COUPE HEALTH

Coupe Benefits Summary

St. Olaf College – Coupe HDHP

Plan Year: January 1, 2025 – December 31, 2025

Medical Benefits				
Medical Services	**Tier 1**	**Tier 2**	**Tier 3**	**Out-of-Network**
Calendar Year Deductible				
Single Family	$3,550 $7,100			$3,550 $7,100
Out-of-Pocket Maximum (includes copays – combine with prescription drug card)				
Single Family	$4,800 $9,600			Unlimited 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 (Moderna, Pfizer, Johnson & Johnson)	No Charge			
Durable Medical Equipment				
Durable Medical Equipment (DME) / item	$65	$85	$140	$170
Emergency Services/Urgent Care				
Emergency Services/Emergency Room	$265			
Urgent Care Facility	$30	$40	$65	$80
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)				
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
Laboratory Services				
Routine Labs	$10	$15	$20	$30
Diagnostic Labs	$40	$55	$90	$110
Maternity				
Preventive & Prenatal Care	No Charge (Included in global delivery copay)			
Delivery & Postnatal Care	$1,425	$1,900	$3,000	$3,800

Medical Services	Tier 1	Tier 2	Tier 3	Out-of-Network
Mental Disorders & Substance Use Disorders				
Office Visit	$15	$20	$30	$40
Inpatient	$1,425	$1,900	$3,000	$3,800
Outpatient	$465	$615	$1,030	$1,236
Physician Services				
Primary Care Physician	$15	$20	$30	$40
Specialist	$30	$40	$65	$80
Telehealth Services				
Doctor on Demand Including Behavioral Health	$0			N/A
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			
Radiology Services				
Diagnostic X-Rays	$40	$55	$90	$110
Advanced Imaging (MRI, MRA, CAT & PET Scans)	$140	$190	$315	$400
Therapy Services				
Chiropractic Care/Spinal Manipulation	$30	$40	$65	$80
Outpatient Therapies (PT, OT, ST)	$30	$40	$65	$80
Other Healthcare Facilities/Services				
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 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
Preventive Drugs (Preventive prescription drugs on the GenRx and ACA Preventive Drug List)	No Charge	Not Covered
Preferred Generic Drugs (Tier 1)	$5 copay/prescription (retail) $15 copay/prescription (mail service) $15 copay/prescription (90-day Rx retail)	Not Covered
Preferred Brand Drugs (Tier 2)	$10 copay/prescription (retail) $25 copay/prescription (mail service) $25 copay/prescription (90-day Rx retail)	Not Covered
Non-Preferred Generic Drugs	$15 copay/prescription (retail) $30 copay/prescription (mail service) $30 copay/prescription (90-day Rx retail)	Not Covered
Non-Preferred Brand Drugs	$15 copay/prescription (retail) $30 copay/prescription (mail service) $30 copay/prescription (90-day Rx retail)	Not Covered
Specialty Drugs	$10 copay/prescription	Not Covered

Pharmacy Drug Vendor: Prime Therapeutics
Rx Network: Select Rx Network
Rx Formulary: GenRx
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.