


COUPE HEALTH


Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Coupe Health Plan

Coverage Period: 01/01/2024 – 12/31/2024

Coverage For: Individual + Family Plan Type: PPO

 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, call your Coupe Health Valet at 1-833-749-1969 or visit us at coupehealth.com. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance after overall deductible](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-833-749-1969 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible ?	Tier 1-3 In-Network \$0	Tier 4 Out-of-Network \$0	There is no overall deductible for this plan.
Are there services covered before you meet your deductible ?	Tier 1 In-Network Yes. There is no overall calendar year deductible	Tier 4 Out-of-Network Yes. There is no overall calendar year deductible	There is no overall deductible for this plan. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.		You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	Tier 1-3 In-Network Employee \$2,000 Family \$4,000	Tier 4 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 limit until the overall family out-of-pocket limit has been met. The out-of-pocket for Tier 1, 2 and 3 cross apply.
What is not included in the out-of-pocket limit ?	Premiums , balance billed charges, health care this plan doesn't cover, cost sharing for most out-of-network benefits, and pre-certification penalties.		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 coupehealth.com or call 1-833-708-0438 for a list of network 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	Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 copay Deductible does not apply	\$25 copay Deductible does not apply	\$40 copay Deductible does not apply	Not Covered	Doctor on Demand \$0 copay ; precertification is required for some provider administered drugs; if no precertification is obtained, no benefits are available
	Specialist visit	\$35 copay Deductible does not apply	\$45 copay Deductible does not apply	\$75 copay Deductible does not apply	Not Covered	
	Preventive care/screening/immunization	No Charge Deductible does not apply	No Charge Deductible does not apply	No Charge Deductible does not apply	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work)	\$50 copay (diagnostic lab and x-ray) Deductible does not apply	\$65 copay (diagnostic lab and x-ray) Deductible does not apply	\$110 copay (diagnostic lab and x-ray) Deductible does not apply	Not Covered	Fee listed include facility and physician charges; precertification may be required for some services; if no precertification is obtained, no benefits are available; routine labs covered tier 1 \$10, tier 2 \$15 and tier 3 \$25 no overall deductible
	Imaging (CT/PET scans, MRIs)	\$170 copay Deductible does not apply	\$230 copay Deductible does not apply	\$380 copay Deductible does not apply	Not Covered	Precertification is required for advanced imaging; if no precertification is obtained, no benefits are available
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at coupehealth.com	Generic Drugs	\$5 copay (retail) \$10 copay (mail order) Deductible does not apply	\$10 copay (retail) Deductible does not apply	Not Covered	Not Covered	Prior authorization required for specific drugs; if no precertification is obtained, no benefits are available; benefits listed are for a 30-day supply at retail and 90-day supply at mail; 31–90-day supply of maintenance medication is allowed at retail with a copay per 30-day supply; specialty drugs are only available for a 30-day supply from a participating specialty drug network supplier
	Preferred Brand Drugs	\$15 copay (retail) \$30 copay (mail order) Deductible does not apply	\$20 copay (retail) Deductible does not apply	Not Covered	Not Covered	
	Non-Preferred Brand Drugs	\$25 copay (retail) \$50 copay (mail order) Deductible does not apply	\$30 copay (retail) Deductible does not apply	Not Covered	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at [coupehealth.com](#)

Common Medical Event	Services You May Need	Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
	Specialty Drugs	\$30 copay Deductible does not apply	Not covered	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$550 copay Deductible does not apply	\$740 copay Deductible does not apply	\$1,235 copay Deductible does not apply	Not Covered	Facility fee listed includes facility and physician charges associated with outpatient facility and surgical services; precertification may be required; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	No Charge Deductible does not apply	No Charge Deductible does not apply	No Charge Deductible does not apply	Not Covered	None
If you need immediate medical attention	Emergency room care	\$325 copay Deductible does not apply	\$325 copay Deductible does not apply	\$325 copay Deductible does not apply	\$325 copay Deductible does not apply	Facility fee listed includes facility and physician charges associated with medical emergency services; services apply to tier 1-3 of the out-of-pocket maximum
	Emergency medical transportation	\$325 copay Deductible does not apply	\$325 copay Deductible does not apply	\$325 copay Deductible does not apply	\$325 copay Deductible does not apply	Services apply to tier 1-3 of the out-of-pocket maximum
	Urgent care	\$35 copay Deductible does not apply	\$45 copay Deductible does not apply	\$75 copay Deductible does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,035 copay Deductible does not apply	\$1,380 copay Deductible does not apply	\$2,000 copay Deductible does not apply	Not Covered	Facility fee listed includes facility and physician charges associated with inpatient services; precertification is required; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	No Charge Deductible does not apply	No Charge Deductible does not apply	No Charge Deductible does not apply	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 copay Deductible does not apply	\$25 copay Deductible does not apply	\$40 copay Deductible does not apply	Not Covered	Benefits listed for outpatient are physician office visit services; additional benefits are available; facility fee listed for inpatient services includes facility and physician; precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization ; if no precertification is obtained, no benefits are available
	Inpatient services	\$1,035 copay Deductible does not apply	\$1,380 copay Deductible does not apply	\$2,000 copay Deductible does not apply	Not Covered	
If you are pregnant	Office visits	No Charge Deductible does not apply	No Charge Deductible does not apply	No Charge Deductible does not apply	Not Covered	Cost sharing does not apply for preventive services . Depending on the type of services, a copayment ,

