COUPE HEALTH

Coupe Health Benefits Summary - High Deductible Plan

Fabcon Companies
Plan Year: July 1st, 2026 - June 30th, 2027
Network: BlueCard® PPO Network

All Coupe Health HDHP services are subject to deductible before copays

Medical Benefits				
	In-Network			Out-of-Network
	Tier 1	Tier 2	Tier 3	Tier 4
Calendar Year Deductible (Indiv/Family)		$2,000/$4,000		$5,500/$11,000
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 after deductible	$25 after deductible	$60 after deductible	$75 after deductible
Retail Health Clinic	$15 after deductible	$25 after deductible	$60 after deductible	$75 after deductible
Specialist	$30 after deductible	$40 after deductible	$90 after deductible	$130 after deductible
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 after deductible		N/A
Maternity				
Initial Prenatal Office Visit	$15 after deductible	$25 after deductible	$60 after deductible	$75 after deductible
Prenatal Office Visit	No Charge			
Delivery & Postnatal Care	$1,600 after deductible	$2,200 after deductible	$3,800 after deductible	$6,000 after deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (Facility Charges)				
Inpatient Hospital	$1,600 after deductible	$2,200 after deductible	$3,800 after deductible	$6,000 after deductible
Outpatient Hospital	$600 after deductible	$900 after deductible	$1,500 after deductible	$1,850 after deductible
Skilled Nursing /Rehabilitation Facility (120 days combined max per plan year)	$1,350 after deductible	$1,800 after deductible	$3,100 after deductible	$5,000 after deductible
Ambulance Services		$250 after deductible		
Ambulatory Surgical Center	$600 after deductible	$900 after deductible	$1,500 after deductible	$1,850 after deductible
Home Health Care	$30 after deductible	$60 after deductible	$100 after deductible	$140 after deductible
Home Infusion	$30 after deductible	$60 after deductible	$100 after deductible	$140 after deductible
Hospice Care	$290 after deductible	$390 after deductible	$650 after deductible	$780 after deductible
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 after deductible	$75 after deductible	$130 after deductible	$170 after deductible
Advanced Imaging (MRI, MRA, CAT & PET Scans)	$175 after deductible	$250 after deductible	$400 after deductible	$560 after deductible

	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 after deductible	$20 after deductible	$40 after deductible	$60 after deductible
Advanced Diagnostic Labs	$60 after deductible	$80 after deductible	$140 after deductible	$170 after deductible
Emergency Services/Urgent Care				
Emergency Services/Emergency Room	$250 after deductible			
Urgent Care Facility	$45 after deductible			
Mental Disorders & Substance Use Disorders				
Office Visit	$15 after deductible	$25 after deductible	$60 after deductible	$75 after deductible
Inpatient	$1,600 after deductible	$2,200 after deductible	$3,800 after deductible	$6,000 after deductible
Outpatient	$600 after deductible	$900 after deductible	$1,500 after deductible	$1,850 after deductible
Therapy Services				
Chiropractic Care/Spinal Manipulation	$30 after deductible	$40 after deductible	$90 after deductible	$105 after deductible
Outpatient Therapies (PT, OT, ST)	$30 after deductible	$60 after deductible	$100 after deductible	$140 after deductible
Durable Medical Equipment*				
Durable Medical Equipment (DME) / Item	$65 after deductible	$90 after deductible	$150 after deductible	$275 after deductible
Other Healthcare Facilities/Services				
Allergy Injections, Serum & Testing	$30 after deductible	$40 after deductible	$90 after deductible	$130 after deductible
Acupuncture	$30 after deductible	$40 after deductible	$90 after deductible	$130 after deductible
Transplants	$1,600 after deductible	$2,200 after deductible	$3,800 after deductible	$6,000 after deductible

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**	**Out-of-Network**
Preferred Generic Drugs	$10 after deductible	No-Coverage
Preferred Brand Drugs	$45 after deductible	No-Coverage
Non-Preferred Generic Drugs	$45 after deductible	No-Coverage
Non-Preferred Brand Drugs	$90 after deductible	No-Coverage
Specialty Drug Program		
Specialty Drugs* (Up to a 31-day Supply)	$200 after deductible	
*Specialty medications are required to be filled through a Specialty Pharmacy.		
Mail Order (90 Day Supply)		
Preferred Generic Drugs	$20 after deductible	
Preferred Brand Drugs	$90 after deductible	
Non-Preferred Generic Drugs	$90 after deductible	
Non-Preferred Brand Drugs	$180 after deductible	
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.	