided the employee is currently eligible for coverage. (If the employee is not a member he or she must enroll at the same time.) Appropriate written documentation is required to determine the qualified status of the Qualified Medical Child Support Order.
- d. Removing Eligible Dependents from Coverage. Dependents who continue to be eligible to participate in the Plan may not be removed from Plan coverage except during the annual open enrollment period unless there is a valid change in family status. The Human Resources Information Center (HRIC) must be notified within 30 days of the change and documentation must be provided.

If a Registered Same-Sex Spousal Equivalent (SSSE) enrolls in another health benefits plan, he or she may be dropped from coverage, as long as evidence of this other coverage is provided to the Human Resources Information Center (HRIC) within 30 days.



PLEASE NOTE: If the Registered Same-Sex Spousal Equivalent is dropped from coverage, his or her children would no longer be eligible to participate in the Plan (unless adopted by the employee) and would also have to be dropped from coverage.

e. Loss of Dependent Eligibility. If a dependent loses his or her eligibility, he or she must be removed from the employee's coverage. The employee should notify the Human Resources Information Center (HRIC) in writing within 30 days of the dependent's change in eligibility status. Except for divorce or death, Plan coverage will end for that dependent as of the last day of the month in which he or she ceased to be eligible for Plan coverage, regardless of when Duke is actually notified of the dependent's change in status. Plan coverage ends for a dependent who dies or who loses eligibility because of divorce on the date of death or divorce. No refunds will be issued for loss of eligibility if the HRIC is notified more than 30 days after the date of ineligibility.

3. **Special Enrollment for Loss of Coverage or for New Dependents.** The Health Insurance Portability and Accountability Act (HIPAA) allows eligible employees and their eligible dependents to request enrollment in the Plan **no later than 30 days** after a loss of other coverage or in case of a birth, marriage, adoption or placement for adoption.

a. Loss of Other Coverage. HIPAA allows a special enrollment period for eligible employees and their eligible dependents that have lost coverage. If the other coverage is COBRA continuation coverage, the enrollment can only occur after the COBRA period has been exhausted and not as a result of failure to pay premiums or for cause (e.g. making a fraudulent claim).

Under the law, an eligible employee who loses coverage may enroll; an eligible dependent who loses coverage may enroll; and both the employee and dependent may enroll if either one loses coverage. However, the Plan still requires that an employee must elect enrollment for himself/herself before his/her eligible dependent may enroll.

Requests for coverage must be made **no later than 30 days** after the loss of other coverage. Coverage may commence *no later* than the first day of the month following the request for enrollment.

b. New Dependents. HIPAA allows a special enrollment period for eligible employees and their eligible dependents in case of a birth, marriage, adoption or placement for adoption. Premiums are not prorated.

An eligible employee and/or any of his/her eligible dependents may elect enrollment as a result of these events. However, the Plan still requires that an employee must elect enrollment for himself/herself before his/her eligible dependent may enroll.

Requests for coverage must be made **no later than 30 days** after the birth, marriage, adoption or placement for adoption. Coverage with respect to marriage may commence no later than the first day of the month following the request for enrollment. Coverage with respect to a birth, adoption or placement for adoption is effective on the date of the 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.

4. **Payment of Premiums.** Premium payments must be received by the **25th** day of the month **proceeding** the month of coverage. For example, payment for coverage for the month of July is due by June 25. If payment is not received on time, coverage will be terminated on the last day of the month for which payment was received.

a. Monthly Cost. Premiums are based on coverage for one full calendar month. There is no prorating of premiums regardless of the eligibility date of the qualifying event.

b. Reinstatement. Members who have had their coverage terminated due to nonpayment have 30 days from the day payment is due to request reinstatement. Members who wish to be reinstated should contact the Human Resources Information Center (HRIC) if active, or Wageworks if under COBRA.

c. Retirees, Employees on Long Term Disability and Surviving Dependents. Employees eligible to continue health care coverage due to their disabled status, former employees eligible to continue health care coverage due to their retiree status and an employee's dependents eligible to continue health care coverage due to their surviving dependent status

must continue to make timely premium payments. Individuals who do not do so and are not reinstated within 30 days of the payment due date (see above) will lose all eligibility for health care coverage.

- d. Time Limit for Refunds. When an employee terminates employment at Duke, coverage continues through the end of the month following month of termination, as deductions are taken one month in advance. Terminating employees who wish coverage terminated early must make this request in writing PRIOR to the coverage period. There is no refund for requests made after the coverage has terminated.

If a dependent loses coverage eligibility, which results in a premium change, and the Human Resources Information Center (HRIC) is not notified by the employee within thirty (30) days, there is no refund, and coverage will be terminated retroactive to the date when eligibility ended. The employee will be responsible for any claims incurred when the dependent was not eligible.

5. **Categories of Coverage**. The Plan offers employees a choice of five different coverage categories:

- Individual: Employee only.
- Employee-Child: Employee plus one dependent child.
- Employee-Children: Employee plus at least two dependent children.
- Employee-Spouse/Partner: Employee plus spouse or Registered Same-Sex Spousal Equivalent.
- Family: Employee, spouse or Registered Same-Sex Spousal Equivalent, and dependent child or children.

Employees select a coverage category at the time of enrollment, and may change it, if dependents are added to or removed from coverage in accordance with the terms of the Plan.

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

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

- Health insurance may also be continued for your spouse or Registered Same-Sex Spousal Equivalent and eligible dependent children who are covered at the time of your retirement.
- If your spouse or Registered Same-Sex Spousal Equivalent and/or eligible dependent children are not enrolled at the time of retirement, they will not be eligible to be enrolled in the future.

Eligibility Requirements for Duke University (Company Code 10 in SAP)

You must meet the Rule of 75, which became effective July 1, 1990. It requires that your age plus years of continuous service with Duke at retirement must be equal to or greater than 75. Thus, an employee or faculty member must have at least ten years of continuous service to retire at 65 and continue Duke Health coverage.

Eligibility Requirements for Duke University Health System (DUHS) (All other Company Codes in SAP)

- Employees hired on or after July 1, 2002 are eligible for retiree health coverage if they meet the following criteria:
 - Have 15 years of continuous service after age 45 - Retiree pays 100% of the premium
 - DUHS employees approved for group long-term disability benefits hired after July 1, 2002, may retain their health coverage until age 65, as currently permitted, but will not receive credit for years of continuous service while on disability.
- Employees employed by DUHS prior to July 1, 2002 are eligible for retiree health coverage if they meet one of the following criteria:
 - Met the Rule of 75 (your age + years of continuous service = 75) as of July 1, 2002
 - Employee had at least 15 years of continuous service (but did not meet the Rule of 75) as of July 1, 2002, then the employee is grandfathered under the Rule of 75 eligibility provision
 - Employee is at least 60 years of age, with 10 or more years of continuous service (but did not meet the Rule of 75) as of July 1, 2002, then the employee is grandfathered under the Rule of 75 eligibility provision
 - All other employees employed by DUHS prior to July 1, 2002 are eligible for retiree health coverage at the time of retirement if they meet one of the following eligibility criteria:
 - ◆ Have 15 years of continuous service after age 45 - DUHS will pay a portion of the premium

OR

- ◆ Met the Rule of 75 - Retiree pays 100% of the premium

NOTE: If a faculty or staff member meets the retiree health eligibility requirements and retires (early or normal), the retiree may suspend health or dental coverage and contributions at any time while employed and receiving benefits elsewhere.* Re-enrollment in the health or dental plan must occur within 60 days of the termination of other employer sponsored coverage. Proof of continuous coverage through another employer plan will be required. If the individual attempts to re-enroll after this 60-day period, the individual must pay the full premium (including the employer share) retroactive to the termination of the prior employer coverage and up to the time of re-enrollment. Thereafter, the individual shall pay the employee/retiree share. Only those dependents covered while under a Duke Health Plan at the time of retirement are eligible for re-enrollment.

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

If while working for another employer after retirement from Duke the retiree dies, their spouse must enroll in the Duke health plan as a surviving spouse within 30 days of the retiree's death and provide proof of continuous coverage.

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

a. Medicare Entitlement While Actively at Work. Members who are actively at work, and plan to continue working after age 65, should contact the Social Security Administration to enroll in Medicare Part A. **At the time of retirement from Duke, you will be given a form allowing you and your spouse, age 65 or older, to enroll in Medicare Part B without a penalty.** Duke Basic will continue as primary coverage for members continuing as active employees after age 65. Duke Basic will also continue as primary for the spouse, age 65 or older, of an active employee, whether or not they are enrolled in Medicare, as long as they are not enrolled in another group health benefits plan.

b. Early Retirees and Their Spouse. Duke Basic will continue as primary coverage for employees who retire before age 65 and are classified as early retirees. At age 65 or if eligible for Medicare prior to age 65 as the result of disability, enrollment in Medicare Part A and Part B is mandatory as Medicare becomes your primary coverage. When you turn age 65, you may continue group health coverage through Duke under the Duke Plus Plan administered by UMR. For more information, please contact the Human Resources Information Center at 919-684-5600 or UMR at:

UMR Inc.
PO Box 8052
Wausau, Wisconsin 54402
1-866-318-DUKE
www.umar.com

c. Retirees Age 65 or Older. Enrollment in Medicare Part A and Part B is mandatory for retirees or their spouses age 65 or older. At least one month before your 65th birthday or retirement date, you must complete the Medicare enrollment process to ensure the effective date of your Medicare coverage is active on or before your retirement, otherwise, you may have a break in health insurance coverage. As a retiree age 65 or older, Medicare is your primary coverage. You may continue group health coverage through Duke under the Duke Plus Plan administered by UMR. For more information, please contact the Human Resources Information Center at 919-684-5600 or UMR at the address and telephone number noted above.

d. Disabled. If you or your spouse are disabled, under age 65, and have been entitled to Social Security disability benefits for 24 months, you are eligible for Medicare coverage. **You must enroll in Medicare Part A and Part B when first eligible.** Medicare is your primary coverage. You may continue group health coverage through Duke under the Duke Plus Plan administered by UMR. For more information, please contact the Human Resources Information Center at 919-684-5600 or UMR at the address and telephone number noted above.

e. End Stage Renal Disease. For members or their covered family members entitled to Medicare solely because they have end stage renal disease, Duke Basic will be the primary coverage for no fewer than 9 but no more than 30 months, starting with the earlier of (a) the month in which a regular course of dialysis is initiated, or (b) in the case of an individual who receives a kidney transplant, the first month in which the individual became entitled to Medicare. Thereafter, if you or your spouse continues active employment at Duke, you may continue group health coverage

under the Duke Basic Plan administered by Aetna but must enroll in Medicare Parts A and B when eligible. For those on disability, please see Paragraph (d) above.


- f. **Coordination with Medicare.** Unless prohibited by 42 U.S.C., Section 1395y (b) (1) (A) (pertaining to discrimination against the working aged with respect to entitlement of benefits under group health plans), if you and/or your spouse are eligible for Medicare, but fail to apply, the Plan will provide supplemental benefits only, i.e., Medicare benefits—both Part A and B will be taken into account when calculating benefits. You must still make all Copayments or coinsurance payments required by the Plan **in addition to paying any costs Medicare would have covered if you had enrolled in Medicare as required.**


B. TERMINATION OF COVERAGE.

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

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

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

 PLEASE NOTE: Any member whose coverage is terminated pursuant to this Section I.B.1 of this Part One permanently loses eligibility to remain or enroll in Duke Health plans in the future.