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Common Medical Event	Services You May Need	Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
	Childbirth/delivery professional services	No Charge Deductible does not apply	No Charge Deductible does not apply	No Charge Deductible does not apply	Not Covered	<p>coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound); facility fee listed includes facility and physician services associated with maternity facility services; precertification is required for some inpatient services; if no precertification is obtained, no benefits are available</p> <p>Post-delivery, a newborn does not generate a separate copay if it is a well-baby stay. If it is a NICU or a sick newborn stay, there will be a separate inpatient copay and the date of service is generally the start date in the NICU.</p>
	Childbirth/delivery facility services	\$1,035 copay Deductible does not apply	\$1,380 copay Deductible does not apply	\$2,000 copay Deductible does not apply	Not Covered	
If you need help recovering or have other special health needs	Home health care	\$35 copay Deductible does not apply	\$45 copay Deductible does not apply	\$75 copay Deductible does not apply	Not Covered	Precertification may be required; if no precertification is obtained, no benefits are available for home infusion services
	Rehabilitation services	\$35 copay Deductible does not apply	\$45 copay Deductible does not apply	\$75 copay Deductible does not apply	Not Covered	None
	Habilitation services	\$35 copay Deductible does not apply	\$45 copay Deductible does not apply	\$75 copay Deductible does not apply	Not Covered	
	Skilled nursing care	\$930 copay Deductible does not apply	\$1,240 copay Deductible does not apply	\$2,000 copay Deductible does not apply	Not Covered	Limited to 120 days per member per calendar year; precertification is required; if no precertification is obtained, no benefits are available
	Durable medical equipment	\$75 copay Deductible does not apply	\$100 copay Deductible does not apply	\$170 copay Deductible does not apply	Not Covered	Wigs limited to one per member per calendar year for services related to alopecia and cancer; precertification may be required; if no precertification is obtained, no benefits are available
	Hospice services	\$185 copay Deductible does not apply	\$245 copay Deductible does not apply	\$410 copay Deductible does not apply	Not Covered	Precertification may be required; if no precertification is obtained, no benefits are available
If your child needs dental or eye care	Children's eye exam	No Charge Deductible does not apply	No Charge Deductible does not apply	No Charge Deductible does not apply	Not covered	Please call your Coupe Health Valet at 1-833-749-1969
	Children's glasses	Not covered	Not covered	Not covered	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at coupehealth.com

Common Medical Event	Services You May Need	Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered	Please call your Coupe Health Valet at 1-833-749-1969

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 .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) 	<ul style="list-style-type: none"> • Long-term care • Weight Loss Programs 	<ul style="list-style-type: none"> • Routine foot care • Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Acupuncture (limited to a maximum of 20 visits per member per calendar year for medical policy diagnosis categories only) • Bariatric surgery • Chiropractic care 	<ul style="list-style-type: none"> • Infertility Treatment (limited to a combined medical and prescription drug lifetime maximum of \$25,000) • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Hearing Aids (limitations apply) • Routine eye care (Adult)

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 <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa> or your plan administrator at the phone number listed in your benefit booklet. 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,

* For more information about limitations and exceptions, see the plan or policy document at coupehealth.com

contact: Your plan administrator at the phone number listed in your benefit booklet. You may also contact Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>.

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 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](#).

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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0
■ Specialist copay	\$35	■ Specialist copay	\$35	■ Specialist copay	\$35
■ Hospital (facility) copay	\$1,035	■ Hospital (facility) copay	\$1,035	■ Hospital (facility) copay	\$1,035
■ Other copay	\$550	■ Other copay	\$550	■ Other copay	\$550
<p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic tests (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$1,600	Copayments	\$700	Copayments	\$1,700
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$40	Limits or exclusions	\$0
The total Peg would pay is	\$1,660	The total Joe would pay is	\$740	The total Mia would pay is	\$1,700

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: coupehealth.com.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.