

## COUPE HEALTH

### Coupe Health Benefits Summary: HDHP Plan

Client Name: Bethel University

Plan Year: January 1st, 2026 - December 31st, 2026

Network: BlueCard® PPO Network

Medical Benefits				
	In-Network			Out-of-Network
	✔ Tier 1	⚡ Tier 2	! Tier 3	
Calendar Year Deductible (Indiv/Family)		\$3,400 / \$6,800		N/A
Out-of-Pocket Maximum (Indiv/Family)		\$5,000 / \$10,000		N/A
*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	\$20	\$25	\$40	\$50
Retail Health Clinic	\$20	\$25	\$40	\$50
Specialist	\$35	\$50	\$80	\$95
Preventative Services & Routine Care				
Well-Child Care (including exams and immunizations)			No Charge	
Adult Physical Examination (including routine GYN visit)			No Charge	
Routine Eye Care			No Charge	
COVID 19 Vaccine			No Charge	
Breast Cancer Screening (any age)			No Charge	
Pap Test			No Charge	
Prostate Cancer Screening			No Charge	
Colorectal Cancer Screening	See plan document for specific coverage based on age/necessity			
Telehealth Services				
E-Visits	\$20	\$25	\$40	\$50
Maternity				
Initial Prenatal Office Visit	\$20	\$25	\$40	\$50
Prenatal Office Visit			No Charge	
Delivery & Postnatal Care	\$1,640	\$2,180	\$3,690	\$4,425
Hospital Expenses or Long-Term Acute Care Facility/Hospital (Facility Charges)				
Inpatient Hospital	\$1,640	\$2,180	\$3,690	\$4,425
Outpatient Hospital	\$535	\$715	\$1,205	\$1,445
Skilled Nursing Facility (120 days combined max per plan year)	\$1,445	\$1,920	\$3,250	\$3,900
Ambulance Services			\$305	
Ambulatory Surgical Center	\$535	\$715	\$1,205	\$1,445
Home Health Care (120 visits per plan year)	\$35	\$50	\$80	\$95
Home Infusion	\$35	\$50	\$80	\$95
Hospice Care	\$180	\$240	\$405	\$485

	In-Network			Out-of-Network
Medical Services	✔ Tier 1	⚡ Tier 2	❗ Tier 3	
Radiology Services				
Diagnostic X-Rays	\$50	\$65	\$105	\$125
Advanced Imaging (MRI, MRA, CAT & PET Scans)	\$165	\$215	\$365	\$435
Laboratory Services				
Basic Labs	\$10	\$15	\$30	\$35
Advanced Diagnostic Labs	\$50	\$65	\$105	\$125
Emergency Services/Urgent Care				
Emergency Services/Emergency Room	\$305			
Urgent Care Facility	\$35			
Mental Disorders & Substance Use Disorders				
Office Visit	\$20	\$25	\$40	\$50
Inpatient	\$1,640	\$2,180	\$3,690	\$4,425
Outpatient	\$535	\$715	\$1,205	\$1,445
Therapy Services				
Chiropractic Care/Spinal Manipulation (20 visits per plan year)	\$35	\$50	\$80	\$95
Outpatient Therapies (PT, OT, ST) (20 visits per plan year)	\$35	\$50	\$80	\$95
Durable Medical Equipment				
Durable Medical Equipment (DME) / Item	\$75	\$100	\$170	\$205
Other Healthcare Facilities/Services				
Allergy Injections, Serum & Testing	\$35	\$50	\$80	\$95
Acupuncture	\$35	\$50	\$80	\$95
Transplants	\$1,640	\$2,180	\$3,690	\$4,425

## Pharmacy Drug Vendor: Prime Therapeutics Rx

### Pharmacy Benefits

**NOTE:** There is no coverage under the plan for prescription drugs obtained from a Non-Participating Partner.

Rx Network: Select Network  
Rx Formulary: FlexRx

If you reach your out-of-pocket maximum, Coupe Health will pay 100% of the applicable allowed benefit for most covered services for the remainder of the year. All copays and other eligible out-of-pocket costs count toward your out-of-pocket maximum, except balance billed amounts.

### Pharmacy Plan Feature

#### Retail Pharmacy

Preventive	\$0
Preferred Generic Drugs	\$8
Non-Preferred Generic Drugs	\$60
Preferred Brand Drugs	\$30
Non-Preferred Brand Drugs	\$60

#### Specialty Drug Program

Specialty Drugs (Up to a 30-day Supply)	\$150
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\*Specialty medications are required to be filled through Mail Order

#### Mail Order (90 Day Supply)

Preferred Generic Drugs	\$16
Non-Preferred Generic Drugs	\$120
Preferred Brand Drugs	\$60
Non-Preferred Brand Drugs	\$120

#### Drug Descriptions

Preferred Generic Drugs	All preferred drugs are covered at this copay level.
Non-Preferred Generic Drugs	All non-preferred generic drugs on this copay level are not on the Preferred Drug List. Discuss using alternatives with your physician or pharmacist.
Preferred Brand Drugs	All preferred drugs are covered at this copay level.
Non-Preferred Brand Drugs	All non-preferred brand drugs on this copay level are not on the Preferred Drug List. Discuss using alternatives with your physician or pharmacist.