COUPE HEALTH

Bethel University – HDHP Plan

Plan Year: January 1st, 2025 – December 31st, 2025
National Network: Bluecard PPO

Medical Benefits				
Medical Services	**Tier 1**	**Tier 2**	**Tier 3**	**Out-of-Network**
Calendar Year Deductible				
Single Family	$3,300 $6,600			
Out-of-Pocket Maximum (includes copays – combine with prescription drug card)				
Single Family	$5,000 $10,000			Unlimited Unlimited
OOP Max applies to in-network services only; Out-of-Network OOP Max is unlimited				
Medical Services	**Tier 1**	**Tier 2**	**Tier 3**	**Out-of-Network**
Covid 19 Services				
Covid 19 Vaccine (Moderna, Pfizer, Johnson & Johnson)	No Charge			
Durable Medical Equipment				
Durable Medical Equipment (DME) / item	$75	$100	$170	$205
Emergency Services/Urgent Care				
Emergency Services/Emergency Room	$305			
Urgent Care Facility	$35			
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
Infertility Treatment	See plan document for specific coverages and exclusions			
Skilled Nursing Facility/Rehabilitation Facility	$1,445	$1,920	$3,250	$3,900
Ambulance Services	$305			
Home Health Care	$35	$50	$80	$95
Hospice Care	$180	$240	$405	$485
Laboratory Services				
Routine Diagnostic Labs	$10	$15	$30	$35
Diagnostic Labs	$50	$65	$105	$125
Maternity				
Initial Office Visit	$20	$25	$40	$50
Preventive & Ongoing Prenatal Care	No Charge (Included in global delivery copay)			
Delivery & Postnatal Care	$1,640	$2,180	$3,690	$4,425

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
Physician Services				
Primary Care Physician	$20	$25	$40	$50
Specialist	$35	$50	$80	$95
Telehealth Services				
E-visits	$20	$25	$40	$50
Preventive Services & Routine Care				
Well-Child Care (Including exams and immunizations)	No Charge			
Adult Physical Examination (Including routine GYN visit)	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			
Radiology Services				
Diagnostic X-Rays	$50	$65	$105	$125
Advanced Imaging (MRI, MRA, CAT & PET Scans)	$165	$215	$365	$435
Therapy Services				
Chiropractic Care/Spinal Manipulation	$35	$50	$80	$95
Outpatient Therapies (PT, OT, ST)	$35	$50	$80	$95
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

Medical Network: Aware®/BlueCard® PPO Network
How to Find a Provider: Log into your member portal at www.coupehealth.com and click on “Find a Doctor and Compare Costs” under the “Benefits” tab.

For questions about your Coupe Health Plan, please contact your Coupe Health Valet:

Email: healthvalet@coupehealth.com **Phone:** 1-833-749-1969

Pharmacy Benefits

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

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 for excluded or non-covered services.

Pharmacy Plan Feature	In-Network Pharmacies	Out-of-Network Pharmacies
Preferred Generics (Tier 1)	$8 copay/prescription (retail) $16 copay/prescription (mail service) $16 copay/prescription (90-day Rx retail)	Not Covered
Non-Preferred Generics	$60 copay/prescription (retail) $120 copay/prescription (mail service) $120 copay/prescription (90-day Rx retail)	Not Covered
Preferred Brand (Tier 2)	$30 copay/prescription (retail) $60 copay/prescription (mail service) $60 copay/prescription (90-day Rx retail)	Not Covered
Non-Preferred Brand	$60 copay/prescription (retail) $120 copay/prescription (mail service) $120 copay/prescription (90-day Rx retail)	Not Covered
Specialty Drugs	$150 copay/prescription	Not Covered

Pharmacy Drug Vendor: Prime Therapeutics
Rx Network: Select Network
Rx Formulary: FlexRx
Specialty Drug Vendor: Prime Therapeutics Specialty Pharmacy

How to Find a Drug: Look up the cost of your medications in the Coupe member portal.

Visit www.coupehealth.com for the most up-to-date drug lists, including the prescription guidelines. Prescription guidelines indicate drugs that require your doctor to obtain prior authorization from Coupe Health before they can be filled and drugs that can be filled in limited quantities.

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