COUPE HEALTH

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 07/01/2026 – 06/30/2027

Fleet Farm Coupe Health

Coverage For: Individual + Family Plan Type: HDHP

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call your Coupe Health Valet at 1-833-749-1969 or visit us at member.member.coupehealth.com.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance after overall deductible, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-833-749-1969 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible?	**Tier 1-3 In-Network** $3,400 / individual or $6,800 / family	**Tier 4 Out-of-Network** $5,500 / individual or $11,000 / family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible
Are there services covered before you meet your deductible?	**Tier 1 In-Network** Yes. Preventive services in-network are covered before you meet your deductible.	**Tier 4 Out-of-Network** Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment may apply. For example, this plan covers certain preventive services without cost-sharing. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No		You don't have to meet a deductible for specific services.
What is the out–of–pocket limit for this plan?	**Tier 1-3 In-Network** $5,000 / individual $10,000 / family	**Tier 4 Out-of-Network** Unlimited	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, health care this plan doesn't cover and pre-certification penalties.		Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See member.coupehealth.com or call 1-833-749-1969 for a list of network providers.		This plan uses a provider network. No out-of-network coverage. Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No		You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	Tier 1 - 3 In-Network			Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay	$25 copay	$45 copay	$50 copay	Precertification may be required for some provider administered drugs; if no precertification is obtained, no benefits are available; Doctor on Demand $15 for Tiers 1-3, not applicable for Tier 4
	Specialist visit	$30 copay	$40 copay	$70 copay	$90 copay	
	Preventive care/screening/ immunization	No Charge				You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Please call your Coupe Health Valet at 1-833-749-1969 to confirm benefits.
If you have a test	Diagnostic test (x-ray, blood work)	Diagnostic Radiology: $60 copay Advanced Diagnostic Labs: $50 copay Basic Labs: $15 copay	Diagnostic Radiology: $80 copay Advanced Diagnostic Labs: $70 copay Basic Labs: $25 copay	Diagnostic Radiology: $140 copay Advanced Diagnostic Labs: $120 copay Basic Labs: $40 copay	Diagnostic Radiology: Advanced Diagnostic Labs: $140 copay Basic Labs: $50 copay	Benefits listed are for diagnostic labs, advanced diagnostic labs and radiology and include facility and physician charges; precertification may be required; if no precertification is obtained, no benefits are available.
	Imaging (CT/PET scans, MRIs)	$200 copay	$270 copay	$450 copay	$540 copay	Precertification is required for advanced imaging; if no precertification is obtained, no benefits are available

Common Medical Event	Services You May Need	Tier 1 - 3 In-Network	Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com or call 1-855-524-0381. The plan is with the Premium Formulary.	Preferred Generic drugs	20% coinsurance/retail, 20% coinsurance/mail	20% coinsurance/retail Not covered mail order drugs	Covers up to a 30-day supply at 1 copay or 90-day supply at 2 copays (retail prescription); 90-day supply (mail order prescription). All maintenance medications must be filled at an Optum Pharmacy. Please visit OptumRx.com to find a Retail 90 pharmacy to fill 90-day supply at Retail Pharmacy. If a Brand Name Drug is purchased when a Generic Drug is available, the participant will be responsible for the difference in cost between the Brand Name Drug and Generic Drug in addition to the Brand Name Drug Copay. This difference does NOT apply to the Annual Out of Pocket Maximum
	Preferred Brand drugs	20% coinsurance/retail. 20% coinsurance/mail	20% coinsurance/retail Not covered mail order drugs	
	Non-preferred drugs	20% coinsurance/retail. 20% coinsurance/mail	20% coinsurance/retail Not covered mail order drugs	
	Specialty drugs	20% coinsurance	Not Covered	Covers up to a 30-day supply (Participating Specialty Drug Network Supplier prescription) No coverage for services from out-of-network providers. Only Generic and Formulary Specialty are covered. Non-Formulary Specialty are not covered and will be 100% member responsibility.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$700 copay / $940 copay / $1,580 copay	$1,890 copay	Facility fee listed includes facility and physician charges associated with outpatient facility and surgical services; precertification may be required; if no precertification is obtained, no benefits are available.
	Physician/surgeon fees	No Charge		Physician charges associated with outpatient facility and surgical services are included in the facility charges listed in the section above.

