

COUPE HEALTH

Coupe Plan Design

St. Olaf College – Coupe HSA

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

COUPE HDHP MONTHLY PREMIUMS

FTE > .75

Employee Only	\$139
Employee plus 1	\$367
Family	\$549

FTE .50 < .75

Employee Only	\$139
Employee plus 1	\$569
Family	\$837

Medical Benefits

Medical Services	Tier 1	Tier 2	Tier 3	Out-of-Network
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Calendar Year Deductible

Single		\$3,550		None
Family		\$7,100		None

Out-of-Pocket Maximum (includes copays – combine with prescription drug card)

Single		\$4,800		Unlimited
Family		\$9,600		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
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Covid 19 Services

Covid 19 Vaccine (Moderna, Pfizer, Johnson & Johnson) Durable Medical Equipment				No Charge
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Equipment

Durable Medical Equipment (DME) / item	\$65	\$85	\$140	\$170
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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
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Ambulance Services			\$265	
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Ambulatory Surgical Center	\$465	\$615	\$1,030	\$1,236
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Home Health Care	\$30	\$40	\$65	\$80
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Hospice Care	\$155	\$205	\$345	\$420
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Laboratory Services

Routine Labs	\$10	\$15	\$20	\$30
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Diagnostic Labs	\$40	\$55	\$90	\$110
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Maternity

Initial Office Visit	\$15	\$20	\$30	\$40
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Preventive & Ongoing Prenatal Care No Charge (Included in global delivery copay)

Delivery & Postnatal Care	\$1,425	\$1,900	\$3,000	\$3,800
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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		No Charge	
Pap Test				
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	Coupe Health Pharmacy Rankings	
Retail Pharmacy		
Generic Drugs (Tier 1) (Up to a 31-day supply)	\$5	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (Up to a 31-day supply)	\$10	All preferred brand drugs are covered at this copay level. All non-preferred brand drugs on this copay level are not on
Non-Preferred Brand Drugs (Tier 3)	\$15	the Preferred Drug List. *Discuss using alternatives with your physician or pharmacist.
Specialty Drug Program		
Specialty Drugs (Tier 4) (Up to a 31-day supply)	\$10	Specialty medications are required to be filled through Specialty Mail Order.
Mail Order Pharmacy (90-day supply)		
Generic Drugs (Tier 1)	\$15	Maintenance drugs of up to a 90-day supply is available through Mail Service Pharmacy.
Preferred Brand Drugs (Tier 2)	\$25	
Non-Preferred Brand Drugs (Tier 3)	\$30	

Pharmacy Drug Vendor: Prime Therapeutics

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.