COUPE HEALTH

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

Coverage Period: 09/01/2023 – 12/31/2024

St. Olaf College 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 Pro 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 https://www.healthcare.gov/sbc-glossary 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 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 $6,500 Family $13,000	**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 maximums for all networks 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	$40 copay No overall deductible	$55 copay No overall deductible	$90 copay No overall deductible	$110 copay No overall deductible	None
	Specialist visit	$80 copay No overall deductible	$105 copay No overall deductible	$175 copay No overall deductible	$210 copay No overall deductible	
	Preventive care/screening/ immunization	No Charge No overall deductible	No Charge No overall deductible	No Charge No overall deductible	Not covered	Please call your Coupe Health Pro at 1-833-749-1969. Additional services are available. 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)	$100 copay No overall deductible	$135 copay No overall deductible	$225 copay No overall deductible	$270 copay No overall deductible	Fee listed include facility and physician charges; precertification may be required for some services. Routine labs covered at Tier 1 $30, Tier 2 $40, Tier 3 $70, Tier 4 $85
	Imaging (CT/PET scans, MRIs)	$350 copay No overall deductible	$475 copay No overall deductible	$790 copay No overall deductible	$950 copay No overall deductible	Precertification is required for advanced imaging

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	$30 copay (retail) $60 copay (mail order) No overall deductible	$35 copay (retail) $60 copay (mail order) No overall deductible	$60 copay (retail) $60 copay (mail order) No overall deductible	Not Covered	Prior authorization required for specific drugs; benefits listed are for a 30-day supply at retail, and 90-day supply at in-network mail order
	Tier 2 (Preferred Brand)	$60 copay (retail) $120 copay (mail order) No overall deductible	$75 copay (retail) $120 copay (mail order) No overall deductible	$120 copay (retail) $120 copay (mail order) No overall deductible	Not Covered	
	Tier 3 (Non-Preferred Brand)	$90 copay (retail) $180 copay (mail order) No overall deductible	$110 copay (retail) $180 copay (mail order) No overall deductible	$185 copay (retail) $180 copay (mail order) No overall deductible	Not Covered	
	Tier 4 (Specialty Drugs)	$120 copay No overall deductible	$120 copay No overall deductible	$120 copay No overall deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$1,150 copay No overall deductible	$1,540 copay No overall deductible	$2,570 copay No overall deductible	$3,100 copay No overall deductible	Facility fee listed includes facility and physician charges associated with outpatient facility and surgical services
	Physician/surgeon fees	No Charge No overall deductible	No Charge No overall deductible	No Charge No overall deductible	No Charge No overall deductible	None
If you need immediate medical attention	Emergency room care	$650 copay No overall deductible	$650 copay No overall deductible	$650 copay No overall deductible	$650 copay No overall deductible	Facility fee listed includes facility and physician charges associated with medical emergency services; services apply to tier 1-3 of the out-of-pocket maximum
	Emergency medical transportation	$650 copay No overall deductible	$650 copay No overall deductible	$650 copay No overall deductible	$650 copay No overall deductible	Services apply to the tier 1-3 of the out-of-pocket maximum
	Urgent care	$80 copay No overall deductible	$105 copay No overall deductible	$175 copay No overall deductible	$210 copay No overall deductible	None

* For more information about limitations and exceptions, see the plan or policy document at coupehealth.com

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)	$3,560 copay No overall deductible	$4,750 copay No overall deductible	$6,500 copay No overall deductible	$7,800 copay No overall deductible	Facility fee listed includes facility and physician charges associated with inpatient services; precertification is required
	Physician/surgeon fees	No Charge No overall deductible	No Charge No overall deductible	No Charge No overall deductible	No Charge No overall deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay No overall deductible	$55 copay No overall deductible	$90 copay No overall deductible	$110 copay No overall deductible	Benefits listed for outpatient are physician office visit services; additional benefits are available; facility fee listed for inpatient services includes facility and physician
	Inpatient services	$3,560 copay No overall deductible	$4,750 copay No overall deductible	$6,500 copay No overall deductible	$7,800 copay No overall deductible	
If you are pregnant	Office visits	$40 copay No overall deductible	$55 copay No overall deductible	$90 copay No overall deductible	$110 copay No overall deductible	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. Post-delivery, a newborn does not generate a separate copay if it is a well-baby stay. If it is a NICU or a sick newborn stay, there will be a separate inpatient copay and the date of service is generally the start date in the NICU
	Childbirth/delivery professional services	No Charge No overall deductible	No Charge No overall deductible	No Charge No overall deductible	No Charge No overall deductible	
	Childbirth/delivery facility services	$3,560 copay No overall deductible	$4,750 copay No overall deductible	$6,500 copay No overall deductible	$7,800 copay No overall deductible	

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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	$80 copay No overall deductible	$105 copay No overall deductible	$175 copay No overall deductible	$210 copay No overall deductible	Benefits are also available for home infusion services
	Rehabilitation services	$80 copay No overall deductible	$105 copay No overall deductible	$175 copay No overall deductible	$210 copay No overall deductible	None
	Habilitation services	$80 copay No overall deductible	$105 copay No overall deductible	$175 copay No overall deductible	$210 copay No overall deductible	
	Skilled nursing care	$3,150 copay No overall deductible	$4,190 copay No overall deductible	$6,500 copay No overall deductible	$7,800 copay No overall deductible	None
	Durable medical equipment	$160 copay No overall deductible	$215 copay No overall deductible	$355 copay No overall deductible	$430 copay No overall deductible	Wigs limited to one per member per calendar year for services related to alopecia
	Hospice services	$385 copay No overall deductible	$515 copay No overall deductible	$855 copay No overall deductible	$1,050 copay No overall deductible	Precertification may be required
If your child needs dental or eye care	Children's eye exam	No Charge No overall deductible	No Charge No overall deductible	No Charge No overall deductible	Not covered	Please call your Coupe Health Pro at 1-833-749-1969
	Children's glasses	Not covered	Not covered	Not covered	Not covered	Not covered; member pays 100%
	Children's dental check-up	No Charge No overall deductible	No Charge No overall deductible	No Charge No overall deductible	Not covered	Please call your Coupe Health Pro at 1-833-749-1969

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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
- Private-duty nursing

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

- Acupuncture
- Chiropractic care
- Bariatric surgery
- Infertility Treatment (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Hearing Aids (limited to children age 18 and younger, additional limitations apply)
- 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 www.dol.gov/ebsa/healthreform. 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 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 www.dol.gov/ebsa/healthreform.

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.

* For more information about limitations and exceptions, see the plan or policy document at coupehealth.com

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 copay/coinsurance	$80/0%
Hospital (facility) copay/coinsurance	$3,560/0%
Other copay/coinsurance	$650/0%

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	$4,310
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$4,370

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 copay/coinsurance	$80/0%
Hospital (facility) copay/coinsurance	$3,560/0%
Other copay/coinsurance	$650/0%

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	$1,450
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$1,490

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

The plan's overall deductible	$0
Specialist copay/coinsurance	$80/0%
Hospital (facility) copay/coinsurance	$3,560/0%
Other copay/coinsurance	$650/0%

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	$2,010
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,010

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.