



Frequently Asked Questions – Open Enrollment 2027

Please review the official plan documents for complete coverage details and applicable criteria. This overview is for informational purposes only and does not replace or modify the plan documents.

Medical Plan

Are premiums increasing?

Yes – there is a small increase to bi-weekly premium rates. For full-time employees, the increases range from \$3 per pay period (for employee-only coverage) to \$16 per pay period (for employee & family coverage).

Are there changes to the networks/tiers within the Medical Plan?

No, the four tiers remain unchanged. Prior to receiving services, please refer to the provider listing available at mycreatehealth.com/employee for the most current information, as provider participation in the BCBS PPO network is subject to change.

- **WakeMed Preferred Tier** – Includes WakeMed services provided at our in- and outpatient locations, all WakeMed Physician Practices locations, and WakeMed's joint venture facilities (Capital City Surgery Center, Peak Rehabilitation Hospital, select Raleigh Radiology locations, etc.) There are lower copays, deductibles and coinsurance for using providers and services in this tier.
- **Other In-Network Tier** – Includes all providers in the BCBS PPO tier that are not part of the WakeMed Preferred Tier or the Duke Health/UNC Health Tier. Out-of-pocket costs for this tier are higher than the WakeMed Preferred Tier, but lower than the other two tiers.
- **Duke Health/UNC Health Tier** – Includes all physicians and services provided at inpatient and outpatient locations owned or operated by Duke Health or UNC Health and their subsidiaries. Out-of-pocket costs for service and providers in this tier are higher than WakeMed Preferred or Other In-Network Tiers.
- **Out-of-Network Tier** – A physician is considered out of network if they are not included in any of the other tier options listed. Services provided by out-of-network physicians and hospitals will cost the most.

Preventive care services such as annual physical exam, well baby/well child, annual prostate/PSA, colonoscopy (preventive & diagnostic) and mammograms (2D/3D, preventive & diagnostic) are covered 100% in the WakeMed Preferred Tier, Other In-Network Tier and the Duke Health/UNC Health Tier. Detailed information is available in the 2027 Benefits Guide.

Are there changes to out-of-pocket costs?

Yes, there are significant decreases in the out-of-pocket costs for several tiers. Detailed information is available in the 2027 Benefits Guide.

- **Other In-Network Tier Changes:**
 - Deductible reduced to \$2,500 Individual/\$5,000 Family
 - Out-of-pocket Maximum decrease to \$5,000 Individual/\$10,000 Family
 - Hospital-Based Physician Services are covered at 100%
- **Duke Health/UNC Health Tier Changes:**
 - Deductible reduced to \$5,000 Individual/\$10,000 Family
 - Out-of-pocket Maximum decrease to \$8,000 Individual/\$16,000 Family
 - Coinsurance decrease to 50%
 - Specialist Office Visit copay set at \$125
 - Hospital-Based Physician Services are covered at 100%
- **Hospital-Based Inpatient/Outpatient Billing:**
 - If a member is being treated by a Other In-Network provider but the services are rendered at a Duke Health/UNC Health facility, the facility claim will be processed as Other In-Network

What are gap services and have there been any changes for 2027?

A gap service is a service covered under a network gap exception when no appropriate WakeMed Preferred Tier network provider is available to provide the needed care. Coverage applies only to the services provided for the approved **condition** and does not include related or additional conditions. Medical plan members may be eligible to have coverage of these services at the Other In-Network tier rate. Please refer to the Summary Plan Description for specific coverage details.

Below is a list of the gap services covered under the 2027 plan:

Adult Hepatology	Orofacial Myology
Allergy & Immunology	Pain Management
Burns	Pediatric Oncology
Dermatology	Pediatric Hematology
Endocrinology	Podiatry
Gynecologic Oncology	Psychiatry
Nephrology	Psychology
Neurology	Radiation Oncology
Neurosurgery	Rheumatology
Ophthalmology	Stereotactic Radiosurgery
Oral Surgery – only covered in medical plan when medically necessary due to accident, congenital, or other medical reasons such as tumor/growth in gum or jaw area	Transplants

What if I am being seen at Duke or UNC for a service WakeMed does not offer?

Medical plan members are always welcome to continue seeing the providers they have established relationships with. We encourage you to look closely at the 2027 Benefits Guide to understand the out-of-pocket costs you will be responsible for.