 PLEASE NOTE: If an enrolled active employee dies, eligibility as a surviving dependent is based on the eligibility of the deceased employee for continuing health benefits in retirement. The eligible deceased employee’s dependents covered at the time of death may continue in effect as if the employee were not deceased. The eligible dependent who is the deceased employee’s spouse, or if there is no surviving spouse, the eldest eligible dependent (or his/her legal guardian if he/she is a minor or legally incapacitated) shall be responsible for taking any actions regarding the Plan which the employee would have been required to take. No additional dependents can be enrolled in the Plan subsequent to the death of the employee. Eligibility for continued coverage as a surviving spouse ends with remarriage. Eligibility for dependent children terminates at age 26. Extended coverage for disabled dependents terminates with the death or remarriage of the spouse or age 26, whichever comes first.

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

C. REVIEW OF ELIGIBILITY DETERMINATIONS.

1. **Requests for Review.** The initial decision affecting your eligibility to become a member under the Plan (either as an eligible employee or dependent) is made by the Plan Administrator at the Human Resources Information Center (HRIC). If you (or any person claiming eligibility for coverage as your dependent) are determined not to be eligible to become a member, you may file a written request for review of that decision with the Plan Administrator. Such request should specifically identify the decision to be reviewed. Upon completion of the review, you will be sent a notice containing: (a) the Plan Administrator’s decision concerning the eligibility determination you asked to be reviewed; (b) if the eligibility determination is upheld in whole or in part, the reasons for upholding the disputed determination; (c) reference to the Plan provisions on which the Plan Administrator based his or her decision; and (d) an explanation of how you can appeal the eligibility decision made by the Plan Administrator, in whole or in part, to the Staff Fringe Benefits Committee.

2. **Time Table for Eligibility Review Decisions.** Generally, eligibility review decisions are made within 90 days of receipt of the claim by the Plan Administrator, but in some cases special circumstances may exist which necessitate extending the period of time for making the claims decision. If additional time is required, you will be sent a notice before the 90-day period is up explaining why more time is needed (“extension notice”). In cases where you receive a notice that more time is needed, the decision will be made within 90 additional days—that is, within a total of 180 days.

Section II - Claims Procedure

A. CLAIMS FOR BENEFITS.

1. **Accessing Your Benefits.** You may access your benefits by presenting your Plan identification card and making the applicable Copayment to your Primary Care Provider or Specialist at the time the service is rendered.
2. **Filing a Claim. All claims must be filed within one hundred eighty (180) days of the date incurred.** There are no claim forms to complete when you receive services from Duke Basic Providers. Claim forms are only required when services are provided by nonparticipating providers in the case of Emergency or Urgent Care and for some items the member must purchase, such as medical supplies. Duke Basic Providers will bill the Plan directly for services provided. On those occasions when you **DO** need to file a claim, the proper claim form should be filed with Aetna. Aetna should receive the claim within one hundred eighty (180) days after the service was provided. Please feel free to call our Member Services Department at 1-800-385-3636 (international callers please use (800) 872-3862 or log onto aetna.com for a claim form or help.
3. **Time Table for Claims Decisions.** Generally, review decisions concerning the processing of claims are made within thirty (30) days of receipt of the claim. However, in some cases, special circumstances beyond the control of the Plan may necessitate an extension of time not to exceed fifteen (15) days. In such cases, the Plan will send you an “extension notice” before the thirty (30) day period has expired explaining why more time is needed and providing an estimate of when the decision shall be made. If the reason that the extension is necessary is that you have not provided enough information, the Plan will provide you with forty-five (45) days to supply the missing information. If additional information is requested, then the period for the Plan to make a decision shall be suspended from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information. In other words, the time that it takes for you to provide the Plan with the additional information is not counted in the Plan’s deadline. Please note that if you do not respond to the Plan’s request for information within forty-five (45) days, then the Plan may make its decision without the requested information.
4. **Claims for Mental Health Benefits.** You or the provider must file the claim directly with Cigna Behavioral Health by submitting a claim on the specified claim form. All claims must be filed within one hundred eighty (180) days of the date services were incurred. Payment by the Plan will be made directly to you or to the provider (in which case you will be sent a notice of the amount paid on your behalf). If the claim is denied in whole or in part, you may submit a written request to Cigna Behavioral Health within one hundred eighty (180) days of the denial date for review along with any supporting documentation. You may reach Cigna Behavioral Health at 1-888-253-8552.
5. **Services Received Outside the United States.** If you need to reach Aetna while outside the United States, you can call (800) 872-3862, or fax information to (866) 474-4040 and ensure your fax identifies you as a DUKE member.
6. **Subrogation of Benefits.** Subrogation refers to the right of the Plan to recover payments made by the Plan for any medical services, medical devices or prescription drugs on behalf of a covered member. The Plan may pursue the responsible party and/or the party’s insurance as well as any other insurance covering the member in order to recover payments made by the Plan.

If the member chooses to pursue recovery of damages from the party responsible for the injuries, the member will be asked to sign a Reimbursement Agreement. This form states that the member agrees to reimburse the Plan for any payments made for services related to injuries for which a third party provides compensation. If the form is not signed by the member, the Plan will cease making any future payments in connection with the injuries.

Any questions regarding this policy may be directed to Aetna Member Services at 1-800-DUKE-MEM (385-3636) or Benefits Administration at 919-684-5600.

Section III – Precertification

Certain services, procedures and inpatient admissions require a Precertification before the Plan will authorize payment for these services. As a general rule, Precertification is to be obtained before the requested service is rendered. When obtaining Precertification, if you or your authorized representative communicate with a Plan representative responsible for handling claims matters and you or your authorized representative fail to follow the proper procedures for filing a Precertification claim, we will notify you or your authorized representative of the proper procedure as soon as possible, but not later than two (2) business days of receipt of all necessary information for non-urgent care or twenty-four (24) hours in the case of a claim involving urgent care. Please note that you or your authorized representative must provide the following information in your initial request for Precertification: a) reference to you or your dependent; b) reference to a specific medical condition or symptom; and c) reference to a specific treatment, service or product for which approval is requested.

Precertification decisions are made as quickly as possible, but no later than twenty-four (24) hours of the request in the case of urgent care and no later than two (2) business days of receipt of all necessary information in the case of non-urgent care. If Precertification is requested and denied, the requested services will not be covered by the Plan. If a Precertification request is denied in whole or in part, you may submit to Aetna a written request within one hundred eighty (180) days of the denial date for review specifically requesting a review of the decision and including with the request any supporting documentation. Please see Section IV.A in this Part One for specific information about the Appeal review process and Part Two, Section II, **What Is Covered**.

Section IV - Appeals, Grievances, Complaints and Quality Issue Procedures

You, or your authorized representative, including a provider, may voluntarily request a review of a decision, policy or action by Aetna. The process to request a review differs depending on the issue. Each section below explains the process and how to contact the Plan administrator to initiate a review.

A. APPEAL ISSUES.


An Appeal is considered a review of the denial of a claim involving a medical necessity determination (also known as a non certification). There are two types of Appeal issues, a non-expedited request and an expedited request.

1. Non-Expedited First Level Appeal Requests.

- a. Filing the Appeal: If a claim involving a medical necessity determination is denied in whole or in part, you may submit to Aetna a written request within one hundred eighty (180) days of the denial date requesting a review. You must specifically identify the decision to be reviewed and include along with the request any supporting documentation. Upon receipt of the request, you will be sent a notice in writing within three (3) business days acknowledging receipt of the request. If you have not received such an acknowledgement, you should contact Aetna to make sure that your submission was received.

Aetna Complaints & Appeals
P.O. Box 14463
Lexington, KY 40512

- b. Appeal Process: The review determination shall be completed and communicated within thirty (30) calendar days after the receipt of the request. Upon completion of the review of the appeal, you will be sent a notice containing (a) the decision concerning the medical necessity determination denial you asked to be reviewed; (b) if the denial is upheld, in whole or in part, the reasons for upholding the denial; (c) reference to the Plan provisions on which the review decision is based; and (d) an explanation of how you can further appeal the review decision to Aetna.

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

2. Right to an External Review

Non-Expedited External Appeal Requests.

- a. Filing the Appeal: If you are not satisfied with the decision made in whole or in part by Aetna, you may request a second and final review. This review will be conducted by an External Review Agency independent from Duke University. The request for the final review must be submitted in writing to the Aetna Appeals Coordinator. The request must be submitted within sixty (60) days of receiving notice of the decision made by Aetna.
- b. External Review Appeal Process: Aetna will submit all information used to make the initial appeal determination to the External Reviewer along with any written comments and any additional written information or materials in support of your appeal. The External Reviewer will review the request and issue a determination within forty-five (45) days of receipt of the request from Aetna. You may request an opportunity to review certain documents used to make the determination, as required by ERISA. Submit requests for an External and final review to:

Aetna Complaints & Appeals
P.O. Box 14463
Lexington, KY 40512

You will receive a written acknowledgement of receipt within three (3) business days. The External Reviewer will provide you with a decision in writing within forty-five (45) days of receipt of the request for an appeal. If your appeal is denied in whole or in part, the written decision shall set forth specific reasons written in a manner that is reasonably understandable, and shall cite the Plan provisions on which the decision is based. *The decision on appeal by the External Reviewer shall be final; you have the right to pursue any available remedies under section 502(a) of ERISA.*

3. **Expedited Appeal Requests.** If you are appealing a decision made for urgent care services (services that you are requesting and that for which a delay in decision could seriously jeopardize your life or health, your ability to regain maximum function, or for care that your treating physician determines is urgent, or determines that a delay would subject you to severe pain that could not be adequately managed without the treatment requested), you can request an expedited appeal by calling the Aetna Member Services Department at (800) 385-3636. You may provide supporting documentation

that you would like us to consider.

If you are dissatisfied with the decision of the Appeal Decision, you may request an Expedited External Review. If your request meets the definition of urgent care, the External Reviewer will notify you of its decision on your Expedited External Appeal within three (3) business days after we receive your appeal request. If your request for appeal does not meet the definition of urgent care, then your appeal will be treated as a Non-Expedited External Appeal Review.

4. **Timeframes for Deciding Appeals.** The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

Type of Notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level(us)	36 hours	15 days	30 days	As appropriate to claim
Extensions	None	None	None	


5. **Limited Right to Representation.** Any action required or permitted to be taken by you regarding the claims process, Precertification requests, requests for review of eligibility determinations, or appeals may be taken by a representative acting on your behalf. You may be required to provide evidence to verify the authority of any such representative to act on your behalf.
6. **Authority of the Plan Administrator.** The Plan Administrator has the duty and discretionary authority to interpret and construe the provisions of the Plan, subject to the terms of the Plan and the procedures described above. Interpretations and determinations made by the Plan Administrator will be applied consistently to all members similarly situated (with due regard for individual differences in circumstances) and will be binding and conclusive upon each member and any other interested person. Such interpretations and determinations made by the Plan Administrator will only be amended by a court of law if the Plan Administrator, as the case may be, is found to have acted arbitrarily and capriciously in interpreting and construing the provisions of the Plan. You have the right to pursue any available remedies under section 502(a) of ERISA.

