

# COUPE HEALTH

## Coupe Benefits Summary

St. Olaf College – Coupe HDHP

Plan Year: September 1, 2023 – December 31, 2024

Medical Benefits				
Medical Services	Tier 1	Tier 2	Tier 3	Out-of-Network
<b>Calendar Year Deductible</b>				
Single		\$4,000		None
Family		\$8,000		None
<b>Out-of-Pocket Maximum (includes copays – combine with prescription drug card)</b>				
Single		\$5,400		Unlimited
Family		\$10,800		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
<b>Covid 19 Services</b>				
Covid 19 Vaccine (Moderna, Pfizer, Johnson & Johnson)			No Charge	
<b>Durable Medical Equipment</b>				
Durable Medical Equipment (DME) / item	\$65	\$85	\$140	\$170
<b>Emergency Services/Urgent Care</b>				
Emergency Services/Emergency Room			\$265	
Urgent Care Facility	\$30	\$40	\$65	\$80
<b>Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)</b>				
Inpatient Hospital	\$1,425	\$1,900	\$3,000	\$3,800
Outpatient Hospital	\$465	\$615	\$1,030	\$1,236
Infertility Treatment	See plan document for specific coverages and exclusions			
Skilled Nursing Facility/Rehabilitation Facility	\$1,255	\$1,675	\$2,795	\$3,400
Ambulance Services			\$265	
Ambulatory Surgical Center	\$465	\$615	\$1,030	\$1,236
Home Health Care	\$30	\$40	\$65	\$80
Hospice Care	\$155	\$205	\$345	\$420
<b>Laboratory Services</b>				
Routine Labs	\$10	\$15	\$20	\$30
Diagnostic Labs	\$40	\$55	\$90	\$110
<b>Maternity</b>				
Initial Office Visit	\$15	\$20	\$30	\$40
Preventive & Ongoing Prenatal Care	No Charge (Included in global delivery copay)			
Delivery & Postnatal Care	\$1,425	\$1,900	\$3,000	\$3,800

<b>Mental Disorders &amp; Substance Use Disorders</b>				
Office Visit	\$15	\$20	\$30	\$40
Inpatient	\$1,425	\$1,900	\$3,000	\$3,800
Outpatient	\$465	\$615	\$1,030	\$1,236
<b>Physician Services</b>				
Primary Care Physician	\$15	\$20	\$30	\$40
Specialist	\$30	\$40	\$65	\$80
<b>Telehealth Services</b>				
Doctor on Demand Including Behavioral Health		\$0		N/A
<b>Preventive Services &amp; Routine Care</b>				
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	
<b>Radiology Services</b>				
Diagnostic X-Rays	\$40	\$55	\$90	\$110
Advanced Imaging (MRI, MRA, CAT & PET Scans)	\$140	\$190	\$315	\$400
<b>Therapy Services</b>				
Chiropractic Care/Spinal Manipulation	\$30	\$40	\$65	\$80
Outpatient Therapies (PT, OT, ST)	\$30	\$40	\$65	\$80
<b>Other Healthcare Facilities/Services</b>				
Allergy Injections, Serum & Testing	\$30	\$40	\$65	\$80
Acupuncture	\$30	\$40	\$65	\$80
Travel expenses			See plan document for specific coverages and exclusions	

\*Diabetic equipment and supplies provided by Livongo are covered at \$0. All other Diabetic Supplies 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](http://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](mailto: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 Excluding CVS/Walgreens	Walgreens	CVS	Description
<b>Retail Pharmacy</b>				
<b>Generic Drugs (Tier 1)</b> (Up to a 31-day supply)	\$5	\$10	\$15	Generic drugs are covered at this copay level.
<b>Preferred Brand Drugs (Tier 2)</b> (Up to a 31-day supply)	\$10	\$15	\$25	All preferred brand drugs are covered at this copay level.
<b>Non-Preferred Brand Drugs (Tier 3)</b>	\$15	\$20	\$30	All non-preferred brand drugs on this copay level are not on the Preferred Drug List. *Discuss using alternatives with your physician or pharmacist.
<b>Specialty Drug Program</b>				
<b>Specialty Drugs (Tier 4)</b> (Up to a 31-day supply)		\$10		Specialty medications are required to be filled through Specialty Mail Order.
<b>Mail Order Pharmacy (90-day supply)</b>				
Generic Drugs (Tier 1)		\$15		Maintenance drugs of up to a 90-day supply is available through Mail Service Pharmacy.
Preferred Brand Drugs (Tier 2)		\$25		
Non-Preferred Brand Drugs (Tier 3)		\$30		

**Pharmacy Drug Vendor:** MedOne Rx

**How to Find a Drug:** Look up the cost of your medications in the Coupe member portal on the “Benefits” tab under the card that says, “Find Drug Prices.” Please refer to the “MedOne Preventative Drug List 2023” found on the Employer Benefits page within the Coupe Health Member Portal for all preventative medications covered at 100% with a \$0 cost to you.

Visit [www.coupehealth.com](http://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.

