

COUPE HEALTH

Coupe Health Benefits Summary

Client Name: IWCO

Plan Year: January 1st, 2025 - December 31st, 2025

Network: BlueCard® PPO Network

Medical Benefits				
	In-Network			Out-of-Network
	✓ Tier 1	✗ Tier 2	❗ Tier 3	
Calendar Year Deductible (Indiv/Family)		\$0		None
Out-of-Pocket Maximum (Indiv/Family) (Includes copays - combine with prescription drug card)		\$5,000 / \$10,000		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
Physician Services				
Primary Care Physician	\$25	\$35	\$60	\$70
Retail Health Clinic	\$25	\$35	\$60	\$70
Specialist	\$55	\$70	\$120	\$145
Preventative Services & Routine Care				
Well-Child Care (including exams and immunizations)		No Charge		N/A
Adult Physical Examination (including routine GYN visit)		No Charge		N/A
COVID 19 Vaccine		No Charge		N/A
Breast Cancer Screening (any age)		No Charge		N/A
Pap Test		No Charge		N/A
Prostate Cancer Screening		No Charge		N/A
Colorectal Cancer Screening	See plan document for specific coverage based on age/necessity			
Telehealth Services				
Doctor on Demand (Default)		\$0		N/A
Maternity				
Initial Prenatal Office Visit	\$25	\$35	\$60	\$70
Prenatal Office Visit		No Charge		
Delivery & Postnatal Care	\$2,705	\$3,605	\$5,000	\$7,210
Hospital Expenses or Long-Term Acute Care Facility/Hospital (Facility Charges)				
Inpatient Hospital	\$2,705	\$3,605	\$5,000	\$7,210
Outpatient Hospital	\$880	\$1,170	\$1,955	\$2,345
Skilled Nursing /Rehabilitation Facility	\$2,390	\$3,185	\$5,000	\$6,370
Ambulance Services		\$500		
Ambulatory Surgical Center	\$880	\$1,170	\$1,955	\$2,345
Home Health Care (120 visits per plan year)	\$55	\$70	\$120	\$145
Hospice Care	\$295	\$390	\$650	\$780

	In-Network			Out-of-Network
Medical Services	✓ Tier 1	✗ Tier 2	⚠ Tier 3	
Radiology Services				
Diagnostic X-Rays	\$75	\$100	\$170	\$205
Advanced Imaging (MRI, MRA, CAT & PET Scans)	\$270	\$360	\$600	\$720
Laboratory Services				
Basic Labs	\$20	\$25	\$40	\$50
Advanced Diagnostic Labs	\$75	\$100	\$170	\$205
Emergency Services/Urgent Care				
Emergency Services/Emergency Room			\$500	
Urgent Care Facility			\$70	
Mental Disorders & Substance Use Disorders				
Office Visit	\$25	\$35	\$60	\$70
Inpatient	\$2,705	\$3,605	\$5,000	\$7,210
Outpatient	\$880	\$1,170	\$1,955	\$2,345
Therapy Services				
Chiropractic Care/Spinal Manipulation (15 visits per plan year)	\$55	\$70	\$120	\$145
Outpatient Therapies (PT, OT, ST) (INN - No visit limit/ OON 15 visits per plan year)	\$55	\$70	\$120	\$145
Durable Medical Equipment*				
Durable Medical Equipment (DME) / Item	\$120	\$160	\$270	\$325
Other Healthcare Facilities/Services				
Allergy Injections, Serum & Testing	\$55	\$70	\$120	\$145
Acupuncture (20 visit limit per plan year)	\$55	\$70	\$120	\$145
Transplants (Blue Distinction Centers)*				
Travel/lodging \$10,000 lifetime maximum per transplant)	\$2,705	\$3,605	\$5,000	\$7,210

*Please refer to the Blue Distinction Centers (BDCT) Program section of this plan for a more detailed description of this benefit.

Temporomandibular Joint Dysfunction	See plan document for specific coverages and exclusions.
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Weight Control/Bariatric Surgery	See plan document for specific coverages and exclusions.
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Regenexx	\$50
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*Diabetic equipment and supplies provided by Livongo are covered at \$0. All other diabetic supplies that are provided by an in-network preferred provider will be paid according to the applicable category of this Medical Schedule of Benefits, such as Durable Medical Equipment (DME).

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

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Pharmacy Drug Vendor: MedOne Rx

Pharmacy Benefits

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

Single Family 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	Tier 1	Tier 2	Tier 3
	In-Network Pharmacies Excluding CVS/Walgreens	Walgreens	CVS
Retail Pharmacy			
Generic Drugs (Up to a 31-day supply)	\$10	\$15	\$20
Preferred Brand Drugs (Up to a 31-day supply)	\$40	\$50	\$80
Non-Preferred Brand Drugs	\$60	\$70	\$120
Specialty Drug Program			
Specialty Drugs* (Up to a 31-day supply)	\$80 for a 31-day supply		

*Specialty medications are required to be filled through Mail Order

Mail Order (90 Day Supply)	
Generic Drugs (Tier 1)	\$20
Preferred Brand Drugs (Tier 2)	\$80
Non-Preferred Brand Drugs (Tier 3)	\$120
Drug Descriptions	
Generic Drugs	Generic drugs are covered at this copay level.
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.