B. GRIEVANCES.

A grievance is an issue that is submitted by a member, a member’s representative, or provider on behalf of a member expressing dissatisfaction with any aspect of the delivery of services (except non-certification decisions) including but not limited to the administration, payment of claims or access to care.

1. **Filing the Grievance.** Each member, or anyone acting on the member's behalf, has the right to submit a written request for a Grievance review within one hundred eighty (180) days of the denial. Receipt of your written grievance is acknowledged in writing. If you have not received such an acknowledgement within three (3) business days of receipt of a grievance, you should contact the Aetna Member Services Department to make sure that your submission was received. To facilitate the first level grievance review, you should submit whatever information you think bears an importance to:
- Aetna Complaints & Appeals
P.O. Box 14463
Lexington, KY 405122.
2. **Grievance Process.** The review determination shall be completed and communicated within fifteen (15) days after the receipt of your request. Upon completion of the review of the grievance, you will be sent a notice containing (a) the decision concerning the grievance you asked to be reviewed; (b) if the denial is upheld, in whole or in part, the reasons for upholding the denial; (c) reference to the Plan provisions on which the review decision is based; and (d) an explanation of how you can have the decision further reviewed by the Staff Fringe Benefits Committee.
3. **Grievances to the Staff Fringe Benefits Committee.**
- a. **Filing the Grievance:** If you are not satisfied with the decision made by Aetna or the External Review Agency, you may file a Second Level Grievance to the Staff Fringe Benefits Committee. The grievance must be submitted in writing to Duke Benefits Administration and addressed to the attention of the Staff Fringe Benefits Committee. This must be submitted within sixty (60) days of receiving notice of the decision you wish to grieve. Such grievance should specifically identify the decision being appealed, and those aspects of the decision that are being disputed.
- Staff Fringe Benefits Committee
705 Broad Street Box 90502
Durham, NC 27708-0502

- b. **Second Level Grievance Process:** The Staff Fringe Benefits Committee will review the decision and issues identified in your written grievance. All materials distributed to members of the Committee have your personal identifying information removed. During this review process, you will have an opportunity to review certain documents, as required by ERISA, and to submit your written comments and any additional written information or materials in support of your grievance. The Staff Fringe Benefits Committee shall provide you its decision in writing within fifteen (15) days of receipt of the request. If your grievance is denied in whole or in part, the Staff Fringe Benefits Committee's written decision shall set forth specific reasons written in a manner that is reasonably understandable, and shall cite the Plan provisions on which the decision is based. *The decision on appeal by the Staff Fringe Benefits Committee shall be final; you have a right to pursue available remedies under section 502(a) of ERISA.*

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

- c. **Time Table for Committee's Decisions:** The Staff Fringe Benefits Committee will reach its decision within fifteen (15) days following receipt of a grievance, but in some cases special circumstances may exist which necessitate extending the time for the grievance decision. If additional time is required, you will be sent an "extension notice" before the fifteen (15) day period has expired, explaining why more time is needed and providing an estimate of when the decision will be made. If the reason the extension is needed is that you have not provided enough information, the Plan will provide you with forty-five (45) days to supply the additional information. If additional information is requested, then the period for the Plan to make a decision shall be suspended from the date on which the extension notice is sent to you until the date on which you respond to the request for additional information. In other words, the time that it takes for you to provide the Plan with the additional information is not counted in the Plan's deadline. Please note that if you do not respond to Plan's request for information within forty-five (45) days, then the Plan may make its decision without the requested information.

C. COMPLAINTS.

1. **Informal Verbal Complaint.** An Informal Complaint is a verbal expression of member dissatisfaction with any aspect of the delivery of services, including administration, payment of claims, or access to care that the member has not been able to resolve by speaking directly with the provider or other involved person.

Members may lodge an Informal Complaint by contacting any representative of Aetna by telephone. Every effort will be made to make an immediate verbal response to the member. If the member requests a written response, the complaint becomes a Formal Complaint.

2. **Formal Written Complaint.** A Formal Complaint is submitted by the member in writing and shall be treated as a Grievance, as described above.

D. QUALITY ISSUES.

The quality of care and services provided to members of the Plan is important. If you have a complaint concerning a Duke Basic provider, Aetna or other administrative staff, please contact the Aetna Member Services Department. This can be done either by calling-1-800-DUKE-MEM (385-3636) or by writing to Aetna at the address above under Appeals.

For the purposes of this section, a complaint about the quality of care received from a Duke Basic provider is called a quality of care complaint. Complaints about service issues involving a Duke Basic provider are called quality of service complaints.

1. **Quality of Care Complaints.** Quality of care complaints are handled by Aetna Quality Management Department. After your quality of care complaint is investigated, you will be provided with a written response that will indicate whether or not a quality of care issue was found to exist. However, because the investigation of a quality of care issue is considered a confidential and privileged professional peer review activity, you should not expect the written response to provide any details about the investigative results or what corrective steps, if any, were taken based on such results.
2. **Quality of Service Complaints.** Quality of service complaints include such issues as excessive waiting time, rudeness of a physician or staff, office conditions, etc., and will be referred to the appropriate department for handling.

Section V - Coordination of Benefits (COB)

Section V, **Coordination of Benefits (COB)**, in this Part One applies when you receive a service which is covered by the Plan and any other Health Plan, including Medicare. For example, you might be covered as the employee under this Plan, and, at the same time, as a dependent under your spouse's health benefits plan. Or your children might be covered at the same time under this Plan and another parent's health benefits plan. Therefore, if you are covered by another Health Plan, and receive a service covered by this Plan and the other Health Plan, your benefits will be coordinated. This is done by determining which Health Plan is "primary" and which Health Plan "secondary." The Health Plan that is primary determines your benefits first, and provides coverage without taking into consideration any benefits available through your secondary Health Plan. The Health Plan that is secondary then determines your benefits, under its terms, taking into account the benefits available under your primary Health Plan. Paragraph C.1 below describes the benefits available under the Plan when you are covered by more than one Health Plan and this Plan is secondary. Paragraph D.1 below sets forth the rules used to determine which of your Health Plans is primary.

A. **APPLICABILITY.** All of the covered benefits described in Part Two of this document are subject to the provisions of this Part One, Section V, **and Coordination of Benefits (COB).**

B. **DEFINITIONS.** For the purposes of this section only, the following words and phrases shall have the following meanings:

1. **"Allowable Expense"** means any necessary, reasonable and customary item of expense, at least a portion of which is covered by a Health Plan covering the member. If a Health Plan (including this Plan) provides benefits in the form of services, the reasonable cash value of the service rendered shall be deemed to be both an Allowable Expense and a benefit provided.
2. **"Claim Determination Period"** means a calendar year (January 1 through December 31), excluding any portion of the year that occurs prior to the effective date of your coverage.
3. **"Health Plan"** means this Plan and any of the following which provide coverage for medical or dental care:
 - A coverage plan or program required or provided by any federal or state government, including but not limited to Medicare, unless coordination of benefits with such plan or program is prohibited by law.
 - Group or group-type, group automobile insurance, and any other coverage arrangement for individuals in a group whether on an insured or uninsured basis, including but not limited to any prepaid coverage, group practice or individual practice coverage and any coverage for students sponsored by or provided through an educational institution above the high school level.

In applying the term "Health Plan":

- Each policy, contract or other arrangement for coverage, benefits or services shall be treated as a separate Health Plan; and
- As to each such policy, contract or other arrangement, if there is a portion thereof which reserves the right to take the benefits of other Health Plans into consideration in determining benefits and a portion which does not, each such portion shall be treated as a separate Health Plan.

C. **AVAILABLE BENEFITS.**

1. **Non-Duplication Provision.** If you are covered under more than one group Health Plan and you receive a service covered under this Plan and another Health Plan, and the other Health Plan is determined to be primary, the Plan will not provide any benefits for the covered service, except as follows:

The Plan pays the difference, if any, between what the Plan would have paid had it been the only plan and the amount actually paid by another group plan. In total, you will receive the maximum benefit of the more generous Health Plan.

If you have coverage under this Plan and another Health Plan, and the other Health Plan is primary, but you receive a service which is not covered by the other Health Plan but is covered by this Plan, then this Plan will pay whatever benefits would have been available for that service if this Plan were determined to be primary.

2. **Limitation on Benefits Available In Any Given Claim Determination Period.** Whenever the sum of all benefits available to a member under this Plan and any other Health Plans would, but for the existence of coordination of benefits provisions such as those contained in this Part One, Section V, exceed the member's Allowable Expenses for a Claim Determination Period, the Plan shall reduce the benefits which it would otherwise provide to the member, so that the benefits available through the other Health Plans and the benefits actually provided by this Plan do not total more than the member's Allowable Expenses. Benefits available under another Health Plan include the benefits the Health Plan would have paid if a claim for benefits had been duly made, even if such a claim was not actually made.

D. DETERMINATION OF BENEFITS.

1. **Rules Governing the Order of Benefit Determinations.** Other than those benefits described in paragraphs H, I and J of this Part One, Section V, the rules in paragraph D.1 below shall be applied in the order in which they are listed to determine which of your Health Plans is primary and which is secondary (and, if applicable, which would come third).
 - a. **Rule 1 - Health Plan without COB provision is primary.** If one Health Plan contains a provision for coordination of benefits (“COB”) and the other does not, the Health Plan without the COB provision is primary.
 - b. **Rule 2 - Health Plan covering you as an employee is primary.** If one Health Plan covers you as an employee, and the other Health Plan covers you as a dependent, the Health Plan covering you as an employee is primary.
 - c. **Rule 3 - When both Health Plans cover you as a dependent child, the Birthday Rule applies.**

Birthday Rule: The Health Plan covering the parent whose birthday occurs first in the calendar year is primary. If both parents have the same birth date, then whichever Health Plan has covered a parent for a longer period of time shall be primary.

Exception to Rule 3: Rule 3 does not apply if the dependent child’s parents are divorced or legally separated.
 - d. **Rules 4 - 7.** When a dependent child’s parents are legally separated or divorced, and each parent has a Health Plan covering the child as a dependent, the following rules apply:
 - i. **Rule 4 - Order or decree determines which Health Plan is primary.** If a court order or decree directs one parent to be financially responsible for the child’s health care expenses, that parent’s Health Plan shall be primary for the child.
 - ii. **Rule 5 - Custody determines which Health Plan is primary.** If Rule 4 does not apply, and one parent has custody of the child and has not remarried, the Health Plan of the custodial parent is primary for the child.
 - iii. **Rule 6 - Remarried Parents.** If Rule 4 does not apply, and one parent has custody of the child and has remarried, and the child is also covered as a dependent under the stepparent’s Health Plan, then the Health Plan of the custodial parent shall be primary for the child, the Health Plan of the stepparent shall be secondary for the child, and the Health Plan of the non-custodial parent shall determine benefits third.
 - iv. **Rule 7 - Joint Custody.** If Rule 4 does not apply and the parents have joint custody of the dependent child, the Birthday Rule applies.
 - e. **Rule 8 - COBRA coverage is secondary.** If another Health Plan covers you as an employee or dependent, and this Plan covers you as a qualified beneficiary under COBRA, then the other Health Plan covering you as an employee or dependent shall be primary.
 - f. **Rule 9 - Laid-off or retired employees.** If one Health Plan covers you as an active employee or as the dependent of an active employee, and the other Health Plan covers you as a laid-off or retired employee or as the dependent of a laid-off or retired employee, then the Health Plan covering you as an active employee or the dependent of an active employee shall be primary. *Exception to Rule 9:* In the event that one Health Plan covering you does not have a provision regarding laid-off or retired employees, and both Health Plans are secondary according to their respective benefit determination rules, Rule 9 shall not apply.
 - g. **Rule 10 - Health Plan covering you longer is primary.** If Rules 1-9 above do not establish the order in which benefits are to be determined, the Health Plan which has covered you for the longer period of time shall be primary, and the Health Plan which has covered you for a shorter period of time shall be secondary.

