



[StudentBlueNC.com/#/Duke](https://StudentBlueNC.com/#/Duke)

# Student Blue<sup>SM</sup>

Health Plan for Duke University Students | 2025-2026



# Student Blue

## A healthy plan for a successful future

Duke University selected Student Blue to provide you with quality health insurance coverage from Blue Cross and Blue Shield of North Carolina (Blue Cross NC). With Student Blue, you have low out-of-pocket costs and worldwide coverage.<sup>1</sup>

| Mandatory Hard Waiver | Annual <sup>2,3</sup> | Dependent Rates <sup>3,4</sup><br>Rates are additional to your student rate | Annual     |
|-----------------------|-----------------------|-----------------------------------------------------------------------------|------------|
| Student               | \$3,751.56            | Add Spouse/Domestic Partner                                                 | \$3,577.74 |
|                       |                       | Add Child(ren)                                                              | \$3,992.14 |
|                       |                       | Add Family                                                                  | \$7,625.61 |

## Blue Options<sup>®</sup> benefit highlights

| Services                                                                                                                                                                                                                   | In-Network                                                                                                                                                                  | Out-of-Network                                                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| All dollar amounts and percentages are what you, as a plan member, would pay.                                                                                                                                              |                                                                                                                                                                             |                                                                                                         |
| <b>Lifetime Maximum, Deductibles and Total Out-Of-Pocket Maximums</b><br>The following deductibles and Total Out-of-Pocket Maximum also apply to Behavioral Health and Substance Use Services.                             |                                                                                                                                                                             |                                                                                                         |
| Lifetime Maximum                                                                                                                                                                                                           | Unlimited                                                                                                                                                                   | Unlimited                                                                                               |
| Deductibles                                                                                                                                                                                                                |                                                                                                                                                                             |                                                                                                         |
| Individual (per benefit period)                                                                                                                                                                                            | \$0                                                                                                                                                                         | \$250                                                                                                   |
| Family (per benefit period)                                                                                                                                                                                                | \$0                                                                                                                                                                         | \$750                                                                                                   |
| Total Out-of-Pocket Maximum                                                                                                                                                                                                |                                                                                                                                                                             |                                                                                                         |
| Individual (per benefit period)                                                                                                                                                                                            | \$2,000                                                                                                                                                                     | \$3,000                                                                                                 |
| Family (per benefit period)                                                                                                                                                                                                | \$4,500                                                                                                                                                                     | \$9,000                                                                                                 |
| <b>Physician Office Services</b><br>(See “Outpatient Clinic Services” for outpatient clinic or hospital-based services.)                                                                                                   |                                                                                                                                                                             |                                                                                                         |
| <b>Office Visits</b><br>Includes office surgery, consultation, X-ray and lab, and benefit period maximum of 4 office visits for the assessment of obesity in- and out-of-network. See “Inpatient and Outpatient Services.” | <b>Primary Care Provider:</b><br>\$25 copayment, 20% coinsurance for all other services<br><br><b>Specialist:</b><br>\$35 copayment, 20% coinsurance for all other services | <b>Primary Care Provider:</b><br>30% after deductible<br><br><b>Specialist:</b><br>30% after deductible |

**Special notice if you choose an out-of-network provider:** Your actual expenses for covered services may exceed the stated coinsurance percentage or copayment amount because actual provider charges may not be used to determine the payment obligations for Blue Cross NC and its members.

# Blue Options benefit highlights (continued)

| Services                                                                                                                                                                                                                                                                                                                                                          | In-Network                                                                                                 | Out-of-Network                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| All dollar amounts and percentages are what you, as a plan member, would pay.                                                                                                                                                                                                                                                                                     |                                                                                                            |                                                                                                                                  |
| <b>Preventive Care</b><br>The following services are state-mandated and required to be offered both in- and out-of- network: Gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, prostate-specific antigen tests and newborn hearing screening.                          | <b>Primary Care Provider and/or Specialist:</b><br>No charge<br><br><b>Outpatient Clinic:</b><br>No charge | <b>Primary Care Provider and/or Specialist:</b><br>30% after deductible<br><br><b>Outpatient Clinic:</b><br>30% after deductible |
| <b>Therapies</b><br>Rehabilitative therapy has a benefit period maximum of 50 visits for physical/occupational therapy (including chiropractic services), and 30 visits for speech therapy. Habilitative services has a benefit period maximum of 50 visits for physical/occupational therapy (including chiropractic services), and 30 visits for speech therapy | <b>Primary Care Provider:</b><br>20% coinsurance                                                           | <b>Primary Care Provider:</b><br>30% after deductible                                                                            |
| <b>Urgent Care Centers, Ambulance and Emergency Room</b><br>Urgent care centers – office visit                                                                                                                                                                                                                                                                    | \$45 copayment                                                                                             | \$90 copayment                                                                                                                   |
| Urgent Care Centers – other services (X-ray, lab and other services)                                                                                                                                                                                                                                                                                              | 20% coinsurance                                                                                            | 30% after deductible                                                                                                             |
| Emergency room visit (with or without Observation)                                                                                                                                                                                                                                                                                                                | \$150 copayment then 20% coinsurance                                                                       | \$150 copayment then 20% coinsurance                                                                                             |
| Ambulance                                                                                                                                                                                                                                                                                                                                                         | 20% coinsurance                                                                                            | 20% coinsurance                                                                                                                  |
| <b>Ambulatory Surgical Center</b>                                                                                                                                                                                                                                                                                                                                 | \$100 copayment then 20% coinsurance                                                                       | 30% after deductible                                                                                                             |
| <b>Outpatient Services</b><br>Outpatient Services - physician charges                                                                                                                                                                                                                                                                                             | 20% coinsurance                                                                                            | 30% after deductible                                                                                                             |
| <b>Hospital-based or outpatient clinic services</b><br>Other Services                                                                                                                                                                                                                                                                                             | \$100 copayment then 20% coinsurance                                                                       | 30% after deductible                                                                                                             |
| <b>Outpatient Diagnostic Services</b><br>Outpatient lab tests, when performed alone or with another service                                                                                                                                                                                                                                                       | \$100 copayment then 20% coinsurance                                                                       | 30% after deductible                                                                                                             |
| Outpatient diagnostic mammography (physician and hospital-based services)<br><br>See “Preventive Care” for coverage of screening mammograms.                                                                                                                                                                                                                      | No charge                                                                                                  | 30% after deductible                                                                                                             |

