COUPE HEALTH

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

Coverage Period: 01/01/2025 – 12/31/2025

Cuningham Architecture – 55073, 55074

Coverage For: Individual + Family **Plan Type: HDHP**

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 member.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 https://www.healthcare.gov/sbc-glossary 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** Self Only / $2,000 Family / $4,000	**Tier 4 Out-of-Network** Self Only / $2,000 Family / $4,000	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?	**Tier 1-3 In-Network** Yes. Preventive services in-network are covered before you meet your deductible.		This plan covers some items and services even if you haven't yet met the annual 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?	No		You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out–of–pocket limit for this plan?	**Tier 1-3 In-Network** Individual / $6,000 Family / $9,000	**Tier 4 Out-of-Network** Unlimited	The out-of-pocket limit is the most you could pay in a year for covered services. This limit helps you plan for health care expenses. This plan has a per member out-of-pocket limit. Once a family member reaches his or her out-of-pocket limit, the plan begins to pay 100% of eligible health care expenses for that person for the rest of the year.
What is not included in the out–of–pocket limit?	Premiums, balance billing charges, health care this plan doesn't cover, 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 member.coupehealth.com or call 1-833-749-1969 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.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay	$25 copay	$40 copay	$50 copay	Precertification is required for some provider administered drugs; if no precertification is obtained, no benefits are available; $0 copay for E-visits, Telehealth and Telephone consultations; out-of-network provider is not covered
	Specialist visit	$35 copay	$50 copay	$80 copay	$95 copay	Precertification is required for some provider administered drugs; if no precertification is obtained, no benefits are available; copay will apply for Allergy Injections, Serum & Testing; 20 visit limit per member per calendar year
	Preventive care/screening/ immunization	No Charge	No Charge	No Charge	No Charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay for. Please call your Coupe Health Valet at 1-833-749-1969.
If you have a test	Diagnostic test (x-ray, blood work)	Basic Diagnostic Labs: $10 copay Advanced Diagnostic Labs & Radiology: $50 copay X-ray: $50 copay	Basic Diagnostic Labs: $15 copay Advanced Diagnostic Labs & Radiology: $65 copay X-ray: $65 copay	Basic Diagnostic Labs: $30 copay Advanced Diagnostic Labs & Radiology: $105 copay X-ray: $105 copay	Basic Diagnostic Labs: $35 copay Advanced Diagnostic Labs & Radiology: $125 copay X-ray: $125 copay	Fee listed include facility and physician charges; precertification may be required for some services; if no precertification is obtained, no benefits are available.
	Imaging (CT/PET scans, MRIs)	$165 copay	$215 copay	$365 copay	$435 copay	Precertification may be required for some services; if no precertification is obtained, no benefits are available.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
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If you need drugs to treat your illness or condition A retail pharmacy is any licensed pharmacy that you can physically enter to obtain a **prescription drug**. A mail service pharmacy dispenses **prescription drugs** through the U.S. Mail. More information about **prescription drug coverage** is available at member.coupehealth.com	Tier 1 (Generic Drugs)	$5 copay (retail) $15 copay (mail order)			Not Covered	Benefits listed are for a 30-day supply at retail and 90-day supply at mail order pharmacy. Specialty drugs are for a 30-day supply at mail order only.
	Tier 2 (Non-Preferred Generic Drugs)	$20 copay (retail) $40 copay (mail order)			Not Covered	
	Tier 3 (Preferred Brand Drugs)	$15 copay (retail) $30 (mail order)			Not Covered	
	Tier 4 (Non-Preferred Brand Drugs)	$20 copay (retail) $40 copay (mail order)			Not Covered	
	Specialty Drugs	$200 copay			Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$535 copay	$715 copay	$1,205 copay	$1,445 copay	Facility fee listed include facility and physician charges associated with outpatient facility and surgical services
	Physician/surgeon fees	No Charge	No Charge	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room care	$305 copay				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	$305 copay				Services apply to the tier 1-3 of the out-of-pocket maximum
	Urgent care	$65 copay				None
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,640 copay	$2,180 copay	$3,690 copay	$4,425 copay	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	No Charge	No Charge	No Charge	

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If you need mental health, behavioral health, or substance abuse services	Outpatient services	$535 copay	$715 copay	$1,205 copay	$1,445 copay	Facility fee listed for inpatient services includes facility and physician; precertification is required; if no precertification is obtained, no benefits are available
	Inpatient services	$1,640 copay	$2,180 copay	$3,690 copay	$4,425 copay	
If you are pregnant	Office visits	No Charge	No Charge	No Charge	$50 copay	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply; a one-time copay will apply for the initial office visit. 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 may be required for some inpatient services; if no precertification is obtained, no benefits are available. 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
	Childbirth/delivery professional services	No Charge	No Charge	No Charge	Not Covered	
	Childbirth/delivery facility services	$1,640 copay	$2,180 copay	$3,690 copay	$4,425 copay	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
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If you need help recovering or have other special health needs	Home health care	$35 copay	$50 copay	$80 copay	$95 copay	Benefits are also available for home infusion services; precertification may be required; if no precertification is obtained, no benefits are available
	Rehabilitation services	$35 copay	$50 copay	$80 copay	$95 copay	None
	Habilitation services	$35 copay	$50 copay	$80 copay	$95 copay	
	Skilled nursing care	$1,445 copay	$1,920 copay	$3,250 copay	$3,900 copay	Limited to 120 days per member per calendar year; precertification may be required; if no precertification is obtained, no benefits are available
	Durable medical equipment	$75 copay	$100 copay	$170 copay	$205 copay	Wigs limited to one per member per calendar year for Alopecia and Cancer, precertification may be required; if no precertification is obtained, no benefits are available
	Hospice services	$180 copay	$240 copay	$405 copay	$485 copay	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				Services listed are routine; Please call your Coupe Health Valet at 1-833-749-1969
	Children's glasses	Not Covered				Not covered; member pays 100%
	Children's dental check-up	No Charge				Services listed are routine; 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.)

- Cosmetic surgery
- Dental care (Adult)
- Glasses, child
- Long-term care
- Private-duty nursing
- 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.)

- Acupuncture (Limited to 20 visits per person per calendar year; specialist copay will apply)
- Bariatric surgery (Limitations apply)
- Chiropractic care (Specialist copay will apply)
- Fertility Treatment (Limitations apply)
- Hearing Aids (Limitations apply)
- Non-emergency care when traveling outside the U.S.
- 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: Minnesota Department of Commerce at 1-800-657-3602; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, extension 61565 or www.cciio.cms.gov. For more information on your rights to continue coverage, contact Blue Cross at 1-866-455-8220. 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.mnsure.com or call 1-855-366-7873.

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: Blue Cross at 1-866-455-8220; the Minnesota Department of Commerce at 1-800-657-3602; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. If you are covered under a plan offered by the State Health Plan, a city, county, school district, or Service Cooperative, or church plan you may contact the Department of Health and Human Services Health Insurance team at 1-888-393-2789.

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)

The plan's overall deductible	$2,000
Specialist copayment	$35
Hospital (facility) copayment	$1,640
Other copayment/coinsurance	$305/20%

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	$1,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,860**

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	$35
Hospital (facility) copayment	$1,640
Other copayment/coinsurance	$305/20%

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	$2,000
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	**$2,340**

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

The plan's overall deductible	$2,000
Specialist copayment	$35
Hospital (facility) copayment	$1,640
Other copayment/coinsurance	$305/20%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,300**