E. FURNISHING INFORMATION. Any member claiming benefits or coverage under this Plan must furnish Aetna with any information Aetna deems necessary to implement this Part One, Section V.

F. FACILITY OF PAYMENT. Whenever payments which should have been made by this Plan have been made by another Health Plan, Aetna shall have the right, exercisable in its sole discretion, to pay over to the Health Plan which made the payments any amounts which Aetna determines to be warranted in order to satisfy the intent of this Part One, Section V. Amounts so paid by or on behalf of the Plan shall be deemed to be benefits paid by the Plan. To the extent of any such payment, the Plan shall be fully discharged from all liability to any person, Health Plan or provider to the extent of such payments.

- G. **DISCLOSURE.** Each member agrees to disclose to the Plan at the time of enrollment, at the time of receipt of services and benefits, and from time to time as requested by Aetna, his/her Social Security Number, birth date, employment, and the existence of any other Health Plan coverage. If the member has other Health Plan coverage, he/she must furnish Aetna with the identity of the insurer or plan sponsor and of the person and/or group through which this other Health Plan coverage was provided.
- H. **SPECIFIED EMPLOYEE PROVIDER.** Services and benefits which are provided directly through a specified health care provider of an employer shall in all cases be provided before the benefits of this Plan.
- I. **MILITARY BENEFITS.** Services and benefits for disabilities connected with military service, to which a member is legally entitled and for which facilities are reasonably available, shall in all cases be provided before the benefits of this Plan.
- J. **WORKERS' COMPENSATION.** Services and benefits available under Workers' Compensation or any similar program with respect to work-related illness or injury shall not be reimbursable by the Plan.
- K. **RELEASE OF INFORMATION.** Aetna may, without the member's consent and without notice to the member, release information concerning the member to any organization or individual, or obtain such information from any such source, which is necessary to implement this Part One, Section V.

PART TWO

DESCRIPTION OF PLAN BENEFITS

Section I - Requirements for All Health Care Services

To be covered by the Plan, a health care service must meet *all* of the requirements described in this Part Two, Section I.

- A. **THE SERVICE MUST BE *MEDICALLY NECESSARY*.** For a service to be *medically necessary*, it must meet *all* of the following conditions:

The service must be provided by an In-Network Duke Basic provider (**Please Note:** It is the member's responsibility to assure the provider (including but not limited to physicians, hospitals, nursing homes, rehab therapy providers, and durable medical equipment vendors) is currently in the Duke Basic network);


The service is required for diagnosing, treating or preventing an illness or injury, or a medical condition such as pregnancy;

If you are ill or injured, it is a service you need in order to keep your condition from getting worse;

It is generally accepted as safe and effective under standard medical practice in your community; and

The service is provided in the most cost-efficient way, while still giving you an appropriate level of care.

Not every service that is medically necessary is covered under the Plan.

 PLEASE NOTE: Although a physician or other health care provider may perform, prescribe or recommend a service, it does not mean that the service is medically necessary and/or covered by the Plan. The service must be specifically listed in Part Two, Section II, **What Is Covered**. For a listing of some services the Plan does not cover at all, see Part Two, Section III, **What Is Not Covered**.


- B. **PLAN REVIEW.** As part of the administrative service it provides on behalf of the Plan, Aetna may review services requested or received by you to determine whether they satisfy all the conditions for coverage. If it is determined that the services did not or do not satisfy coverage requirements, you will be required to pay for the services. If you disagree with the coverage decision, you can appeal the decision by following the procedures described in Part One, Section IV, **Appeals, Grievances, Complaints and Quality Issue Procedures**.

- C. **MEMBER INQUIRIES.** If you are unsure whether a service is covered, please call the Aetna Member Services Department at 1-800-DUKE MEM (385-3636) to help prevent you from mistakenly obtaining a service that is not covered.

- D. **DUKE BASIC BENEFITS.** Except for services which are determined by Aetna on behalf of the Plan to be for Emergency Care or Urgent Care covered under Part Two, Section II.F, covered services are available only at Duke Basic providers.

1. **Member Payments.**

- a. **Copayments.** When using your benefits, you are required to make a payment at the time you receive the service. This payment is called your "Copayment." You must make your Copayment to the health care provider at the time you receive the service. If you visit an In-Network PCP, you will be responsible for the PCP Copayment. If you visit an In-Network Specialist, you will be responsible for the In-Network Specialist Copayment. However, an office visit Copayment will not apply if you receive only diagnostic services, injections such as immunizations or allergy shots, or other services from an RN, LPN, or technician.
- b. **Deductibles.** Your benefits are subject to the Deductibles described in Section IV, **Deductible**, of this Part Two. Please note that your Copayments do not apply to your Deductible.
- c. **Coinsurance Maximums.** Your benefits are subject to the Coinsurance Maximums described in Section V, **Coinsurance Maximum**, of this Part Two. Please note that your Copayments and Deductibles do not apply to your Coinsurance Maximum.
- d. **You must obtain the service from participating providers and facilities in the Duke Basic Network.** The term "participating" refers to health care providers and facilities that are part of the Duke Basic Network. For information on the participating providers and facilities in the Duke Basic Network, check the provider directory online at aetna.com/dsepublic/#/dukeuniversity. **Please Note:** It is the member's responsibility to assure the provider is currently in the Duke Basic network.

 PLEASE NOTE: **Precertification Decisions.** Certain services, procedures and inpatient admissions require a Precertification before the Plan will authorize payment for these services. As a general rule, Precertification is to be obtained before the requested service is rendered. Precertification decisions are made as quickly as possible, but no later than seventy-two (72) hours of the request in the case of urgent care and no later than two (2) business days of receipt of all necessary information in the case of non-urgent care. If Precertification is requested and denied, the requested services will not be covered by the Plan. If a Precertification request is denied in whole or in part, you may submit to Aetna a written request within one hundred eighty (180) days of the denial date for review specifically requesting a review of the decision and including with the request any supporting documentation. Please see Part One, Section IV.A for specific information about the Appeal review process.

Section II - What Is Covered

A. PREVENTIVE HEALTH CARE SERVICES.

1. **Physical Exam.** A physical exam by the provider for members 2 years of age or older. The provider decides how extensive this exam should be, based on Plan guidelines. The Plan *does not* cover physicals for travel outside the United States, or for employment, extracurricular activities, camps or recreational activities.

Copay Required: \$25 Primary Care, \$75 Specialist

2. **Well-Child Care.** Well-child care provided by the provider for members through age 17. The provider decides how frequent and extensive it should be, based on Plan guidelines.

- For newborns, inpatient “well baby” services, including the initial physical are only covered when the baby is enrolled in the Plan. Newborn services will only be covered if the newborn is enrolled in the Plan as a dependent within 30 days of his/her date of birth.
- Well-Child Care exams are covered as follows:
 - 7 exams 1st year (first 3-5days, then 1st month, 2nd month, 4th month, 6th month, 9th month, 12th month)
 - 3 exams 2nd year
 - 3 exams 3rd year
 - 1 exam per year through age 17
 - 18 & older one exam per year

Copay Required: None for children age 2 and under; \$25 Primary Care, \$75 Specialist

3. **Routine Immunizations.** Routine immunizations recommended by the American Academy of Pediatrics and/or U.S. Preventive Services Task Force and/or U.S. Public Health Service for people in the United States. **However, the Plan does not cover immunizations for travel outside the United States, or for employment, school sports, extracurricular activities, or recreation activities.** Flu shots are covered. Persons requiring flu shots for employment should contact their employers’ occupational health office. Tetanus shots, Gardasil (human papilloma virus) and meningitis vaccine for college students are covered as recommended by the provider. The shingles vaccine, flu shot, and the pneumonia vaccine are also available under the Express Scripts pharmacy benefit from local pharmacies at no charge for members age 14 and older.

Copay Required: None, unless seen by a provider

4. **Routine Sight, Speech and Hearing Screenings for Children.** Routine screenings of vision, speech and hearing for members through age 17. In the event of a diagnosis of hearing loss, the Plan does cover the initial audiometric exam. However, the Plan *does not* cover testing or fitting for hearing aids, or hearing, occupational, or educational therapy, except for children under the age of 22.

Copay Required: \$25 Primary Care, \$75 Specialist

5. **Well Eye Exam.** One eye exam per calendar year. The exam includes routine screening for eye diseases and assessment of the need for corrective lenses. A prescription for corrective lenses may be given, but the Plan does not cover the cost of the lenses.

Fitting for contact lenses is not covered by the Plan. However, any prescription given during the well eye exam can be taken to the practitioner who will be fitting the contact lenses.

Copay Required: \$75 Specialist

B. ADDITIONAL PREVENTIVE SERVICES.

1. ***Routine Gynecological Examinations.*** The Plan covers one routine gynecological exam per calendar year. This exam may include a mammography screening, pelvic exam and Pap smear on the schedule recommended by the examining provider.

Copay Required: \$25 Primary Care, \$75 Specialist

C. OUTPATIENT SERVICES.

1. ***Physician Office Visits.*** The Plan covers visits to a physician's office for diagnosis or treatment of an illness or injury.

Copay Required: \$25 Primary Care, \$75 Specialist

2. ***Laboratory Services.*** The Plan covers laboratory services prescribed by your Duke Basic provider.

Copay Required: None

3. ***Radiology Services.*** The Plan covers x-rays, radiation therapy and other radiology services for diagnosis or treatment.

Copay Required: Magnetic Resonance Imaging (MRI), CAT Scans, Positron Emission Tomography (PET Scans), \$150 per visit. (Copay does not apply when Member is receiving Emergency Care and/or inpatient care)

Copay Required: None for other radiological services.

4. ***Surgical Procedures in Physician's Office.*** The Plan covers surgical procedures performed in the physician's office. If the surgical procedure involves general anesthesia or is performed in a surgical suite, it must meet the requirements for ambulatory surgery specified in Part Two, Section II.C.14, **Ambulatory and Same-Day Surgery.**

Copay Required: \$25 Primary Care, \$75 Specialist



PLEASE NOTE: Duke Family Medicine is a Hospital Outpatient Department. Thus, surgical procedures performed will be subject to deductible and coinsurance.

5. ***Second Opinions.*** The Plan covers second opinions about a covered surgery or covered diagnostic procedure recommended by another Duke Basic provider.

Copay Required: \$25 Primary Care, \$75 Specialist

6. ***Medications and Materials Administered or Applied in Physician's Office or by Infusion Service.*** The following medications and materials are covered *if* they are generally available in the physician's office *and* they are administered or applied there *or* by an infusion service *and* are not limited or excluded as listed in Part Two, Section III, **What Is Not Covered:**

- Medications or vaccinations administered orally, by injection or otherwise covered separately under your Prescription Drug Program;
- Biologicals and fluids may also be covered under your Prescription Drug Program;
- Radioactive materials and inhalation therapy;
- Dressings, casts and splints (where splints are commonly used instead of casts); and
- Flu shots.