Many specialty services – such as dermatology or rheumatology – are available in our area through alternate providers within the BCBS PPO Network. Should you choose to change to a physician in the Other-in-Network tier, out of pocket costs would be less than seeing a Duke or UNC provider. To find a list of in-network physicians, visit: mycreatehealth.com/employee.

For services that are **only** available at Duke and UNC, such as organ transplants or radiation oncology, WakeMed will continue to consider these covered services under gap services. Medical plan members may be eligible to have coverage of these services at the Other In-Network tier rate. Additional information can be found online at: provider.bcbs.com.

Why are Duke and UNC in a separate, more expensive tier?

WakeMed has a self-funded medical plan, which means that the costs for the medical plan – including plan administration, payments to health care providers – are paid by WakeMed and our employees (through your premium deductions).

In recent years, the costs associated with care delivered at Duke and UNC – often for services WakeMed also offers – have increased dramatically. This puts a financial strain on WakeMed as the organization, and our employees, are paying our competitors for services that our physicians and facilities also offer.

We understand that some employees and family members do not feel comfortable having medical care provided by their peers and colleagues, even with HIPAA and other privacy protections in place. This is one reason we chose Blue Cross NC as our medical plan administrator. Their network is very broad and robust, offering a wide range of specialists and primary care providers in our area, across the state, and nationally. Additional information and a list of in-network physicians can be found online at: mycreatehealth.com/employee.

Will I receive a new ID card for 2027?

Yes, all plan members will receive new cards this year with the new out-of-pocket amounts printed on the card. Prior to January 1, 2027, cards will be mailed to your home address listed in The HUB. New ID cards are also available through the member app and mycreatehealth.com/employee. Please verify your address is correct and up to date in The HUB by November 13 to ensure accurate and timely delivery of your new card.

Who do I contact with questions regarding the medical plan or with claims processing?

Brighton Health Plan Solutions is the health plan administrator for Blue Cross Blue Shield (Blue Cross NC) and handles all claims processing and customer support. Please contact their customer service department directly at 1-800-956-2462 with any questions regarding the plan, coverage, providers, claims processing, or appeals. The WakeMed benefits team does not have access to your claim details.

Coming Soon! Starting in November, a dedicated Brighton Health Plan Solutions customer service representative will be available to support our medical plan members and will be located at WakeMed. Watch for additional information regarding contact details and service hours.

Where can I find detailed information on covered services and associated costs?

The information in the Benefits Guide is a quick reference guide of the plan design. A detailed listing of all services and associated coverage amounts can be found in the Summary Plan Description (SPD). The SPD is the official plan document that outlines eligibility, benefits, coverage details, participant rights, and plan provisions. Every medical plan member should thoroughly review this document on an annual basis and become familiar with the plan coverage. The SPD is available at the beginning of the plan year and is posted on the Benefits website: <https://flimp.live/WakeMed-Benefits>.

If you are having medical services such as planned surgery, check with your provider's office for a detailed overview of what types of charges to expect. Many providers utilize external vendors for additional services (such as anesthesia or durable medical equipment) that could fall under a different tier and are billed separately.

What types of coverage extensions are available on the medical plan?

- Transition of Care – temporary continuation of care with an out-of-network provider while transitioning to an in-network provider for new medical plan members
- Continuity of Care – continuation of care with a provider when an immediate transfer could negatively impact treatment for existing members whose provider is becoming out-of-network
- Gap/Tier Exceptions – no exception process exists

Refer to the Overview of Coverage Extension grid (addendum at the end of this FAQ) provided by Brighton Health Plan Solutions for more information, which also includes details regarding appeals and disputes.

What is Resilient with WakeMed?

Resilient with WakeMed is a benefit for medical plan members and dependents (age 7+). Resilient with WakeMed offers no-cost access to primary care, urgent care and specialty care consults, from home or via a hybrid CloudClinic in-office visit. There is no copay and no deductible for Resilient with WakeMed services, and plan members can access the benefit as many times as needed during the year.

Resilient with WakeMed offers concierge-style same-day and next-day primary care services both in-person at CloudClinics, via at-home telehealth and 24/7 messaging. The Resilient with WakeMed's care team can also provide hands-on care coordination to help plan members seamlessly access needed specialty care within the WakeMed Preferred Tier.

Pharmacy Benefit

Are there changes to pharmacy coverage for 2027?

