COUPE HEALTH

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2025 – 12/31/2025

Allianz Life Coupe Health

Coverage For: Individual + Family **Plan Type: PPO**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call your Coupe Health Valet at 1-833-749-1969 or visit us at member.coupehealth.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance after overall deductible, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-833-749-1969 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible?	**Tier 1-3 In-Network** There is no deductible.	**Tier 4 Out-of-Network** No Coverage	There is no overall deductible for this plan.
Are there services covered before you meet your deductible?	**Tier 1 In-Network** Yes. There is no overall calendar year deductible.	**Tier 4 Out-of-Network** No Coverage	There is no overall deductible for this plan. But a copayment may apply. For example, this plan covers certain preventive services without cost-sharing. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No		You don't have to meet a deductible for specific services.
What is the out–of–pocket limit for this plan?	**Tier 1-3 In-Network** $3,250 / individual $6,500 / family	**Tier 4 Out-of-Network** No Coverage	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, health care this plan doesn't cover, cost sharing for most out-of-network benefits, and pre-certification penalties.		Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See member.coupehealth.com or call 1-833-749-1969 for a list of network providers.		This plan uses a provider network. No out-of-network coverage. Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No		You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	Tier 1 - 3 In-Network			Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay	$25 copay	$40 copay	Not Covered	Precertification may be required for some provider administered drugs; if no precertification is obtained, no benefits are available; primary care visits includes Retail Health Clinics, E-Visits, Telehealth and Telephone; no Charge for Doctor on Demand.
	Specialist visit	$40 copay	$50 copay	$80 copay	Not Covered	
	Preventive care/screening/ immunization	No Charge			Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Please call your Coupe Health Valet at 1-833-749-1969 to confirm benefits.
If you have a test	Diagnostic test (x-ray, blood work)	Diagnostic Radiology/ Diagnostic Labs: $45 copay Basic Labs: $10 copay	Diagnostic Radiology/ Diagnostic Labs: $60 copay Basic Labs: $15 copay	Diagnostic Radiology/ Diagnostic Labs: $105 copay Basic Labs: $25 copay	Not Covered	Fee listed is for diagnostic labs, x-rays and radiology and include facility and physician charges; precertification may be required for some services.
	Imaging (CT/PET scans, MRIs)	$185 copay	$245 copay	$410 copay	Not Covered	None

Common Medical Event	Services You May Need	Tier 1 - 3 In-Network	Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at coupehealth.com	Tier 1 (Generic Drugs)	$10 copay (retail) $25 copay (mail order) $25 copay (90 day Rx retail)	Not Covered	Prior authorization may be required for some drugs; if prior authorization is not obtained, no benefits are available.
	Tier 2 (Non-Preferred Generic Drugs)	$75 copay (retail) $150 copay (mail order) $150 copay (90 day Rx retail)	Not Covered	
	Tier 3 (Preferred Brand Drugs)	$35 copay (retail) $70 copay (mail order) $70 copay (90 day Rx retail)	Not Covered	
	Tier 4 (Non-Preferred Brand Drugs)	$75 copay (retail) $150 copay (mail order) $150 copay (90 day Rx retail)	Not Covered	
	Tier 5 (Specialty Drugs)	$125 copay (retail)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$600 copay / $800 copay / $1,355 copay	Not Covered	Facility fee listed includes facility and physician charges associated with outpatient facility and surgical services.
	Physician/surgeon fees	No Charge	Not Covered	Physician charges associated with outpatient facility and surgical services are included in the facility charges listed in the section above.
If you need immediate medical attention	Emergency room care	$250 copay		Facility fee listed includes facility and physician charges associated with medical emergency services; no copay for Prenatal complications; no copay for Maternity complications; copay waived if admitted within 24 hours; services apply to tier 1-3 out-of-pocket maximum.
	Emergency medical transportation	$250 copay		Services apply to tier 1-3 out-of-pocket maximum.

Common Medical Event	Services You May Need	Tier 1 - 3 In-Network			Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
	Urgent care	$75 copay			Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,655 copay	$2,210 copay	$3,200 copay	Not Covered	Facility fee listed includes facility and physician charges associated with inpatient services; precertification is required.
	Physician/surgeon fees	No Charge			Not Covered	Physician charges associated with inpatient services are included in the facility charges listed in the section above
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: No Charge Outpatient facility services: $20 copay	Office visit: No Charge Outpatient facility services: $25 copay	Office visit: No Charge Outpatient facility services: $40 copay	Not Covered	Facility fee listed for inpatient services includes facility and physician; most outpatient counseling covered at $0 copay. Autism, Adaptive Behavior Treatment, Convulsive Therapy, Day or Partial Day Treatment remain at copay listed to the left.
	Inpatient services	$1,655 copay	$2,210 copay	$3,200 copay	Not Covered	
If you are pregnant	Office visits	Prenatal Care: No Charge Postnatal Care: $20 copay	Prenatal Care: No Charge Postnatal Care: $25 copay	Prenatal Care: No Charge Postnatal Care: $40 copay	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment may be required. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); facility fee listed includes facility and physician services associated with maternity facility services; office visit copay applies to initial office visit to determine pregnancy.
	Childbirth/delivery professional services	No Charge			Not Covered	

Common Medical Event	Services You May Need	Tier 1 - 3 In-Network			Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
	Childbirth/delivery facility services	$1,655 copay	$2,210 copay	$3,200 copay	Not Covered	
If you need help recovering or have other special health needs	Home health care	$40 copay	$50 copay	$80 copay	Not Covered	Precertification may be required; benefits are also available for home infusion services.
	Rehabilitation services	$20 copay	$25 copay	$40 copay	Not Covered	None
	Habilitation services	$20 copay	$25 copay	$40 copay	Not Covered	
	Skilled nursing care	$1,450 copay	$1,930 copay	$3,200 copay	Not Covered	Precertification may be required.
	Durable medical equipment	$85 copay	$110 copay	$185 copay	Not Covered	Precertification may be required.
	Hospice services	$200 copay	$265 copay	$445 copay	Not Covered	Precertification may be required.
If your child needs dental or eye care	Children's eye exam	No Charge			Not Covered	None
	Children's glasses	Not Covered			Not Covered	Not covered; member pays 100%
	Children's dental check-up	No Charge			Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture (except as specified in plan benefits)
- Cosmetic surgery (except as specified in plan benefits)
- Dental care (except as specified in plan benefits)
- Long-term care
- Medications not on the covered list unless an exception is obtained
- Private-duty nursing
- Routine foot care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (limitations apply)
- Chiropractic care
- Hearing Aids (limitations apply)
- Infertility Treatment (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa or your plan administrator at the phone number listed in your benefit booklet. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Your plan administrator at the phone number listed in your benefit booklet. You may also contact Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$1,655
Other copayment	$250

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$2,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,260

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$1,655
Other copayment	$250

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$1,140

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$1,655
Other copayment	$250

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,100

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: member.coupehealth.com.