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

Bethel University

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 Valets at 1-833-749-1969 or visit us at 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** $0	**Tier 4 Out-of-Network** $0	There is no overall deductible for this plan.
Are there services covered before you meet your deductible?	**Tier 1-3 In-Network** Yes. There is no overall calendar year deductible	Tier 4 **Out-of-Network** Yes. There is no overall calendar year deductible	There is no overall deductible for this plan. But a copayment or coinsurance 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 deductible for specific services.
What is the out–of–pocket limit for this plan?	**Tier 1-3 In-Network** Employee $4,000 Family $8,000	**Tier 4 Out-of-Network** Unlimited	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. The out-of-pocket for Tier 1, 2 and 3 cross apply.
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 coupehealth.com or call 1-833-749-1969 for a list of network providers.		This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). 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 In-Network	Tier 2 In-Network	Tier 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	$25 copay	$35 copay	$70 copay	$85 copay	Precertification is required for some provider administered drugs; if no precertification is obtained, no benefits are available
	Specialist visit	$40 copay	$55 copay	$95 copay	$110 copay	
	Preventive care/screening/ immunization	No Charge				Please call your Coupe Health Valets at 1-833-749-1969. 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.
If you have a test	Diagnostic test (x-ray, blood work)	$70 copay (diagnostic x-ray and labs) $20 copay (routine labs)	$95 copay (diagnostic x-ray and labs) $25 copay (routine labs)	$155 copay (diagnostic x-ray and labs) $40 copay (routine labs)	$190 copay (diagnostic x-ray and labs) $50 copay (routine labs)	Fee listed include facility and physician charges; precertification may be required for some services; if no precertification is obtained, no benefits are available
	Imaging (CT/PET scans, MRIs)	$260 copay	$345 copay	$585 copay	$700 copay	Precertification is required for advanced imaging; if no precertification is obtained, no benefits are available

Common Medical Event	Services You May Need	Tier 1 In-Network	Tier 2 In-Network	Tier 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)	$8 copay (retail) $16 copay (mail order)			Not Covered	Prior authorization required for specific drugs; if no precertification is obtained, no benefits are available; benefits listed are for a 30-day supply at retail and 90-day supply at mail; 31-90 day supply of maintenance medication is allowed at retail with a copay per 30-day supply; specialty drugs are only available for a 30-day supply from a participating specialty drug network supplier
	Tier 2 (Non-Preferred Generic Drugs)	$60 copay (retail) $120 copay (mail order)			Not Covered	
	Tier 3 (Preferred Brand Drugs)	$30 copay (retail) $60 copay (mail order)			Not Covered	
	Tier 4 (Non-Preferred Brand Drugs)	$60 copay (retail) $120 copay (mail order)			Not Covered	
	Tier 5 (Specialty Drugs)	$150 copay			Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$830 copay	$1,105 copay	$1,865 copay	$2,240 copay	Facility fee listed includes facility and physician charges associated with outpatient facility and surgical services; precertification may be required for some services; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	No Charge				None
If you need immediate medical attention	Emergency room care	$405 copay				Facility fee listed includes facility and physician charges associated with medical emergency services; services apply to tier 1-3 of the out-of-pocket limit
	Emergency medical transportation	$405 copay				Services apply to tier 1-3 of the out-of-pocket limit
	Urgent care	$55 copay				None

Common Medical Event	Services You May Need	Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	$2,530 copay	$3,365 copay	$4,000 copay	$6,835 copay	Facility fee listed includes facility and physician charges associated with inpatient services; precertification is required; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	No Charge				None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay	$35 copay	$70 copay	$85 copay	Facility fee listed for inpatient services includes facility and physician services; precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization; if no precertification is obtained, no benefit is available
	Inpatient services	$2,530 copay	$3,365 copay	$4,000 copay	$6,835 copay	
If you are pregnant	Office visits	$25 copay (initial visit)	$35 copay (initial visit)	$70 copay (initial visit)	$85 copay (initial visit)	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. 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; precertification may be required for some inpatient services; if no precertification is obtained, no benefits are available
	Childbirth/delivery professional services	No Charge				
	Childbirth/delivery facility services	$2,530 copay	$3,365 copay	$4,000 copay	$6,835 copay	

Common Medical Event	Services You May Need	Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	$55 copay	$70 copay	$120 copay	$140 copay	Precertification may be required; if no precertification is obtained, no benefits are available; limited to 120 days per member per calendar year; benefits are also available for home infusion services
	Rehabilitation services	$40 copay	$55 copay	$95 copay	$110 copay	Benefits listed are for Rehabilitation & Habilitation services; each service has a maximum of 20 visits per therapy for occupational, physical and speech therapy per year
	Habilitation services	$40 copay	$55 copay	$95 copay	$110 copay	
	Skilled nursing care	$2,300 copay	$3,060 copay	$4,000 copay	$6,210 copay	Limited to 120 days per member per calendar year; precertification is required; if no precertification is obtained, no benefits are available
	Durable medical equipment	$115 copay	$155 copay	$260 copay	$315 copay	Wigs limited to one per member per calendar year for services related to Alopecia; precertification may be required; if no precertification is obtained, no benefits are available
	Hospice services	$285 copay	$375 copay	$635 copay	$765 copay	Precertification may be required; if no precertification is obtained, no benefits are available
If your child needs dental or eye care	Children's eye exam	No Charge				Please call your Coupe Health Valets at 1-833-749-1969
	Children's glasses	Not covered				Not covered; member pays 100%
	Children's dental check-up	No Charge				Please call your Coupe Health Valets at 1-833-749-1969

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.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Weight Loss Programs
- Routine foot care
- Bariatric surgery

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

- Acupuncture (limited to medical policy diagnosis categories only)
- Infertility Treatment (including Assisted Reproductive Technology) ($8,000 medical benefits per lifetime; $3,500 pharmacy per lifetime)
- Non-emergency care when traveling outside the U.S.
- Chiropractic care (limited to 20 visits per member per calendar year)
- Hearing Aids (limited to one per ear per three calendar years)
- 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	$2,530
Other copayment	$405

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	$3,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,260

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

T The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$2,530
Other copayment	$405

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	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$940

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	$2,530
Other copayment	$405

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	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,500

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: Coupehealth.com.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.