

# COUPE HEALTH

## Coupe Health Benefits Summary - Low

Client Name: Winnebago Industries

Plan Year: January 1st, 2026 - December 31st, 2026

Network: BlueCard® PPO Network

Medical Benefits				
	In-Network			Out-of-Network
	Tier 1	Tier 2	Tier 3	
Calendar Year Deductible (Indiv/Family)	\$0			N/A
Out-of-Pocket Maximum (Indiv/Family)	\$7,000 / \$14,000			N/A
*OOP Max applies to in-network services only				
	In-Network			Out-of-Network
Medical Services	Tier 1	Tier 2	Tier 3	
<b>Physician Services</b>				
Primary Care Physician	\$50	\$65	\$110	\$125
Retail Health Clinic	\$50	\$65	\$110	\$125
Specialist	\$95	\$125	\$210	\$250
<b>Preventative Services &amp; Routine Care</b>				
Well-Child Care (including exams and immunizations)	No Charge			
Adult Physical Examination (including routine GYN visit)	No Charge			
Routine Eye Care	\$50	\$65	\$110	\$125
Routine Hearing Care	\$50	\$65	\$110	\$125
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			
<b>Telehealth Services</b>				
Doctor on Demand	\$0			N/A
<b>Maternity</b>				
Initial Prenatal Office Visit	\$50	\$65	\$110	\$125
Prenatal Office Visit	No Charge			\$125
Delivery & Postnatal Care	\$4,095	\$5,445	\$7,000	\$11,055
<b>Hospital Expenses or Long-Term Acute Care Facility/Hospital (Facility Charges)</b>				
Inpatient Hospital	\$4,095	\$5,445	\$7,000	\$11,055
Outpatient Hospital	\$1,325	\$1,760	\$2,980	\$3,575
Skilled Nursing /Rehabilitation Facility	\$3,625	\$4,820	\$7,000	\$10,500
Ambulance Services	\$750			
Ambulatory Surgical Center	\$1,325	\$1,760	\$2,980	\$3,575
Home Health Care	\$95	\$125	\$210	\$250
Home Infusion	\$95	\$125	\$210	\$250
Hospice Care	\$445	\$590	\$1,000	\$1,400

	In-Network			Out-of-Network
Medical Services	Tier 1 	Tier 2 	Tier 3 	
<b>Radiology Services</b>				
Diagnostic X-Rays	\$115	\$155	\$260	\$315
Advanced Imaging (MRI, MRA, CAT & PET Scans)	\$405	\$535	\$910	\$1,090
<b>Laboratory Services</b>				
Basic Labs	\$50	\$65	\$110	\$125
Advanced Diagnostic Labs	\$115	\$155	\$260	\$315
<b>Emergency Services/Urgent Care</b>				
Emergency Services/Emergency Room			\$750	
Urgent Care Facility			\$65	
<b>Mental Disorders &amp; Substance Use Disorders</b>				
Office Visit		\$0		\$125
Inpatient	\$4,095	\$5,445	\$7,000	\$11,055
Outpatient	\$1,325	\$1,760	\$2,980	\$3,575
<b>Therapy Services</b>				
Chiropractic Care/Spinal Manipulation	\$50	\$65	\$110	\$125
Outpatient Therapies (PT, OT, ST)	\$95	\$125	\$210	\$250
<b>Durable Medical Equipment</b>				
Durable Medical Equipment (DME) / Item	\$185	\$245	\$415	\$575
<b>Other Healthcare Facilities/Services</b>				
Allergy Injections, Serum & Testing	\$95	\$125	\$210	\$250
Acupuncture	\$95	\$125	\$210	\$250
Transplants (Travel/lodging \$5,000 lifetime maximum)	\$4,095	\$5,445	\$7,000	\$11,055

## 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: FlexRx

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

Preferred Generic Drugs (Tier 1)	\$35
Preferred Brand Drugs (Tier 2)	\$70
Non-Preferred Generic Drugs	\$95
Non-Preferred Brand Drugs	\$95

#### Specialty Drug Program

Specialty Drugs* (Up to a 30-day Supply)	\$200
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\*Specialty medications are required to be filled through a Specialty Pharmacy.

#### Mail Order (90 Day Supply)

Preferred Generic Drugs (Tier 1)	\$105
Preferred Brand Drugs (Tier 2)	\$210
Non-Preferred Generic Drugs	\$285
Non-Preferred Brand Drugs	\$285

#### 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.