Copay Required: None, unless seen by a provider, or if provider requires that drug be obtained from a pharmacy. Then prescription drug copay and deductible applies.

7. ***Pre-Natal and Post-Natal Obstetrical Care.*** The Plan covers pre-natal and post-natal visits, diagnostic amniocentesis and chorionic villus sampling but only for the employee, the employee's spouse or the employee's Registered Same-Sex Spousal Equivalent. There is no coverage for dependent children of the employee.

Copay Required: \$25 for Primary Care confirmation of pregnancy visit, \$75 for Specialist confirmation of pregnancy visit. There is no Copay for all other pre-natal and post-natal visits and services noted above. **For inpatient maternity and obstetrical services, please note that the inpatient Coinsurance and Deductible applies.**



PLEASE NOTE: There are no benefits available for the normal delivery of a baby (vaginal or cesarean section) outside the Duke Basic Network Service Area beyond the 35th week of pregnancy.

8. ***Lactation Consultant.*** The Plan covers medically necessary visits with a Lactation Consultant.

Copay Required: None, for first six visits, for the 7th visit and there after covered 100% after the applicable office visit copay.

9. **Short-Term Rehabilitation, Physical and Occupational Therapy.** The Plan covers short-term outpatient rehabilitation, physical and occupational therapy and pain management services that meet *all* of these conditions:
- the services are designed to restore function if you have lost existing function as a result of injury or disease and suffer significant impairment of activities of daily living; and
 - the services are received from Duke Basic providers; and
 - Aetna determines, on behalf of the Plan, that the services can be expected to significantly improve your condition during the course of the treatment.

Please Note: Rehabilitation, physical and occupational therapy services received in the home are subject to the same copays and limitations as those received in an outpatient environment. Coverage is limited to a maximum combined treatment period of 40 visits per illness or injury.

Copay Required: \$75 per visit

10. **Speech Therapy.** The Plan covers speech therapy services that meet *all* of these conditions:

- services are received from Duke Basic providers; and
- Aetna determines, on behalf of the Plan, that the services can be expected to significantly improve your condition during the course of the treatment; and

Please Note: Speech therapy services received in the home are subject to the same copays and limitations as those received in an outpatient environment. Coverage is limited to a maximum treatment period of 20 visits per calendar year.

Copay Required: \$75 per visit

11. **Pulmonary and Cardiac Rehabilitation Therapy.** The Plan covers outpatient pulmonary and cardiac rehabilitation therapy services following a qualifying event. Examples of qualifying events include acute myocardial infarction, new onset angina, congestive heart failure (CHF) or chronic obstructive pulmonary disease (COPD); or recent acute exacerbation of chronic CHF, angina or COPD. The services must be precertified by Aetna in order to be covered.

Pulmonary and Cardiac Rehabilitation Therapy must follow a specific treatment plan ordered by a physician.

Copay Required: \$75 per visit

12. **Chiropractic Services.** The Plan covers short-term manual manipulation of the spine for the treatment of symptoms of pain or partial loss of sensation or range of motion when such symptoms are caused by an acute condition or injury and result in significant functional impairment.

Copay Required: \$75 Specialist

13. **Podiatric Services.** The Plan covers certain podiatric services when such services are required for treatment of a medically necessary foot condition and are not considered routine foot care.

Copay Required: \$75 Specialist

14. **Ambulatory and Same-Day Surgery.** The Plan covers outpatient surgery performed in an ambulatory surgery facility and same-day surgery performed in a hospital without an overnight stay, including anesthesia. When the procedure is non-surgical, such as laser treatment, the deductible and coinsurance applies; the only exclusion would be pulsed die laser treatment.

Copay Required: Deductible applies. 10% Coinsurance per Outpatient Hospital visit

15. **Physician Services at Home.** The Plan covers physician services provided to you at home, but only if:

- You are unable, for medical reasons, to leave your home, *and*
- The services could not be performed by someone who is not a physician.

Copay Required: \$25 Primary Care, \$75 Specialist

16. **Allergy Testing and Injections.** The Plan covers testing and injections for allergies.

Copay Required: Allergy Testing: \$25 Primary Care, \$75 Specialist. Injections: No Copayment required, unless seen by a Provider.

17. **Growth Hormone.** Growth hormone treatments through age 18 for pituitary dwarfism and Turner’s syndrome are covered under your Prescription Drug Program when precertified in accordance with Aetna guidelines. **NOTE:** Growth hormone for short stature is not covered.

Copayments, and other additional conditions of and limitations on coverage, are described in your Prescription Drug Program document.

18. **Biofeedback.** All biofeedback must be precertified by Aetna to determine whether treatment is being ordered for medical or mental health reasons.

Copay Required: \$75 Specialist

19. **Colonoscopy.** The Plan covers colonoscopies for all members subject to the recommendations by the Public Health Service Task Force.

Copay Required: None

20. **Dialysis Services.** The plan covers dialysis at In-Network centers for End Stage Renal Failure for no more than 30 months, starting with the earlier of (a) the month in which a regular course of dialysis is initiated, or (b) in the case of an individual who receives a kidney transplant, the first month in which the individual becomes entitled to Medicare. When you become eligible for Medicare due to end stage renal disease, you must enroll in both Medicare A&B, regardless of your employment status. Patients receiving dialysis services, who, while on vacation, need out-of-network services, must have those precertified in advance through Aetna.

Copay Required: None

21. **Registered Dietician (Nutritionist) Visits.** The plan covers six visits per calendar year.

Copay Required: \$25 per visit

D. FAMILY PLANNING.

1. **Family Planning.** The Plan covers these family planning services:

- Information and counseling on contraception, including prescribing a contraceptive;
 - Coverage for long acting, reversible contraception including including implants and intrauterine devices (IUD ;
 - Fitting a diaphragm;
 - Vasectomy;
 - Elective tubal ligation;
 - Voluntary termination of pregnancy, covered only for employee, employee’s spouse, and employee’s Registered Same-Sex Spousal Equivalent, but not other enrolled dependents; and
- Depo-Provera and oral contraceptives are covered under your Prescription Drug Program and must be purchased at a participating pharmacy using your pharmacy card.

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

Consistent with Sec. 506 of the Federal Consolidated Appropriations Act, Duke's self-insured health plan does not use federal funding to pay for abortions (termination of pregnancy) for any plan participant. Rather, such costs are paid from Duke's general assets, distinct from any mechanism under which federal funding has been appropriated.

E. INPATIENT SERVICES.

Except for admissions following Emergency Care or Urgent Care described in Part Two, Section II.F, Precertification is required for all admissions to any hospital, skilled nursing facility or other inpatient facility. Inpatient admissions will be certified only for a specific period of time. If you stay longer than the time authorized, you will have to pay the charges for your additional stay.

Benefits for maternity services are available for the employee, the employee’s spouse and the employee’s Registered Same-Sex Spousal equivalent only, and are not available for dependent children.

For newborns, inpatient “well baby” services, including the initial physical are only covered when the baby is enrolled in the Plan and services are received in the network. If the mother is covered under another health plan, newborn services will only be covered if the newborn is enrolled in the Plan as a dependent within 30 days of his/her date of birth.

Copay Required: Deductible applies. 10% Coinsurance per inpatient admission; waived for subsequent admission(s) if readmitted within two (2) weeks for the same condition.

THE INPATIENT SERVICES COVERED BY THE PLAN ARE:

1. **Room, Meals and Nursing Care.** Room, meals and general nursing care are covered during your inpatient stay. The Plan covers special diets if they are medically necessary and prescribed by your physician.
2. **Medical, Surgical and Obstetrical Services.** The Plan covers these medical, surgical and obstetrical services during your precertified inpatient stay:
 - Physician services.
 - Operating room and related facilities.
 - Anesthesia and oxygen services.
 - Intensive care and other special care units and services.
 - X-ray, laboratory and other diagnostic tests.
 - Prescription medications and biologicals for use while you are an inpatient.
 - Radiation and inhalation therapies.
 - Visualizing dyes, intravenous (IV) preparations and chemotherapy.
 - The administration and processing of whole blood. However, the Plan does not cover storage, freezing or replacement costs for blood or blood products.
 - a. **Obstetrical Services.** Under the federal legislation known as the Newborns' and Mothers' Health Protection Act (NMHPA), the Plan may not restrict benefits for any hospital length of stay in connection with childbirth to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. Physicians are *not* required to obtain prior authorization from the Plan before prescribing a length of stay that does not exceed these limits. However, all inpatient admissions *do* require notification by the facility.
 - b. **Breast Reconstructive Surgery after Mastectomy.** Under the federal legislation known as the Women's Health and Cancer Rights Act, the Plan provides coverage for breast reconstruction following a medically necessary mastectomy, including:
 - Reconstruction of the breast on which the mastectomy has been performed;
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
 - Prostheses; and
 - Treatment of physical complications of all stages of mastectomy, including lymphedemas.
3. **Rehabilitation, Physical, Speech and Occupational Therapy.** Inpatient rehabilitation, physical and speech therapy and pain management services provided in conjunction with an acute illness or injury are covered if they meet all of these conditions:
 - You are receiving other covered inpatient care at the same time, or it is determined that the services can only be provided on an inpatient basis; and
 - It is determined that the services can be expected to significantly improve your condition; and
 - Precertification is obtained for the services; and
 - Your participating Duke Basic physician authorizes the services.Your coverage for these services is limited to a maximum treatment period of 60 consecutive days per illness or injury. The 60 day treatment period commences on the date you first receive the services.
4. **Transplant Services.** Eligible health services include organ transplant services provided by a physician and hospital.

Organ means:

 - Solid organ
 - Hematopoietic stem cell
 - Bone marrow
 - CAR-T and T-cell receptor therapy for FDA-approved treatments

Network of transplant specialist facilities
You can get transplant services from:

 - A Duke facility
 - If not available at Duke, then an Institutes of Excellence™ (IOE) facility designated by Aetna to perform the transplant you need.

The National Medical Excellence (NME) Program® will coordinate all solid organ, bone marrow and CAR-T and T-cell therapy services, and other specialized care you need.

All the following conditions must also be met:

- The proposed Transplant is not experimental or investigational as defined in Part Two, Section III, **What Is Not Covered**; and
- The proposed Transplant is not to be performed in connection with a drug, device or medical treatment procedure that is experimental or investigational; and
- The medical facility designated to evaluate the member's case has determined that the proposed Transplant is appropriate for treatment of the member's condition and has agreed to perform the transplant; and
- Precertification is obtained for the transplant services.

Donor-related services: The Plan does not cover any expenses related to the donation of organs, tissues, bone marrow or peripheral stem cells by live donors unless the donor is a living relative and the donor expenses were not covered under the donor's health plan.

5. **Skilled Nursing Facility Care.** The Plan covers inpatient care in a skilled nursing facility if it meets *all* of these conditions:

- If you were not admitted to a skilled nursing facility, you would need acute care hospitalization; and
- Your physician authorizes it;
- The facility is In-Network and
- The admission is precertified.

