The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bluecrossnc.com or contact the Duke HR Information Center by calling 919-684-5600. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 919-684-5600 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $2,000 person / $6,000 family; Out of-network: $6,000 person / $12,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care and most services that may require a copayment.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes; $100 per person for retail brand prescription drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network: $6,800 person / $13,600 family; Out of-network: $13,600 person / $27,200 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care charges this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bluecrossnc.com/FindADoctor or call 877-275-9787 for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment	40% coinsurance of allowed amount after deductible	Medically necessary
	Specialist visit	$55 copayment		Medically necessary
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Limits may apply. Nutrition - Up to six visits per calendar year at no charge, in-network. Most contraceptive drugs, IUDs and birth control implants are covered at no charge.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance of allowed amount after deductible	Medically necessary
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible		Medically necessary; prior authorization may be required or services will not be covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	Retail (Up to 34 day supply): $15 copayment; Mail Order (Up to 90 day supply): $25 copayment	Your reimbursement will be the contracted rate less the copayment. You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications 50% coinsurance with $15 or cost minimum and $30 maximum. Step therapy and/or preauthorization may apply.
	Preferred brand drugs	Retail (Up to 34 day supply): $50 copayment after $100 brand deductible; Mail Order Up to 90 day supply): $130 copayment	Your reimbursement will be the contracted rate less the copayment. You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications 50% coinsurance with $70 minimum and $165 maximum. No deductible for Duke pharmacies. Step therapy and/or preauthorization may apply.
	Non-preferred brand drugs	Retail (Up to 34 day supply): $70 copayment after $100 brand deductible; Mail Order Up to 90 day supply): $180 copayment	Your reimbursement will be the contracted rate less the copayment. You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications 50% coinsurance with $85 minimum and $180 maximum. No deductible for Duke pharmacies. Step therapy and/or preauthorization may apply.
	Specialty drugs	Same as above for generic and brand.	Same as above for generic and brand.	Prior authorization required for some specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance of allowed amount after deductible	Medically necessary; prior authorization may be required or services will not be covered.
	Physician/surgeon fees	20% coinsurance after deductible		Medically necessary; prior authorization may be required or services will not be covered.
If you need immediate medical attention	Emergency room care	$250 copayment.	$250 copayment.	Medically necessary
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Medically necessary
	Urgent care	$50 copayment	$50 copayment	Medically necessary
If you have a hospital stay	Facility fee (e.g., hospital room)	$600 or $700 per admission copayment, then 20% coinsurance after deductible	$900 per admission copayment, then 40% coinsurance of allowed after deductible	Precertification required. $600 copayment for Duke, Duke Regional and Duke Raleigh Hospitals and $700 for all other participating hospitals; prior authorization may be required or services will not be covered.
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment/office visit; 20% coinsurance/ outpatient	40% coinsurance of allowed amount after $650 deductible	Medically necessary; prior authorization may be required or services will not be covered
	Inpatient services	Preferred: $600 per admission copayment then 20% coinsurance; Non-Preferred: $700 per admission copayment then 20% coinsurance.	40% coinsurance of allowed amount after $900 deductible	Prior authorization may be required or the services will not be covered
If you are pregnant	Office visits	$25 copayment	40% coinsurance of allowed after deductible	This benefit applies in limited situations. *See Family Planning section.
	Childbirth/delivery professional services	$600 or $700 per admission copayment, then 20% coinsurance after deductible	$900 per admission copayment, then 40% coinsurance	Certification required. $600 copayment for Duke, Duke Regional and Duke Raleigh Hospitals and $700 for all other participating hospitals. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance of allowed amount after deductible	100 visit limit combined in-and out-of-network; prior authorization may be required or services will not be covered.
	Rehabilitation services	$55 copayment	40% coinsurance of allowed amount after deductible	*See Therapies section. Combined 40 visits in a calendar year for physical/occupational therapy and chiropractic services. Speech therapy 20 visits per calendar year.
	Habilitation services	$55 copayment	40% coinsurance of allowed amount after deductible	Habilitation services are combined with the Rehabilitation Service limits listed above.
	Skilled nursing care	$250 per admission copayment, then 20% coinsurance after deductible	40% coinsurance of allowed amount after deductible	Up to 60 day annual maximum. Precertification is required.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance of allowed amount after deductible	Medically necessary
	Hospice services	20% coinsurance after deductible		Must be authorized by doctor.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Excluded Service
	Children's glasses	Not Covered	Not Covered	Excluded Service
	Children's dental check-up	Not Covered	Not Covered	Excluded Service

Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric Surgery
- Cosmetic surgery
- Dental care (Adult and Child) except for limited exceptions for accidental injury to sound natural teeth
- Long-term care
- Routine eye care
- Routine foot care that is palliative or cosmetic.
- Weight loss programs

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

- Chiropractic care - $55 copayment. Up to 40 visits per calendar year, combined in-network, out-network and with rehabilitation visits.
- Hearing aids for children under 22. Limited to one every 36 months.
- Infertility treatment – Diagnosis only. Patient copayment applies. COH, IVF, and other types of artificial conception are excluded
- Non-emergency care when traveling outside the U.S.
- Private duty nursing

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross NC at 1-877-275-9787 or www.BlueConnectNC.com or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, if applicable.

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

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

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

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-275-9787.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-275-9787.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-275-9787.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-275-9787.

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

About these Coverage Examples:

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

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

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

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1,880
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,9400**

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

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

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,320
Copayments	$250
Coinsurance	$540
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,130**

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

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

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,870
Copayments	$330
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,200**

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

Notice of Nondiscrimination

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

Duke University:

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

If you need these services, contact Kimberly Hewitt.

If you believe that Duke University has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Kimberly Hewitt, Vice President for Institutional Equity & Chief Diversity Officer, 114 S. Buchanan Blvd, Bay 8, Box 90012, Durham NC 27708, 919-684-8222 (p), 919-684-8580 (f), oie-help@duke.edu. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kimberly Hewitt, Vice President for Institutional Equity & Chief Diversity Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

Notice of Language Assistance

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

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

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

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

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

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

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

العربية (Arabic): -1 اتصل برقم .إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان :ملحوظة1-919-684-5600.رقم)

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

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

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

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

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

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

ខ្មែរ (Cambodian): ប្រយ័ត្ន៖ បើសិនអ្នកនិយ ភាសខ្មរ, សវាជំនួយផកា បយមិនគិតឈ្ល គឺចនសំប់បំរអ្ក។ ចូរ ទូរស័ព 1-919-684-5600.។

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