COUPE HEALTH

# Bethel University – HDHP Plan

**Plan Year:** January 1st, 2025 – December 31st, 2025
**National Network:** Bluecard PPO

| Medical Benefits | | | | |
|---|---|---|---|---|
| **Medical Services** | **Tier 1** | **Tier 2** | **Tier 3** | **Out-of-Network** |
| **Calendar Year Deductible** | | | | |
| Single<br>Family | $3,300<br>$6,600 | | | |
| **Out-of-Pocket Maximum (includes copays – combine with prescription drug card)** | | | | |
| Single<br>Family | $5,000<br>$10,000 | | | Unlimited<br>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** |
| **Covid 19 Services** | | | | |
| Covid 19 Vaccine<br>(Moderna, Pfizer, Johnson & Johnson) | No Charge | | | |
| **Durable Medical Equipment** | | | | |
| Durable Medical Equipment (DME) / item | $75 | $100 | $170 | $205 |
| **Emergency Services/Urgent Care** | | | | |
| Emergency Services/Emergency Room | $305 | | | |
| Urgent Care Facility | $35 | | | |
| **Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)** | | | | |
| Inpatient Hospital | $1,640 | $2,180 | $3,690 | $4,425 |
| Outpatient Hospital | $535 | $715 | $1,205 | $1,445 |
| Infertility Treatment | See plan document for specific coverages and exclusions | | | |
| Skilled Nursing Facility/Rehabilitation Facility | $1,445 | $1,920 | $3,250 | $3,900 |
| Ambulance Services | $305 | | | |
| Home Health Care | $35 | $50 | $80 | $95 |
| Hospice Care | $180 | $240 | $405 | $485 |
| **Laboratory Services** | | | | |
| Routine Diagnostic Labs | $10 | $15 | $30 | $35 |
| Diagnostic Labs | $50 | $65 | $105 | $125 |
| **Maternity** | | | | |
| Initial Office Visit | $20 | $25 | $40 | $50 |
| Preventive & Ongoing Prenatal Care | No Charge (Included in global delivery copay) | | | |
| Delivery & Postnatal Care | $1,640 | $2,180 | $3,690 | $4,425 |

| | | | | |
|---|---|---|---|---|
| **Mental Disorders & Substance Use Disorders** | | | | |
| Office Visit | $20 | $25 | $40 | $50 |
| Inpatient | $1,640 | $2,180 | $3,690 | $4,425 |
| Outpatient | $535 | $715 | $1,205 | $1,445 |
| **Physician Services** | | | | |
| Primary Care Physician | $20 | $25 | $40 | $50 |
| Specialist | $35 | $50 | $80 | $95 |
| **Telehealth Services** | | | | |
| E-visits | $20 | $25 | $40 | $50 |
| **Preventive Services & Routine Care** | | | | |
| 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 | | | |
| Colorectal Cancer Screening | See plan document for specific coverage based on age/necessity | | | |
| **Radiology Services** | | | | |
| Diagnostic X-Rays | $50 | $65 | $105 | $125 |
| Advanced Imaging (MRI, MRA, CAT & PET Scans) | $165 | $215 | $365 | $435 |
| **Therapy Services** | | | | |
| Chiropractic Care/Spinal Manipulation | $35 | $50 | $80 | $95 |
| Outpatient Therapies (PT, OT, ST) | $35 | $50 | $80 | $95 |
| **Other Healthcare Facilities/Services** | | | | |
| Allergy Injections, Serum & Testing | $35 | $50 | $80 | $95 |
| Acupuncture | $35 | $50 | $80 | $95 |
| Transplants | $1,640 | $2,180 | $3,690 | $4,425 |

**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

# 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 | Out-of-Network Pharmacies |
|---|---|---|
| **Preferred Generics** | $8 copay/prescription (retail)<br>$16 copay/prescription (mail service)<br>$16 copay/prescription (90-day Rx retail) | Not Covered |
| **Non-Preferred Generics** | $60 copay/prescription (retail)<br>$120 copay/prescription (mail service)<br>$120 copay/prescription (90-day Rx retail) | Not Covered |
| **Preferred Brand** | $30 copay/prescription (retail)<br>$60 copay/prescription (mail service)<br>$60 copay/prescription (90-day Rx retail) | Not Covered |
| **Non-Preferred Brand** | $60 copay/prescription (retail)<br>$120 copay/prescription (mail service)<br>$120 copay/prescription (90-day Rx retail) | Not Covered |
| **Specialty Drugs** | $150 copay/prescription | Not Covered |

**Pharmacy Drug Vendor:** Prime Therapeutics
**Rx Network:** Select Network
**Rx Formulary:** FlexRx
**Specialty Drug Vendor:** Prime Therapeutics Specialty Pharmacy

**How to Find a Drug:** Look up the cost of your medications in the Coupe member portal.

Visit 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.