Your coverage is limited to a maximum of 60 days per illness or injury per year. However, the Plan *does not* cover:

- Custodial care and intermediate care for Alzheimer's disease, senile deterioration, persistent vegetative state, mental retardation, mental deficiency, or any similar persistent illness or disorder, as described in Part Two, Section III, **What Is Not Covered**; or
- Care for persistent illnesses and disorders that, in the opinion of the Plan, cannot be relieved or improved by medical treatment, as described in Part Two, Section III, **What Is Not Covered**.

Copay Required: None

F. EMERGENCY CARE AND URGENT CARE.

1. **Definitions.** For the purposes of this Paragraph the following terms shall have the following meanings:

- a. "Emergency Care" means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:
- (i) Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
 - (ii) Serious impairment to bodily functions.
 - (iii) Serious dysfunction of any bodily organ or part.

Some examples of Emergency Care include but are not limited to: broken bones; chest pain; seizures or convulsions; severe or unusual bleeding; severe burns; suspected poisoning; trouble breathing; and vaginal bleeding during pregnancy.

b. "Urgent Care" is:

Treatment received for a medical problem that is not a true emergency but still requires quick medical attention usually falls into the category of "Urgent Care."

c. Requirements for Emergency Care. Emergency Care is covered by your Benefits, regardless of whether you obtain this care from or through the Duke Basic Network.

- You (or someone acting for you) must *contact your PCP or Aetna* for advice and instructions *as soon as possible* after the occurrence of any emergency or urgent condition for which hospitalization or continuing outpatient treatment is required. You must contact Aetna within 48 hours if an admission results from the emergency condition, unless that is not reasonably possible; and
- You are transferred to the care of participating providers as soon as this can be done without harming your condition.



PLEASE NOTE: If, at the point when you could be transferred, you continue to use non-participating providers, the services will not be covered by your Duke Basic Benefits.

Aetna will pay for out-of-area Urgent Care services if you experience a sudden and unexpected illness or injury and the following are true:

- You could not have foreseen the need for care before leaving the service area;
- You did not specifically leave the service area to obtain care; and
- The care cannot be safely delayed until you are able to return to the service area.

d. **Services and Copayments.** Your In-Network Benefits for services which are determined to meet the coverage requirements for Emergency Care or Urgent Care set forth in Paragraphs 1.a, 1.b, and 1.c of this Section cover:

- Hospital emergency room services.
- Copay Required: \$250 per Emergency Care visit, but this is waived if you are admitted to the hospital from the emergency room. If you are kept for observation, the copay is **not** waived.
- Services in an outpatient Urgent Care center.
- Copay Required: \$50 per Urgent Care visit.
- Ambulance service for Emergency Care to the nearest medical facility able to provide appropriate care. Deductible applies, and your payment is 20% Coinsurance per ambulance service.

2. **Payment Procedures.** Your coverage for Emergency Care and Urgent Care is provided in one of two ways:

- The Plan will reimburse you for payments you made for covered services filed within 180 days; or
- The Plan will arrange to pay the providers of the services directly.

3. **Plan Review.** As part of the administrative services it has agreed to provide the Plan, Aetna may review all services that you were provided and the circumstances in which you received them to determine if the care provided meets or met the requirements for Emergency Care or Urgent Care. **Determinations made by the Plan on all Emergency Care or Urgent Care will be based on presenting symptoms and not the final diagnosis.** If you disagree with the coverage decision, you can appeal the decision using the procedures described in Part One, Section II, **and Claims Procedures.**

4. **Claim Submission.** Claims for all services for which you are required to pay and submit to the Plan for reimbursement must be submitted within 180 days from the date the services were rendered. Claim submissions beyond the 180 days will **not** be considered. Forward Claims to:

Duke Basic
c/o Aetna P.O. Box 981106
El Paso, TX 79998

G. OTHER HEALTH CARE SERVICES.

1. **Home Health Care/Infusion Services.** The Plan covers home health care services ordered by your physician and precertified by Aetna. However, the Plan *does not* cover:

- Custodial care and intermediate care for Alzheimer’s disease, senile deterioration, persistent vegetative state, mental retardation, mental deficiency, or any similar persistent illness or disorder (described in Part Two, Section III, **What Is Not Covered**); or
- Care for persistent illnesses and disorders that cannot be relieved or improved by medical treatment (described in Part Two, Section III, **What Is Not Covered**).

This coverage is limited to 100 visits in a calendar year.

Covered only if:

- The services are precertified by Aetna; and
- The services are provided by a participating Duke Basic provider; and
- Your PCP or participating specialist authorizes the services.

Copay Required: \$25 per visit

Please Note: Speech, rehabilitation, physical and occupational therapy services received in the home are subject to the same copays and limitations as those received in an outpatient environment.

2. **Non-Emergency Ambulance Service.** The Plan covers non-emergency ambulance service, including air ambulance service, if it is medically necessary **and** is precertified.

Copay Required: Deductible applies, and your payment is 20% Coinsurance per ambulance service.

3. ***Implant, Non-Cosmetic Prosthetic Devices.*** The Plan covers internal, non-cosmetic prosthetic devices, including permanent aids and supports for defective parts of your body. Examples of prosthetic devices the Plan covers are joint replacements, internal and external cardiac pacemakers, permanent lenses (only following cataract surgery), and minor devices such as screw nails, sutures and wire mesh. The Plan also covers the replacement, repair and maintenance of any of these covered prosthetic devices.

Prosthetic devices will be covered only for uses that have been approved by the U.S. Food and Drug Administration. The Plan *does not* cover hearing aids for adults over age 21 or mechanical organ replacement devices such as artificial hearts.

Copay Required: None

4. ***External, Non-Cosmetic Prosthetic Devices, Corrective Appliances, and Orthotics.*** The Plan covers the purchase of standard external, non-cosmetic prosthetic devices, corrective appliances, and orthotics, including replacements when medically necessary due to a change in the member's physical condition, as well as repair and maintenance. An external prosthetic device, corrective appliance, and orthotic, is a device that (a) replaces or supports all or part of a body part that is missing or inoperative or malfunctioning, and (b) is not surgically implanted. Some examples of covered external prosthetic devices, corrective appliances, and orthotics are: artificial arms, legs, eyes, hands and a wig.

The prosthetic device, corrective appliance, and orthotic, including any replacement of the device, must be prescribed by the member's physician and precertified.

No prosthetic device, corrective appliance, or orthotic, will be replaced more often than once every 36 months, regardless of the reason why replacement is sought, unless replacement is precertified.

Devices which are not covered include (but are not limited to) orthopedic shoes and other supportive devices for the feet (except if medically indicated and precertified for diabetic members or members with ischemic foot disease), dentures, eyeglasses, mechanical organ replacement devices, such as mechanical hearts, and cosmetic prostheses (except for breast prostheses).

Copay Required: Deductible applies. 20% Coinsurance

5. ***Hearing Aids.*** The Plan covers medically necessary hearing aids and related services that are ordered by a Physician or a licensed audiologist for each member under twenty-two (22) years of age.

Benefits are provided for one hearing aid per hearing-impaired ear, and replacement hearing aids when alterations to an existing hearing aid are not adequate to meet the Member's needs. This benefit is limited to once every 36 months.

The initial evaluation, fitting, and adjustments of hearing aids or replacement of hearing aids, and supplies, including ear molds are covered as part of this benefit.

6. ***Cochlear Implants.*** The Plan covers unilateral or bilateral cochlear implantation of an FDA approved cochlear implant device when considered medically necessary in patients who meet these criteria:

- Age 12 months and older; and
- Bilateral severe-to-profound pre- or post-lingual (sensorineural) hearing loss, defined as a hearing threshold of pure-tone average of 70dB (decibels) hearing loss or greater at 500 Hz (hertz), 1000 Hz and 2000 Hz; and
- Limited or no benefit from hearing aids.

Copay Required: Deductible applies. Inpatient: 10% Coinsurance up to maximum of \$2,000; Outpatient: 10% Coinsurance

A cochlear implant may not be covered for the following conditions:

- Deafness due to lesions of the eighth cranial (acoustic) nerve, central auditory pathway or brain stem,
- Active or chronic infections of the external or middle ear and mastoid cavity or tympanic membrane perforation,
- Cochlear ossification may prevent electrode insertion, and
- Absence of cochlear development as demonstrated on CT scans is an absolute contraindication

Cochlear implants must be prescribed by a physician and, precertified by calling Aetna at 1-800-385-3636 and provided within the Duke Basic Network.

7. ***Durable Medical Equipment (DME).*** The Plan covers the rental or purchase of standard durable medical equipment, which is defined as equipment that can withstand repeated use, is primarily and customarily used to serve a medical

purpose, generally is not useful to a person who is not ill or injured, is used in the home and is appropriate for such use, may be used by more than one person, and does not require an individual prescription for construction. The maintenance, repair or replacement of covered durable medical equipment is also covered, unless it is needed because of the member's inappropriate use or maintenance of such equipment. Disposable items necessary for the operation of covered durable medical equipment are also covered (examples of disposable items necessary for the operation of DME equipment are masks used with CPAP machines, suction catheters needed with suction machines). Such items as alcohol wipes and under pads are not required for the use of equipment and therefore would not be covered. Some examples of covered durable medical equipment are wheelchairs; aids for standing and walking, such as crutches and canes; braces for legs or back; equipment for traction; oxygen equipment; insulin pumps (supplies are available using your Prescription Drug Program card); replacement batteries for DME and external prosthesis; and hospital beds. TMJ splints are covered when medically necessary.

The durable medical equipment must be prescribed by a physician, meet medical necessity criteria, and be purchased from an approved vendor.

The decision whether to rent or purchase the equipment shall be made by Aetna on behalf of the Plan. Purchased equipment shall be the property of the Plan and must be returned to the Plan when the equipment is no longer medically necessary or the member's coverage terminates.

Breast Pumps will be covered as any other DME expense.

A cranial helmet will be covered as a DME expense and is subject to a \$600 lifetime maximum benefit.

Items which are not covered include (but are not limited to) comfort or convenience items, bed boards, bath lifts, over-bed tables, air purifiers, exercise equipment, stethoscopes, blood pressure gauges, orthopedic shoes, and arch supports.

Copay Required: Deductible applies, 20% Coinsurance

8. ***Medical Supplies.*** The Plan covers purchase of certain medical supplies, such as ostomy bags.

Copay Required: None- No Deductible Paid 100%

9. ***Administration of Blood.*** The Plan covers whole blood and blood products, including administration. Autologous blood is covered for a currently scheduled procedure only. However, the Plan *does not* cover any related storage, freezing or replacement costs for blood, blood products, or umbilical cord blood; long-term storage of autologous blood for future use (except for currently scheduled surgery); or directed transfusions.

Copay Required: None- No Deductible Paid 100%

10. ***Limited Dental-Related Services.*** The Plan provides limited coverage for the following dental-related services:

- a. Treatment of a fractured or dislocated jaw or damage to sound natural teeth, *if*:
 - The fracture, dislocation or damage results from an accidental injury; and
 - Both the injury and treatment occur while your coverage under this Plan is in effect; and
 - You seek treatment within 72 hours of the accidental injury, unless incapacitated at time of trauma. Coverage is limited to the functional restoration of structures and treatment resulting in fracture of jaw or laceration of mouth, tongue, or gums within 24 months of the traumatic event.
- b. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations. The services must be precertified.
- c. Diagnostic and surgical treatment of the temporomandibular joint (jaw or craniomandibular joint) by splinting, the use of intraoral prosthetic appliances to reposition the bones, or surgery including arthroscopy, if:
 - such treatment is medically necessary to treat a condition which prevents normal functioning of the particular bone or joint involved; and
 - there is clearly demonstrable radiographic evidence that the joint abnormality is caused by disease or traumatic injury

The services must be precertified.

