COUPE HEALTH

Coupe Health Benefits Summary

Client Name: 7-Eleven
Plan Year: January 1st, 2025 - December 31st, 2025
Standard HSA Plan
(without HSA funding)

Medical Benefits				
	In-Network			Out-of-Network
	Tier 1	Tier 2	Tier 3	
Calendar Year Deductible Individual	$2,500			No Coverage
Calendar Year Deductible Family	$5,000			No Coverage
Out-of-Pocket Maximum Individual	$5,000 Individual			No Coverage
Out-of-Pocket Maximum Family	$9,200 Individual / $10,000 Family			No Coverage
OOP Max applies to in-network services only				

	In-Network			Out-of-Network
Medical Services	**Tier 1**	**Tier 2**	**Tier 3**	
Physician Services				
Primary Care Physician	$30	$60	$90	No Coverage
Retail Health Clinic	$30	$60	$90	No Coverage
Specialist	$75	$150	$300	No Coverage
Preventative Services & Routine Care				
Well-Child Care (including exams and immunizations)	No Charge			No Coverage
Adult Physical Examination (including routine GYN visit)	No Charge			No Coverage
Routine Eye Care	No Charge			No Coverage
COVID 19 Vaccine	No Charge			No Coverage
Breast Cancer Screening	No Charge			No Coverage
Pap Test	No Charge			No Coverage
Prostate Cancer Screening	No Charge			No Coverage
Colorectal Cancer Screening	See plan document for specific coverage based on age/necessity			
Virtual Health				
Virtual PCP Visit	$10	$60	$90	No Coverage
Maternity				
Initial Prenatal Office Visit	$30	$60	$90	No Coverage
Prenatal Office Visit	No Charge			
Delivery & Postnatal Care	$2,000	$3,000	$4,000	No Coverage
Hospital Expenses or Long-Term Acute Care Facility/Hospital (Facility Charges)				
Inpatient Hospital	$2,000	$3,000	$4,000	No Coverage
Outpatient Hospital	$1,500	$2,000	$3,500	No Coverage
Skilled Nursing /Rehabilitation Facility	$2,000	$3,000	$4,000	No Coverage
Ambulatory Surgical Center	$1,500	$2,000	$3,500	No Coverage
Home Health Care	$150	$200	$300	No Coverage
Hospice Care	$400	$600	$900	No Coverage

	In-Network			Out-of-Network
Medical Services	Tier 1	Tier 2	Tier 3	
Radiology Services				
Routine X-Ray (OneImaging)		$25		No Coverage
Routine X-Ray (In-network providers)	$75	$250	$500	No Coverage
Advanced Imaging (OneImaging) (MRI & CT)		$100		No Coverage
Advanced Imaging (In-network providers) (MRI, MRA, CT & PET Scans)	$250	$500	$800	No Coverage
Laboratory Services				
Basic Labs	$50	$100	$150	No Coverage
Advanced Diagnostic Labs	$200	$250	$400	No Coverage
Emergency Services/Urgent Care				
Emergency Services/Emergency Room		$750		
Ambulance Services		$750		
Urgent Care Facility		$100		No Coverage
Mental Disorders & Substance Use Disorders				
Office Visit	$30	$60	$90	No Coverage
Inpatient	$2,000	$3,000	$4,000	No Coverage
Outpatient	$1,500	$2,000	$3,500	No Coverage
Therapy Services				
Chiropractic Care/Spinal Manipulation	$75	$150	$300	No Coverage
Outpatient Therapies (PT, OT, ST)	$75	$150	$300	No Coverage
Durable Medical Equipment*				
Durable Medical Equipment (DME) / Item	$250	$400	$600	No Coverage
Other Healthcare Facilities/Services				
Allergy Injections, Serum & Testing (in office)	$30	$60	$90	No Coverage
Acupuncture	$75	$150	$300	No Coverage
Transplants (see plan document for travel/lodging benefits)	$2,000	$3,000	$4,000	No Coverage

*Diabetic supplies that are provided by an in-network preferred provider will be paid according to the applicable category of this Medical Schedule of Benefits, such as Durable Medical Equipment (DME).

Medical Network: Bluecard Network**
**select Networks for residents of FL (NetworkBlue), NY (Blue Access) and WI (Blue Preferred)

This plan summary is for comparision purposes only and does not create right not given through the benefit plan.