Common Medical Event	Services You May Need	Tier 1 - 3 In-Network	Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	$250 copay		Facility fee listed includes facility and physician charges associated with medical emergency services
	Emergency medical transportation	$250 copay		Services apply to tier 1-3 out-of-pocket maximum. Tier 4 applies to the out-of-network out-of-pocket maximum
	Urgent care	$30 copay		None

Common Medical Event	Services You May Need	Tier 1 - 3 In-Network			Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,700 copay	$2,270 copay	$3,830 copay	$4,590 copay	Facility fee listed includes facility and physician charges associated with inpatient services; precertification is required; if no precertification is obtained, no benefits are available.
	Physician/surgeon fees	No Charge				None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician's Office: $15 copay Outpatient: $700 copay	Physician's Office: $25 copay Outpatient: $940 copay	Physician's Office: $45 copay Outpatient: $1,580 copay	Physician's Office: $50 copay Outpatient: $1,890 copay	Facility fee listed for inpatient services includes facility and physician services; precertification is required for intensive outpatient partial hospitalization and inpatient hospitalization; if no precertification is obtained, no benefits are available
	Inpatient services	$1,700 copay	$2,270 copay	$3,830 copay	$4,590 copay	
If you are pregnant	Office visits	Initial Visit: $15 copay	Initial Visit: $25 copay	Initial Visit: $45 copay	Initial Visit: $50 copay	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment may be required. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); facility fee listed includes facility and physician services associated with maternity facility services; precertification may be required for some inpatient services; if no precertification is obtained, no benefits are available
	Childbirth/delivery professional services	No Charge				
	Childbirth/delivery facility services	$1,700 copay	$2,270 copay	$3,830 copay	$4,590 copay	

Common Medical Event	Services You May Need	Tier 1 - 3 In-Network			Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	$45 copay	$60 copay	$110 copay	$130 copay	Precertification may be required; if no precertification is obtained, no benefits are available; benefits are also available for home infusion services.
	Rehabilitation services	$30 copay	$40 copay	$70 copay	$90 copay	Benefits listed are for Rehabilitation & Habilitation services; no visit maximum for occupational, physical and speech therapy; behavioral health diagnosis does not apply to limits
	Habilitation services	$30 copay	$40 copay	$70 copay	$90 copay	
	Skilled nursing care	$1,400 copay	$1,870 copay	$3,150 copay	$3,780 copay	Precertification may be required; if no precertification is obtained, no benefits are available.
	Durable medical equipment	$100 copay	$140 copay	$230 copay	$270 copay	Wigs limited to one per member per calendar year for services related to alopecia; cochlear implants are covered; precertification may be required; if no precertification is obtained, no benefits are available.
	Hospice services	$230 copay	$310 copay	$520 copay	$630 copay	Precertification may be required; if no precertification is obtained, no benefits are available.
If your child needs dental or eye care	Children's eye exam	$0 copay				Please call your Coupe Health Valet at 1-833-749-1969
	Children's glasses	Not covered				Not covered; member pays 100%
	Children's dental check-up	$0 copay				Please call your Coupe Health Valet at 1-833-749-1969

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Medications not on the covered list unless an exception is obtained
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limited to 15 visits per member per year/ all providers/ all networks for chronic pain management)
- Bariatric surgery (limited to one surgery per member per lifetime)
- Chiropractic care (no visit maximum, $500 benefit maximum per member per benefit period
- Hearing Aids (limited to 1 per ear per 3 years, all providers/ all networks, childhood hearing loss to age 19)
- Infertility Treatment ($5,000 benefit maximum per benefit period)
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa or your plan administrator at the phone number listed in your benefit booklet. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Your plan administrator at the phone number listed in your benefit booklet. You may also contact Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes/No**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3.400
Specialist copayment	$30
Hospital (facility)copayment	$1,700
Other copayment	$250

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,400
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	$5,070

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,400
Specialist copayment	$30
Hospital (facility)copayment	$1,700
Other copayment	$250

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,000
The total Joe would pay is	$5,100

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,400
Specialist copayment	$30
Hospital (facility)copayment	$1,700
Other copayment	$250

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	$2,010

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: member.coupehealth.com.