- d. Dental services related to medical treatment of a severe congenital abnormality of the jaw and/or facial structures (e.g. cleft lip/palate or a lesion of similar severity) which results in functional disability sufficient to impair nutrition. This benefit is limited to dependent children and Precertification of medical necessity is required. For children with the above-noted abnormalities, medically necessary orthodontia and orthognathic surgery are considered eligible for coverage.

- e. Dental services to treat, repair or remove teeth as a result of poor hygiene or infection, or where there are enamel defects or missing **teeth** resulting from a developmental abnormality or a Genetic abnormality (e.g., ectodermal dysplasia or amelogenesis imperfecta) are **not** considered eligible for coverage under medical.
- f. **Dental-Related Anesthesia and Hospital or Ambulatory Facility Charges** are covered for children below the age of nine years with serious mental or physical conditions or significant behavioral problems, where the Provider treating the patient certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the dental procedure(s).

Anesthesia and Hospital or facility charges for dental services performed in a Hospital or ambulatory surgical facility in connection with dental procedures, persons will be covered. Prior Authorization of the facility will be required in accordance to the Aetna utilization review process. The professional component of the anesthesia services is covered; however any other professional component (such as dentistry) is not covered.

Copay Required: \$25 Primary Care, \$75 Specialist; Deductible applies, 10% Coinsurance per Outpatient Hospital visit



PLEASE NOTE: The services described above are the *only* dental-related services covered by the Plan. See Part Two, Section III, **What Is Not Covered**.

H. HOSPICE SERVICES.

If you are terminally ill, the Plan covers hospice services and related counseling for your family members (whether provided before or after your death), if *all* of these conditions are met:

- You elect to receive care in or by a hospice; and
- Your physician certifies that you have a life expectancy of six months or less; and
- Before the services are provided, your physician prepares a written treatment plan authorizing the services; and
- The services are precertified.

Copay Required: None

I. PRECERTIFICATION.

If you wish to know whether a particular service needs to be precertified, or whether Precertification has been obtained for a particular service, please contact Aetna at 1-800-385-3636.

Section III - What Is Not Covered

It is important that you understand what services are not covered under your Plan. There are two general rules to remember:

- The Plan covers only the health care services specified in Part Two, Section II of this booklet, **What Is Covered**. If a service is not listed in Part Two, Section II with benefits for your type of coverage, it is not covered.
- You must always meet the applicable conditions for coverage described in Parts One and Two of this document. Duke University also offers its employees additional free programs that may cover services that are not covered by the Plan:
 - **Employee Occupational Health Service**
 - **Live for Life**
 - **Personal Assistance Service**
 - **DukeWell**

The Plan does not cover and will not pay for the following services:

1. Acupuncture, acupressure, naturopathy, homeopathy, rolfing, hypnotherapy, massage therapy, aromatherapy, art therapy, hydrotherapy, Equestrian therapy (hippo therapy), pet therapy, cognitive therapy, llama therapy, and similar services.
2. Administrative charges billed by a provider, including charges for telephone consultation, failure to keep a scheduled visit, completion of claim forms, obtaining medical records, and late payments. Costs in excess of the allowed amount for services usually provided by one doctor, when those services are provided by multiple doctors of medical care provided by more than one doctor for treatment of the same condition by multiple doctors or medical care provided by more than one doctor for treatment of the same condition.
3. Anti-smoking treatments and programs, such as nicotine patches or gum.
4. Any blood storage, freezing or replacement costs (including umbilical cord blood), or the cost of directed transfusions or autologous blood transfusions not related to a planned, scheduled procedure.
5. Any services or items for which you have no legal obligation to pay, or for which no charge would ordinarily be made. Examples of this include care for conditions related to your military service, care while you are in the custody of any government authority, and any care that is required by law to be provided in a public facility.
6. Any service or supply that is not a covered service or that is directly or indirectly a result of receiving a non-covered service except that complications which constitute a Medical Emergency will be covered until the Emergency condition is stabilized.
7. Any services and/or supplies, or supply that are not provided by participating providers in accordance with our utilization management policies and procedures. This exclusion shall not apply to Medical Emergencies in or outside the service area and Urgent Care services outside the service area. We reserve the right to evaluate and determine coverage for care not directly provided by a participating provider.
8. Audiometric testing and expenses for the purpose of the provision of hearing aids and tinnitus maskers, except for the limited services described in Section G.5.
9. Braces and supports needed primarily for athletic participation or employment.
10. Care for senile deterioration, persistent vegetative state, mental retardation, mental deficiency, or any other persistent illness, disorder or condition that the Plan determines cannot be significantly relieved or improved by medical treatment.
11. Charges for continuation of care received after the coverage termination date, regardless of when the care initially commenced.
12. Charges for missed appointments, telephone consultations, charges for completion of any forms, medical records or charges for medical information required by the Plan.
13. Charges for services incurred more than 180 days prior to submission of a claim to the Plan.
14. Charges for treatment and services received after the coverage termination date, regardless of when the treated condition occurred.

15. Chelation therapy, except in the treatment of conditions which are considered medically necessary.
16. Claims not submitted to Aetna within 180 days of the date the charge was incurred, except in the absence of legal capacity of the member.
17. Convenience items such as, but not limited to, devices and equipment used for environmental control, urinary incontinence devices (including bed wetting devices) and equipment, heating pads, hot water bottles, ice packs and personal hygiene items.
18. Corrective orthopedic shoes, arch supports, foot orthotics, braces, splints or other foot care items.
19. Cosmetic or other reconstructive procedures (including any related prostheses) that are not medically necessary and complications resulting from such procedures. Cosmetic surgery means surgery to change the texture or appearance of the skin; or the relative size or position of any part of the body; when such surgery is not needed to correct or substantially improve a bodily function. Removal of skin lesions is considered cosmetic unless the lesions interfere with normal body functions or malignancy is suspected.
20. Removing or altering sagging skin; any procedure that does not repair a functional disorder; changing the appearance of any part of your body (such as enlargement, reduction or implantation); hair transplants or removal; peeling or abrasion of the skin; Renova® or any other cosmetic drug or treatment; and any procedure that is primarily intended to improve your physical appearance, whether for emotional, psychological or any other reasons.
21. Services received either before or after the coverage period of the Plan, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination.
22. Costs of travel, whether or not recommended by a doctor.
23. Dental treatments, diagnostics, implants, services, appliances and supplies. For instance, the Plan does not cover routine dental work, x-rays or exams; dentures; dental prostheses or cosmetic surgery for shortening or lengthening your jaw; orthodontics; splints; positioners; or extracting teeth. The only dental-related coverage provided under the Plan is described in Section II.G.8 of this Part Two.
24. Durable Medical Equipment, such as comfort or convenience items; bed boards; patient, bath, and toilet lifts; chairs and rails; over-bed tables; stair lifts and wheelchair ramps; wheelchair trays and flotation devices; air purifiers; exercise equipment; stethoscopes; blood pressure gauges; orthotics; orthopedic shoes; shoe inserts and arch supports; heel lifts, cups and pads. Durable Medical Equipment required for environmental accommodations.
25. Services primarily for educational purposes including, but not limited to, books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction and counseling, except as specifically covered by the Plan.

The following equipment:

Devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, chair lifts, stair lifts, home elevators, and ramps.

Air conditioners, furnaces, humidifiers, dehumidifiers, vacuum cleaners, electronic air filters and similar equipment

Physical fitness equipment, hot tubs, Jacuzzis, heated spas, pool or memberships to health clubs.
26. Educational testing or neuro-psychological testing related to issues of school performance, learning disability or school behavior. Neuro-psychiatric testing and other evaluation to aid in the determination of disputed child custody.
27. Except for the eye-exam covered under Part Two, Section II.A.5, eyeglasses, contact lenses, and any other items or services for the correction of your eyesight, including orthoptics, refraction tests, vision training, vision therapy and radial keratotomy or keratoplasty.
28. Experimental or investigational drugs, devices, treatments or procedures. This exclusion also applies to any drug, device, treatment or procedure that would not be used in the absence of the experimental or investigational drug, device, treatment or procedure. A drug, device, treatment or procedure is considered to be experimental or investigational if any of the following applies:
 - a) Any health product or service that is considered not to have demonstrated value based on clinical evidence reported in peer reviewed medical literature and by generally recognized academic experts.
 - b) The health product or service under consideration is not as beneficial as established alternatives that remain suitable for the patient.
 - c) There is inconclusive evidence in peer-reviewed medical literature to permit the Plan to evaluate the therapeutic value of the health product or service.

- d) Any health product or service that is the subject of a clinical trial that meets criteria for Phase I as set forth by FDA regulations.
- e) Any drug or device or biologic not approved for human use by the FDA.

When Clinical Trial Services for Life-Threatening Conditions are Covered.

The plan may provide coverage for clinical trial services when **all** of the following criteria are met:

- 1) The member, who is a potential clinical trial enrollee, has a current diagnosis with a grave prognosis (life expectancy less than 2 years);
 - Even if treated with currently accepted treatment options; and/or
 - Standard therapies have not been effective in significantly improving the condition of the member or would not be medically appropriate; and
- 2) The proposed treatment is likely to be beneficial to the member based on at least two independent documents of medical and scientific evidence; and
- 3) The member is to be treated as part of a clinical trial satisfying all of the following criteria:
 - The investigational drug, device, therapy or procedure is under current review by the FDA and has an Investigational New Drug number (when applicable) or is classified as an Investigational Device Exemption (IDE), or the study involves a new combination of FDA approved drugs; and
 - The clinical trial has passed independent scientific review and has also been approved by an Institutional Review Board that will oversee the investigation; and
 - The clinical trial must be a phase II, phase III or phase IV patient research study approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, the Department of Veterans Affairs, or other entities at the plan's discretion; and
 - The clinical trial must be conducted in a setting and by personnel who maintain a high level of expertise because of their training, experience, and volume of patients; and
- 4) The member must:
 - Be enrolled in the trial; and
 - Provide informed consent; and
 - Be treated according to protocol.

In the event that clinical trial services are not adequately provided in state, MEMBERS have the right to make a request to have the service furnished by an out-of-state provider. Such requests can be made by calling Aetna.

When Clinical Trial Services for Life-Threatening Conditions are **not covered**:

- Clinical trial services for life-threatening conditions are not covered when the criteria above are not met.
- After the clinical trial ends, coverage is not provided for non-FDA approved drugs that were provided or made available to an enrollee during a covered clinical trial.
- Coverage is NOT allowed for any clinical trial services for which the costs have been or are funded by governmental/national agencies, foundation, commercial manufacturers, distributors, charitable grants or other such research sponsors of participant's individual trials. If the service provided includes a transplant, coverage is NOT provided for organs sold rather than donated to a recipient.

In addition, the following clinical trial costs are not covered:

- Services that are not health care services;
- Services provided solely to satisfy data collection and analysis needs;
- Services related to investigational drugs and devices; and

- Services not provided for the direct clinical management of the patient.

