

COUPE HEALTH

Coupe Health Benefits Summary - Copay Plan

Fabcon Companies

Plan Year: July 1st, 2026 - June 30th, 2027

Network: BlueCard® PPO Network

Medical Benefits				
	In-Network			Out-of-Network
	✔ Tier 1	⊖ Tier 2	! Tier 3	Tier 4
Calendar Year Deductible (Indiv/Family)	\$0			
Out-of-Pocket Maximum (Indiv/Family)	\$4,500/\$9,000			Unlimited
*OOP Max applies to in-network services only				
	In-Network			Out-of-Network
Medical Services	✔ Tier 1	⊖ Tier 2	! Tier 3	Tier 4
Physician Services				
Primary Care Physician	\$15	\$25	\$60	\$75
Retail Health Clinic	\$15	\$25	\$60	\$75
Specialist	\$30	\$40	\$90	\$130
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)	See plan document for specific coverage based on age/necessity			
Pap Test	See plan document for specific coverage based on age/necessity			
Prostate Cancer Screening	See plan document for specific coverage based on age/necessity			
Colorectal Cancer Screening	See plan document for specific coverage based on age/necessity			
Telehealth Services				
Doctor on Demand - Urgent/Behavioral Health/Preventive Visit	No Charge			N/A
Doctor on Demand - Virtual PCP	\$15			N/A
Maternity				
Initial Prenatal Office Visit	\$15	\$25	\$60	\$75
Prenatal Office Visit	No Charge			
Delivery & Postnatal Care	\$1,600	\$2,200	\$3,800	\$6,000
Hospital Expenses or Long-Term Acute Care Facility/Hospital (Facility Charges)				
Inpatient Hospital	\$1,600	\$2,200	\$3,800	\$6,000
Outpatient Hospital	\$600	\$900	\$1,500	\$1,850
Skilled Nursing / Rehabilitation Facility (120 days combined max per plan year)	\$1,350	\$1,800	\$3,100	\$5,000
Ambulance Services	\$250			
Ambulatory Surgical Center	\$600	\$900	\$1,500	\$1,850
Home Health Care	\$30	\$60	\$100	\$140
Home Infusion	\$30	\$60	\$100	\$140
Hospice Care	\$290	\$390	\$650	\$780
Radiology Services				
*When x-rays and imaging (excludes advanced imaging) are done as part of an office visit, only the office visit copay applies.				
Diagnostic X-Rays	\$50	\$75	\$130	\$170
Advanced Imaging (MRI, MRA, CAT & PET Scans)	\$175	\$250	\$400	\$560

	In-Network			Out-of-Network
Medical Services	✓ Tier 1	⊖ Tier 2	⚠ Tier 3	Tier 4
Laboratory Services				
*When basic labs are done as part of an office visit, only the office visit copay applies.				
Basic Labs	\$15	\$20	\$40	\$60
Advanced Diagnostic Labs	\$60	\$80	\$140	\$170
Emergency Services/Urgent Care				
Emergency Services/Emergency Room			\$250	
Urgent Care Facility			\$45	
Mental Disorders & Substance Use Disorders				
Office Visit	\$15	\$25	\$60	\$75
Inpatient	\$1,600	\$2,200	\$3,800	\$6,000
Outpatient	\$600	\$900	\$1,500	\$1,850
Therapy Services				
Chiropractic Care/Spinal Manipulation	\$30	\$40	\$90	\$105
Outpatient Therapies (PT, OT, ST)	\$30	\$60	\$100	\$140
Durable Medical Equipment*				
Durable Medical Equipment (DME) / Item	\$65	\$90	\$150	\$275
Other Healthcare Facilities/Services				
Allergy Injections, Serum & Testing	\$30	\$40	\$90	\$130
Acupuncture	\$30	\$40	\$90	\$130
Transplants	\$1,600	\$2,200	\$3,800	\$6,000

Pharmacy Drug Vendor: Prime Therapeutics

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: FocusRx	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	In-Network
Preferred Generic Drugs	\$10
Preferred Brand Drugs	\$45
Non-Preferred Generic Drugs	\$45
Non-Preferred Brand Drugs	\$90
Specialty Drug Program	
Specialty Drugs* (Up to a 31-day Supply)	\$200
*Specialty medications are required to be filled through a Specialty Pharmacy.	
Mail Order (90 Day Supply)	
Preferred Generic Drugs	\$20
Preferred Brand Drugs	\$90
Non-Preferred Generic Drugs	\$90
Non-Preferred Brand Drugs	\$180
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.