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.contigohealth.com or call Contigo Health at 1-833-569-0319. 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.dol.gov/ebsa/healthreform or https://www.healthcare.gov/sbc-glossary or call 1-833-569-0319.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	WakeMed Preferred: $1,000 person/$2,000 family Partners Plus: $2,000 person/$4,000 family Network: $5,000 person/$10,000 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. Certain preventive care, services received through an emergency department, and all services with copayments are covered and paid by the plan before you meet your deductible.	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-carebenefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	WakeMed Preferred: $2,000 person/$4,000 family Partners Plus: $4,000 person/$8,000 family Network: $7,900 person/$15,000 family Out-of-Network: Unlimited	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing (unless balance billing is prohibited), charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. WakeMed Preferred & Partners Plus: Visit www.contigohealth.com or call 1-833-569-0319 for a list of network providers. Network: Visit www.medcost.com for a list of network providers. Out-of-Area: Visit First Health at https://providerlocator.firsthealth.com/home/index or call 1-800-226-5116 for a list of providers.	You pay the least if you use a WakeMed Preferred provider. You pay more if you use a Partners Plus or Network Provider. 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
		WakeMed Preferred (You will pay the least)	Partners Plus Providers	Network Providers	Out-of-Network Providers (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	$10 copayment/visit	$20 copayment/visit	$60 copayment/visit	60% coinsurance	Deductible applies to Out-of-Network providers. Copayment applies to office visit charge only.
	Specialist visit	$20 copayment/visit	$40 copayment/visit	$120 copayment/visit	60% coinsurance	
	Preventive care/screening/ immunization	No Charge	No Charge	No Charge	60% coinsurance	Deductible applies to Out-of-Network providers. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Services are subject to age and frequency limitation. Visit www.healthcare.gov for preventive care guidelines.
If you have a test	Diagnostic test (x-ray, blood work)	$50 copayment/test	$60 copayment/test	50% coinsurance	60% coinsurance	Deductible does not apply to services with a copayment. Outpatient diagnostic lab testing covered at No Charge in the office when no office visit is charged.
	Imaging (CT/PET scans, MRIs)	$50 copayment/test	$100 copayment/test	50% coinsurance	60% coinsurance	Deductible does not apply to services with a copayment. Preauthorization is required. If you do not receive a preauthorization, benefits may be reduced.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		WakeMed Pharmacy	All other In-Network Pharmacies	Out-of-Network Pharmacies	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available from OptumRx at www.optumrx.com or call 1-800-334-8134.	Generic drugs	30 Day Supply: $5 copayment 90 Day Supply: $10 copayment	30 Day Supply: $25 copayment 90 Day Supply: Not Covered	Not Covered	Covered under a separate prescription drug plan. Copayments represent prescriptions purchased at a retail pharmacy. See your Employer for additional benefit details. Maintenance medications are required to be filled at WakeMed. Specialty drugs are required to be filled at WakeMed and are only available for up to a 30 day supply.
	Preferred brand drugs	30 Day Supply: 5% coinsurance Maximum of $45 copayment 90 Day Supply: 5% coinsurance Maximum of $110 copayment	30 Day Supply: 25% coinsurance Maximum of $75 copayment 90 Day Supply: Not Covered	Not Covered	
	Non-preferred brand drugs	30 Day Supply: 25% coinsurance Maximum of $85 copayment 90 Day Supply: 25% coinsurance Maximum of $200 copayment	30 Day Supply: 45% coinsurance Maximum of $125 copayment 90 Day Supply: Not Covered	Not Covered	
	Specialty drugs	30 Day Supply: 20% coinsurance Maximum of $350 copayment 90 Day Supply: Not Covered	Not Covered		

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		WakeMed Preferred (You will pay the least)	Partners Plus Providers	Network Providers	Out-of-Network Providers (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	50% coinsurance	60% coinsurance	Deductible applies.
	Physician/ surgeon fees	0% coinsurance	0% coinsurance	0% coinsurance	60% coinsurance	Deductible applies to Out-of-Network Providers.
If you need immediate medical attention	Emergency room care	$300 copayment/visit				Deductible does not apply. Copayment waived if admitted.
	Emergency medical transportation	0% coinsurance				Deductible does not apply.
	Urgent care	$20 copayment/visit	$40 copayment/visit	$60 copayment/visit	60% coinsurance	Deductible applies to Out-of-Network Providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	50% coinsurance	60% coinsurance	Deductible applies. Preauthorization is required. If you do not receive a preauthorization, benefits may be reduced.
	Physician/surgeon fees	0% coinsurance	0% coinsurance	0% coinsurance	60% coinsurance	Deductible applies to Out-of-Network Providers.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: Not Available Other Outpatient Services: Not Available	Office Visits: $20 copayment/visit Other Outpatient Services: 20% coinsurance	Office Visits: $20 copayment/visit Other Outpatient Services: 50% coinsurance	60% coinsurance	Deductible does not apply to services with a copayment.
	Inpatient services	10% coinsurance	20% coinsurance	50% coinsurance	60% coinsurance	Deductible applies. Preauthorization is required. If you do not receive a preauthorization, benefits may be reduced.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		WakeMed Preferred (You will pay the least)	Partners Plus Providers	Network Providers	Out-of-Network Providers (You will pay the most)	
If you are pregnant	Office visits	$10 copayment/visit	$20 copayment/visit	$60 copayment/visit	60% coinsurance	Deductible does not apply to services with a copayment. Office visit copayment applies to initial office visit only. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% coinsurance	0% coinsurance	0% coinsurance	60% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	50% coinsurance	60% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	50% coinsurance	60% coinsurance	Deductible applies. Limited to 60 visits/benefit year. Preauthorization is required. If you do not receive a preauthorization, benefits may be reduced.
	Rehabilitation services	$25 copayment/visit	$50 copayment/visit	50% coinsurance	60% coinsurance	Deductible does not apply to services with a copayment. Limited to 60 combined visits/benefit year for Occupational Therapy, Physical Therapy & Speech Therapy.
	Habilitation services	$25 copayment/visit	$50 copayment/visit	50% coinsurance	60% coinsurance	
	Skilled nursing care	Not Available	20% coinsurance	20% coinsurance	60% coinsurance	Deductible applies. Limited to 120 days/benefit year. Preauthorization is required. If you do not receive a preauthorization, benefits may be reduced.
	Durable medical equipment	20% coinsurance	20% coinsurance	20% coinsurance	60% coinsurance	Deductible applies to Out-of-Network providers. Includes orthotics and prosthetics.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		WakeMed Preferred (You will pay the least)	Partners Plus Providers	Network Providers	Out-of-Network Providers (You will pay the most)	
	Hospice services	10% coinsurance	20% coinsurance	50% coinsurance	60% coinsurance	Deductible applies. Preauthorization is required. If you do not receive a preauthorization, benefits may be reduced.
If your child needs dental or eye care	Children's eye exam	Not Covered	$20 copayment	$20 copayment	Not Covered	Covered under separate vision plan. Routine child eye exams are covered under the preventive care benefit.
	Children's glasses	Not Covered	Not Covered	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Child)
- Long-Term Care
- Routine Foot Care
- Weight Loss Programs

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

- Bariatric Surgery
- Hearing Aids
- Infertility Treatment, diagnosis/testing only
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing, 82 visits/benefit year
- Routine Eye Care

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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform .

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 1-833-569-0319.

*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	$1,000
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$200
Coinsurance	$800
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$2,000

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

The plan's overall deductible	$1,000
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$800
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,020

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

The plan's overall deductible	$1,000
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,700

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