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Continued

# Blue Options benefit highlights (continued)

| Services                                                                          | In-Network                           | Out-of-Network       |
|-----------------------------------------------------------------------------------|--------------------------------------|----------------------|
| All dollar amounts and percentages are what you, as a plan member, would pay.     |                                      |                      |
| <b>Inpatient Services</b>                                                         |                                      |                      |
| Physician Services                                                                | 20% coinsurance                      | 30% after deductible |
| Hospital and hospital-based services                                              | 20% coinsurance                      | 30% after deductible |
| Emergency room visit (with inpatient admission)                                   | 20% coinsurance                      | 20% coinsurance      |
| <b>Other Services</b>                                                             |                                      |                      |
| Skilled nursing facility (60 days per benefit period)                             | 20% coinsurance                      | 30% after deductible |
| Home health care, durable medical equipment and hospice                           | 20% coinsurance                      | 30% after deductible |
| <b>Maternity</b><br>(Maternity delivery includes prenatal and post-delivery care) |                                      |                      |
| Hospital services (Delivery)                                                      | 20% coinsurance                      | 30% after deductible |
| Professional services (Delivery)                                                  | 20% coinsurance                      | 30% after deductible |
| <b>Transplants</b>                                                                |                                      |                      |
| Hospital services                                                                 | 20% coinsurance                      | 30% after deductible |
| Professional services                                                             | 20% coinsurance                      | 30% after deductible |
| <b>Infertility Services</b>                                                       |                                      |                      |
| Primary Care Provider and/or Specialist                                           | \$25 / \$35 copayment                | 30% after deductible |
| Hospital services                                                                 | \$100 copayment then 20% coinsurance | 30% after deductible |
| Inpatient and outpatient professional services                                    | 20% coinsurance                      | 30% after deductible |
| <b>Mental Health and Substance Use Services</b>                                   |                                      |                      |
| Office visits                                                                     | \$10 copayment                       | 30% after deductible |
| Inpatient                                                                         | 20% coinsurance                      | 30% after deductible |
| Outpatient                                                                        | \$100 copay then 20% coinsurance     | 30% after deductible |

**Special notice if you choose an out-of-network provider:** Your actual expenses for covered services may exceed the stated coinsurance percentage or copayment amount because actual provider charges may not be used to determine the payment obligations for Blue Cross NC and its members.