There are no changes to the pharmacy benefit for 2027. As a standard practice, OptumRx reviews and updates its formulary twice each year. During these reviews, medications may be added, removed, moved to a different tier, or have changes to coverage requirements such as prior authorization, step therapy, or quantity limits. Members are encouraged to periodically check the formulary, as covered medications, tier levels, and coverage requirements may change following these reviews.

Are GLP-1s covered for 2027?

No. GLP-1 medications for weight loss continue to be excluded from the pharmacy benefit for 2027.

GLP-1 medications will still be covered for those with a diagnosis of diabetes, which WakeMed defines as a current or historical Hemoglobin A1C value greater than or equal to 6.5%.

Other Benefit Programs

Are there changes to other benefit vendors or plans?

Yes, please review this summary and refer to the 2027 Benefits Guide for additional information:

- There is no increase in Vision premiums. The frame allowance has increased from \$140 to \$150 and has the addition of a sight and sound benefit that covers hearing frames.
- Flexible Spending Accounts (FSA) will have a \$3,400 annual limit for the 2027 plan year and \$680 rollover from the 2026 plan year.
- There are no changes to plan designs or premiums for Dental or other Voluntary Benefits.

Overview of Coverage Extension

Transition of Care (TOC)*	Continuity of Care (COC)**	Gap/Tier Exceptions	Appeals	Disputes
Who Qualifies? New health plan members whose current provider is out-of-network under their new plan.	Who Qualifies? Existing members whose provider is becoming out-of-network (i.e. terminating from the BCBS network).	Exceptions? No exceptions process exists. Requests that do not meet TOC, COC, or plan provisions are not eligible for review.	Who Qualifies? A Covered Member, or their Authorized Representative (including rendering/ordering providers), has one hundred eighty (180) calendar days following receipt of a medical adverse benefit determination (denial) notice to submit a written first level appeal.	Who Qualifies? A Covered Member, or their Authorized Representative (including rendering/ordering providers), has ninety (90) calendar days following receipt of an adverse benefit determination (denial) or claim final determination notice to submit a dispute.
Member Type: New employees only	Member Type: All employees	Member Type: Not available	Member Type: A covered member or their authorized representative	Member Type: A covered member or their authorized representative
Qualifying Conditions: Pregnancy (2nd/3rd trimester), active cancer treatment, life-threatening illness, post-complex surgery care, dialysis, transplant care, significant behavioral health treatment, rare and complex conditions.		None.	When can you appeal? A medical adverse benefit determination is required. Such as a prior authorization denial or claim denial for medical records to determine medical necessity. Each party, Provider and Member, have 1 level of appeal to use. If the first appeal is submitted by the Provider; the second appeal (which would be reviewed by IRO) would need to be submitted by the Member or the Provider on the Member's behalf with the Member ERISA Authorized Representative Form included. Any out-of-area appeals are required to be submitted to the out-of-area Blue plan and then they're sent to BCNC/Brighton for a final determination.	When can you submit a dispute? An adverse benefit determination or claim processing final determination is required. Such as a provider pricing issue, cost sharing dispute or benefit limitation issue. There is only 1 level of dispute available. Any out-of-area disputes are required to be submitted to the out-of-area Blue plan and then they're sent to BCNC/Brighton for a final determination.
Purpose: Allows temporary continuation of care with an out-of-network provider while transitioning to an in-network provider.	Purpose: Allows continuation of care with a provider when an immediate transfer could negatively impact treatment.	n/a	Purpose: Reconsideration of a medical adverse benefit determination (denial).	Purpose: Reconsideration of an adverse benefit determination (denial) or claim final determination notice.
Application Deadline: Must be submitted within thirty (30) days of the new plan effective date.	Application Deadline: Submit the Continuity of Care application when provider network status changes.	n/a	Appeal Deadline: One hundred eighty (180) calendar days following receipt of a medical adverse benefit determination notice to submit a written first level appeal.	Dispute Deadline: Ninety (90) calendar days following receipt of an adverse benefit determination or claim final determination notice.
Provider Requirement: Provider must agree to accept in-network reimbursement rates		n/a	Medical records submission may be required.	Medical records may not be required, but can be submitted to support the request.
Coverage Duration: Temporary and limited to the approved condition and timeframe		n/a	n/a	n/a
Not Eligible: Routine exams, routine pediatric care, stable chronic conditions (diabetes, asthma, hypertension, arthritis, allergies), elective procedures		n/a	n/a	n/a

*Applies when moving from another plan to the WakeMed plan

**Applies to a provider network change

Please refer to the Create portal for applicable forms.