COUPE HEALTH

City of Enid - Coupe Copay Plan B

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) (Includes copays - combine with prescription drug card)		$6,600 / $13,200		N/A
OOP Max applies to in-network services only; Out-of-Network OOP Max is unlimited				
	In-Network			Out-of-Network
Medical Services	Tier 1	Tier 2	Tier 3	
Physician Services				
Primary Care Physician	$35	$50	$80	$100
Retail Health Clinic	$35	$50	$80	$100
Specialist	$75	$90	$145	$175
Preventative Services & Routine Care				
Well-Child Care (including exams and immunizations)		No Charge		$100
Adult Physical Examination (including routine GYN visit)		No Charge		$100
Routine Eye Care		No Charge		$100
COVID 19 Vaccine		No Charge		$100
Breast Cancer Screening (any age)		No Charge		$100
Pap Test		No Charge		$100
Prostate Cancer Screening		No Charge		$100
Colorectal Cancer Screening		See plan document for specific coverage based on age/necessity		
Telehealth Services				
Virtual Care		$22		
Maternity				
Initial Prenatal Office Visit	$35	$50	$80	$100
Prenatal Office Visit		No Charge		
Delivery & Postnatal Care	$3,255	$4,330	$6,500	$8,800
Hospital Expenses or Long-Term Acute Care Facility/Hospital (Facility Charges)				
Inpatient Hospital	$3,255	$4,330	$6,500	$8,800
Outpatient Hospital	$1,065	$1,415	$2,400	$2,880
Skilled Nursing /Rehabilitation Facility (per event)	$2,875	$3,825	$6,500	$7,700
Ambulance Services / Air Ambulance		$600		
Ambulatory Surgical Center	$1,065	$1,415	$2,400	$2,880
Home Health Care (per visit)	$65	$85	$145	$175
Home Infusion	$75	$90	$145	$175
Hospice Care (per event)	$345	$460	$775	$935

	In-Network			Out-of-Network
Medical Services	**Tier 1**	**Tier 2**	**Tier 3**	
Radiology Services *Please note that all Advanced Imaging Services will generate individual copays. Advanced Imaging services only bundle when part of an inpatient or ER stay.				
Diagnostic X-Rays (Ultrasounds)	$95	$125	$210	$250
Advanced Imaging (MRI, MRA, CAT & PET Scans)	$315	$415	$700	$840
Laboratory Services				
Basic Labs	$25	$35	$55	$65
Advanced Diagnostic Labs	$95	$125	$210	$250
Emergency Services/Urgent Care				
Emergency Services/Emergency Room	$600			
Urgent Care Facility	$65			
Mental Disorders & Substance Use Disorders				
Office Visit	$35	$50	$80	$100
Inpatient	$3,255	$4,330	$6,500	$8,800
Outpatient	$1,065	$1,415	$2,400	$2,880
Therapy Services				
Chiropractic Care/Spinal Manipulation (per visit)	$65	$85	$145	$175
Outpatient Therapies (PT, OT, ST) (per visit)	$65	$85	$145	$175
Durable Medical Equipment				
Durable Medical Equipment (DME) per month rental until purchase price met	$150	$200	$340	$410
Other Healthcare Facilities/Services				
Allergy Injections, Serum & Testing	$75	$90	$145	$175
Acupuncture	Not Covered			
Transplants	$3,255	$4,330	$6,500	$8,800

Pharmacy Benefits

Retail Pharmacy Program	Participating Retail Pharmacy	Out-of-Network Retail Pharmacy
Generic Drugs	$15 retail - $30 mail copay/prescription; deductible does not apply	$15 retail copay/prescription; deductible does not apply
Preferred brand drugs	35% coinsurance; deductible does not apply	35% coinsurance; deductible does not apply
Non-preferred brand drugs	35% coinsurance; deductible does not apply	35% coinsurance; deductible does not apply
Specialty drugs	35% coinsurance; deductible does not apply	Not Covered