In the event a claim contains charges related to covered clinical trial services but those charges have not been or cannot be separated from costs related to noncovered services, benefits will not be provided.

29. Gastric bypass surgery.
30. Genetic testing, except for high risk patients when the therapeutic or diagnostic course would be determined by the outcome of the testing.
31. Growth hormones for short stature or for persons over age 18.
32. Hair Analysis.
33. Hair pieces and hair implants for any reason.
34. Health care services for any work-related injury or illness.
35. Holistic medicine services. Holistic medical services are unproven preventive or treatment modalities, generally described as alternative, integrative or complementary medicine, whether performed by a physician or any other provider.
36. Home services to meet personal, family, domestic needs.
37. Infertility diagnosis, testing and treatment, including: reversal of sterilization; gamete intra-fallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); donation, preservation, preparation, analysis and storage of sperm, eggs or embryos; any costs related to surrogate parenting; infertility services required because of a sex change by the member or the member's partner; artificial insemination for reasons other than documented infertility; or any assisted reproductive technology or related treatment.
38. Inoculations and physicals for travel outside the United States or for employment, sports or extracurricular activities.
39. Inpatient or outpatient custodial care and intermediate care for Alzheimer's disease, senile deterioration, persistent vegetative state, mental retardation, mental deficiency, or any similar persistent illness or disorder. Custodial care is care that:
 - Primarily helps with or supports daily living activities (such as bathing, dressing, eating and eliminating body wastes); *or*
 - Can be given by people other than trained medical personnel.Care can be custodial even if it is prescribed by a physician or given by trained medical personnel, and even if it involves artificial methods such as feeding tubes or catheters.
40. Intoxication: Injuries or illnesses caused while the Member is driving under the influence of alcohol and has a blood alcohol level of 0.08 or greater, unless the injury or illness is caused primarily as a result of other medical conditions (physical or mental) or to domestic violence.
41. Maternity benefits for dependent children.
42. Repatriation of remains.
43. Modifications to home or motor vehicles or special equipment for motor vehicles.
44. Services provided by nonparticipating providers, except when approved in advance by Aetna or in an emergency. Services that would not be necessary if a noncovered service had not been received, except for emergency services in the case of an emergency.
45. Over-the-counter supplies such as ACE wraps/elastic supports/finger splints, orthotics, and relief bands for motion sickness; non-prescription (over-the-counter) medications except when given in a hospital.
46. Personal care items such as air conditioners, furnaces, humidifiers, dehumidifiers, vacuum cleaners, electronic air filters and similar equipment.
47. Primary payment for any condition, disease, ailment, injury or diagnostic service to the extent that such benefits are covered under, or eligible for coverage under, Title XVIII of the Social Security Act of 1965 including amendments (Medicare) as primary payer, except as otherwise provided by federal law.
48. Private or special duty nursing services.
49. Respite care except as specifically covered by the Plan.

50. Reimbursement for losses or damage to medications and medical equipment caused by theft, negligence, acts of nature, or any other reasons.
51. Routine foot care, including treatment of flat feet, corns, bunions, calluses, and ingrown toenails, except when such care is provided to diabetics or others with peripheral ischemic disease, and with the approval of the member's physician.
52. Sensory integration therapy, re-integration therapy and kinetic therapy.
53. Services and benefits for military service-connected disabilities to which you are legally entitled and for which facilities are reasonably available.
54. Services and/or supplies rendered as result of injuries sustained during the commission of an illegal act.
55. Services prescribed by or directed by a provider for himself/herself or his/her immediate family.
56. Services such as stomach stapling and drugs (appetite suppressants or stimulants), exercise and weight-loss programs intended primarily to treat obesity and morbid obesity.
57. Gender reassignment surgery.
58. Shoe lifts and shoes of any type unless part of a brace.
59. Take home drugs and take home disposable or consumable outpatient supplies, such as sheaths, bags, elastic garments and bandages, syringes, needles, blood or urine testing supplies, home testing kits, vitamins, dietary supplements and replacements, and special food items, unless they are specified as covered.
60. Televisions, telephones, guest beds and other items for your comfort or convenience in a hospital or other inpatient facility, including admission kits provided to you by a hospital or other inpatient facility.
61. Testing and therapy for learning disabilities.
62. Transplant services except for those specifically covered under Section II.E.4 of this Part Two. Charges for bone marrow searches are not covered. Services and supplies furnished to a donor when the recipient is not a covered person are not covered. Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness are not covered. Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness are not covered.
63. Transportation, except for an ambulance in a medical emergency or non-emergency ambulance service specified as covered in Section II.G.2 of this Part Two.
64. Treatments and evaluations required by employers, insurers, camps, courts, licensing authorities and other third parties; physician consultations and special medical reports not directly related to treatment; or appearances by a provider at court hearings and other legal proceedings.
65. Treatment and testing for disorders of articulation and/or disfluency, including stuttering.
66. Treatment of any illness or injury suffered after the member's effective date while in active or reserve military service.
67. Treatment or services ordered by a court that are otherwise excluded benefits under the Plan.
68. Treatment, therapy, and drugs for sexual dysfunction.
69. Weight reduction therapy, supplies, services and drugs, including but not limited to diet programs, tests, examinations or services and medical or surgical treatments such as intestinal bypass surgery, stomach stapling, balloon dilation, wiring of the jaw and other procedures of a similar nature.

Section IV - Deductible

A. INDIVIDUAL AND FAMILY DEDUCTIBLES.

The Individual Deductible under the Duke Basic Plan is \$600.00 per member. The Family Deductible under the Duke Basic Plan is \$1,800.00 per family.

Please Note: Your Copayments do not apply to your Deductible under the Plan.

Section V - Coinsurance Maximum

A. INDIVIDUAL AND FAMILY COINSURANCE MAXIMUMS.

The Individual Coinsurance Maximum under the Duke Basic Plan is \$2,000.00 per member. The Family Coinsurance Maximum under the Duke Basic Plan is \$6,000.00 per family.

Please Note: Your Copayments and Deductibles do not apply to your Coinsurance Maximum under the Plan.

PART THREE

DEFINITIONS

<i>COPAYMENT</i>	A fixed dollar amount for a covered service, which a member must pay directly to a health care provider at the time the service, is rendered.
<i>COVERED SERVICES</i>	Health care services for which benefits are available as indicated in Part Two, Section II, What Is Covered .
<i>ELIGIBLE DEPENDENT</i>	An Eligible Employee's spouse, Registered Same-Sex Spousal Equivalent or Child who meets the applicable eligibility requirements set forth in subparagraph 2.a of Section I.A of Part One of the Member Schedule of Benefits .
<i>ELIGIBLE EMPLOYEE</i>	A Duke employee or person under contract with Duke who meets the eligibility requirements set forth in subparagraph 1.a of Section I.A of Part One of the Member Schedule of Benefits .
<i>EMERGENCY CARE</i>	<p>A medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:</p> <ul style="list-style-type: none"> (a) Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy. (b) Serious impairment to bodily functions. (c) Serious dysfunction of any bodily organ or part.
<i>FMLA LEAVE</i>	An Eligible Employee's leave of absence from employment by Duke pursuant to, and in accordance with the terms of, the Family and Medical Leave Act of 1993.
<i>HEALTH CARE PROVIDER</i>	A physician, hospital, pharmacy or other professional person or facility licensed or otherwise duly authorized to provide health care services under the laws of the jurisdiction in which such person or facility renders the services.
<i>HOSPITAL</i>	<ul style="list-style-type: none"> (1) An institution operating pursuant to state law that is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services, under the supervision of a staff of physicians and with twenty-four (24) hour-a-day registered nursing service, or (2) An institution that does not meet all of the requirements of subparagraph (1) above, but does meet state requirements for licensing as a hospital and is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations. <p>In no event does "Hospital" include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, skilled nursing facility, or facility primarily for rehabilitative or custodial services.</p>
<i>HUMAN RESOURCES INFORMATION CENTER (HRIC)</i>	The Benefits Administration department of Duke University and the Human Resources offices at Duke Raleigh Hospital and Duke Regional Hospital.
<i>MEDICARE</i>	Title XVIII of the Social Security Act and the regulations thereunder.
<i>MEMBER</i>	An Eligible Employee or Eligible Dependent enrolled in the Plan.
<i>PARTICIPATING</i>	As applied to any health care provider, "participating" means that the health care provider is under contract with the Duke Basic Network to provide covered services to members.
<i>PHYSICIAN</i>	An individual who is licensed as a physician and practicing within the scope of that license.

<i>PLAN</i>	The Duke Basic Plan.
<i>PRECERTIFICATION</i>	The prior approval by the Plan of a procedure, treatment, inpatient admission or other service to be rendered to or provided to a member. To see if Precertification by the Plan is required for a particular type of service, please contact Member Services. Precertification is not a guarantee that the service will be covered by the Plan; all other applicable coverage requirements must be met.
<i>PRIMARY CARE PROVIDER (PCP)</i>	The health care provider selected by a member from the Duke Basic network of participating health care providers, to provide the member basic and preventive covered services and coordinate the provision of other covered services to the member.
<i>REASONABLE AND CUSTOMARY FEE</i>	The lesser of: (1) the amount charged by the health care provider for the service in question, or (2) the amount most other health care providers in the same geographic area would charge for the equivalent service, as reasonably determined by Aetna.
<i>RESIDENCE</i>	The member's primary, permanent dwelling.
<i>REGISTERED SAME-SEX SPOUSAL EQUIVALENT (SSSE)</i>	<p>A person eighteen years of age or older living in a committed family relationship with an Eligible Employee of the same gender, and the person and the Eligible Employee (i) are not legally allowed to marry under current laws of the state in which they reside, (ii) are not married to anyone, (iii) are not of any blood relation which would bar marriage under the laws of the state in which they reside, and (iv) are each other's sole SSSE and intend to remain so indefinitely.</p> <p>To be eligible for coverage under the Plan, the Eligible Employee and his or her SSSE must submit a completed Affidavit of Registered Same-Sex Spousal Equivalent Relationship prior to January 1, 2016 ("the affidavit") to the Human Resources Information Center (HRIC), and the person's status as the SSSE of the Eligible Employee must be verified by the Human Resources Information Center (HRIC). An Eligible Employee may remove his or her SSSE from Plan coverage only during the annual open enrollment period, or when the SSSE enrolls in another health benefits plan, or because of the death of the SSSE. The SSSE relationship is terminated by filing an Affidavit of Termination with the Human Resources Information Center (HRIC); however, the Eligible Employee may not enroll a spouse in the Plan until at least one year has elapsed from the date of the filing of the Affidavit of Termination terminating the Eligible Employee's relationship with his or her previous SSSE. Please contact the Human Resources Information Center (HRIC) for a copy of the affidavit, and the Information Sheet describing limitations and conditions applicable to Plan coverage for a Registered Same-Sex Spousal Equivalent, the terms of which are incorporated herein by reference.</p>
<i>URGENT CARE</i>	Care that is not Emergency Care, but: (1) is needed urgently, (2) could not reasonably have been anticipated, and (3) cannot safely be postponed until the member can be seen by his or her PCP.
<i>AETNA</i>	Aetna Life Insurance Company., which has agreed to provide certain administrative services to the Plan.

Nondiscrimination Notice

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

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-888-982-3862

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com..

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator 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 Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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