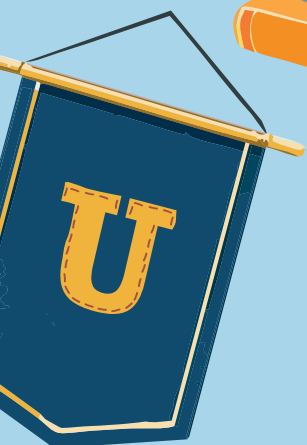
Continued



# Blue Options benefit highlights (continued)

| Services                                                                                                                                                                                                                                                                                | In-Network      | Out-of-Network                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|---------------------------------------------------|
| All dollar amounts and percentages are what you, as a plan member, would pay.                                                                                                                                                                                                           |                 |                                                   |
| <b>Prescription Drugs</b><br>Up to 30-day supply. 31-60 day supply is two copayments and 61-90 day supply is three copayments. MAC B Brand Pricing Penalty.                                                                                                                             |                 |                                                   |
| <b>Tier 1:</b><br>The prescription drug tier which consists of the lowest-cost tier of prescription drugs. Most are generic.                                                                                                                                                            | \$10 copayment  | Copayment + charge over in-network allowed amount |
| <b>Tier 2:</b><br>The prescription drug tier which consists of medium-cost prescription drugs (most are generic) and some brand-name prescription drugs.                                                                                                                                | \$20 copayment  | Copayment + charge over in-network allowed amount |
| <b>Tier 3:</b><br>The prescription drug tier which consists of high-cost prescription drugs. Most are brand-name prescription drugs.                                                                                                                                                    | \$35 copayment  | Copayment + charge over in-network allowed amount |
| <b>Tier 4:</b><br>The prescription drug tier which consists of the higher-cost prescription drugs. Most are brand-name prescription drugs, and some specialty drugs.                                                                                                                    | \$70 copayment  | Copayment + charge over in-network allowed amount |
| <b>Tier 5:</b><br>The prescription drug tier which consists of the highest-cost prescription drugs most are specialty drugs.<br><br>There is a \$100 per drug minimum for each 30-day supply of Tier 5 drugs. There is a \$200 per drug maximum for each 30-day supply of Tier 5 drugs. | 25% coinsurance | Copayment + charge over in-network allowed amount |
| <b>Insulin</b>                                                                                                                                                                                                                                                                          | \$10 copayment  | Copayment + charge over in-network allowed amount |
| <b>Diabetic supplies, spacers and peak flow meters</b><br>(Obtain at the retail pharmacy)                                                                                                                                                                                               | \$10 copayment  | Copayment + charge over in-network allowed amount |
| <b>Lens and Frame Coverage</b><br>Prescribed Eyeglass Lens and Frame Benefit Period maximum: Blue Cross NC will reimburse you up to the benefit period maximum for glasses and hard, soft or disposable contact lenses.                                                                 |                 | \$100                                             |

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# Additional Information about Blue Options from Blue Cross NC

## Health and wellness programs

Because we want to help you stay healthy, we offer a variety of wellness benefits and services. You can take advantage of Health Line Blue<sup>SM</sup>, our 24-hour health information service; a health topics library; asthma and diabetes management; and a prenatal program. You will also have access to online health and wellness information at [BlueCrossNC.com](https://www.bluecrossnc.com). With our programs, you can get health advice any time you need it, so you can learn how to take charge of your health.

## What is not covered?

The following is a summary of some of the coverage restrictions. A full explanation and listing of restrictions will be found in your benefit booklet.

- For treatment that is not medically necessary
- For injury or illness resulting from an act of war
- For personal hygiene and convenience items
- For inpatient admissions that are primarily for diagnostic studies
- For palliative or cosmetic foot care
- For investigative or experimental purposes
- For cosmetic services or cosmetic surgery
- For custodial care, domiciliary care or rest cures
- For treatment of obesity, except for surgical treatment of morbid obesity, or as specifically covered by your health benefit plan
- For reversal of sterilization
- For treatment of sexual dysfunction not related to organic disease
- For conception by artificial means
- For self-injectable drugs in the provider's office

The benefit highlights is a summary of Blue Options benefits. This is meant only to be a summary. Final interpretation and a complete listing of benefits and what is not covered are found in and governed by the group contract and benefit booklet. You may preview the benefit booklet by requesting a copy of the Blue Options benefit booklet from Blue Cross NC Customer Service.

#### Important legal notices for students

Deductibles, coinsurance, limitations and exclusions apply to this coverage. Further details of coverage, limitations and exclusions, and terms under which the policy can be continued in force will be provided in your benefit booklet.

#### Special enrollment

If you are declining enrollment for yourself or your dependents (including your spouse/domestic partner) because of other health insurance, including Medicaid, Children's Health Insurance Program (CHIP) or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (other than Medicaid or CHIP), or if the employer stops contributing toward your or your dependents' other coverage and within 60 days after the loss of Medicaid or CHIP eligibility. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption or foster care, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption or foster care, except when adding a dependent child will not change your coverage type or premiums that are owed.

For questions or to obtain more information, contact:

Blue Cross and Blue Shield of North Carolina  
P.O. Box 2073, Durham, NC 27702, or call 800-579-8022.

#### Policy dates are 08/01/25 - 07/31/26

- 1 GeoBlue® travel insurance is covered in 190 countries and territories worldwide through the GeoBlue program. Blue Cross and Blue Shield Association Internal Data: [about.geo-blue.com/](https://about.geo-blue.com/) (Accessed October 2024).
- 2 A portion of the cost of the Student Insurance Program is retained by Duke University to pay for student health services supplied by Duke University and administrative costs. All charges for the Student Insurance Program, including reserve funds, are retained by Duke University solely for the purposes of funding plan expenses and/or for the equitable and nondiscriminatory benefit of plan participants.
- 3 Premium due for student coverage must be paid through the student's Duke account.
- 4 Dependent rate is an additional premium above the student premium and does not include the cost for student coverage.

Blue Cross NC provides the Health Line Blue program for your convenience. Blue Cross NC is not liable in any way for the goods or services received through Health Line Blue. Blue Cross NC reserves the right to discontinue or change the program at any time without prior notice. Decisions regarding your care should be made with the advice of a doctor. Depending on your plan, selected programs may not be available to you at this time. Check with your benefits administrator or Blue Cross NC Customer Service to determine your eligibility. Blue Cross NC has contracted with a third-party vendor independent from Blue Cross NC to bring you Health Line Blue.



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