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:** HDHP

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** Employee $4,000 Family $8,000	**Tier 4 Out-of-Network** Employee $4,000 Family $8,000	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Tier 1-3 In-Network** Yes.	**Tier 4 Out-of-Network** Yes.	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 deductible for specific services.
What is the out–of–pocket limit for this plan?	**Tier 1-3 In-Network** Employee $5,400 Family $10,800	**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	$15 copay	$20 copay	$30 copay	$40 copay	None
	Specialist visit	$30 copay	$40 copay	$65 copay	$80 copay	
	Preventive care/screening/ immunization	No Charge	No Charge	No Charge	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)	$40 copay	$55 copay	$90 copay	$110 copay	Fee listed include facility and physician charges; precertification may be required for some services. Labs covered at Tier 1 $10, Tier 2 $15, Tier 3 $20, Tier 4 $30
	Imaging (CT/PET scans, MRIs)	$140 copay	$190 copay	$315 copay	$400 copay	Precertification is required for advanced imaging
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	$5 copay (retail) $15 copay (mail order)	$10 copay (retail) $15 copay (mail order)	$15 copay (retail) $15 copay (mail order)	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)	$10 copay (retail) $25 copay (mail order)	$15 copay (retail) $25 copay(mail order)	$25 copay (retail) $25 copay(mail order)	Not Covered	
	Tier 3 (Non-Preferred Brand)	$15 copay (retail) $30 copay (mail order)	$20 copay (retail) $30 copay (mail order)	$30 copay (retail) $30 copay (mail order)	Not Covered	
	Tier 4 (Specialty Drugs)	$10 copay	$10 copay	$10 copay	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$465 copay	$615 copay	$1,030 copay	$1,236 copay	Facility fee listed includes facility and physician charges associated with outpatient facility and surgical services
	Physician/surgeon fees	No Charge Included in facility fee	No Charge Included in facility fee	No Charge Included in facility fee	No Charge Included in facility fee	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 need immediate medical attention	Emergency room care	$265 copay	$265 copay	$265 copay	$265 copay	Facility fee listed includes facility and physician charges associated with medical emergency services; services apply to the tier 1-3 of the out-of-pocket maximum
	Emergency medical transportation	$265 copay	$265 copay	$265 copay	$265 copay	Services apply to the tier 1-3 of the out-of-pocket maximum
	Urgent care	$30 copay	$40 copay	$65 copay	$80 copay	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,425 copay	$1,900 copay	$3,000 copay	$3,800 copay	Facility fee listed includes facility and physician charges associated with inpatient services; precertification is required
	Physician/surgeon fees	No Charge Included in facility fee	No Charge Included in facility fee	No Charge Included in facility fee	No Charge Included in facility fee	None

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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 mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay	$20 copay	$30 copay	$40 copay	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	$1,425 copay	$1,900 copay	$3,000 copay	$3,800 copay	
If you are pregnant	Office visits	$15 copay	$20 copay	$30 copay	$40 copay	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 Included in facility fee	No Charge Included in facility fee	No Charge Included in facility fee	No Charge Included in facility fee	
	Childbirth/delivery facility services	$1,425 copay	$1,900 copay	$3,000 copay	$3,800 copay	

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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	$30 copay	$40 copay	$65 copay	$80 copay	Benefits are also available for home infusion services
	Rehabilitation services	$30 copay	$40 copay	$65 copay	$78 copay	None
	Habilitation services	$30 copay	$40 copay	$65 copay	$78 copay	
	Skilled nursing care	$1,255 copay	$1,675 copay	$2,795 copay	$3,400 copay	None
	Durable medical equipment	$65 copay	$85 copay	$140 copay	$170 copay	Wigs limited to one per member per calendar year for services related to alopecia
	Hospice services	$155 copay	$205 copay	$345 copay	$420 copay	Precertification may be required
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	No Charge	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 Charge	No Charge	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	• Long-term care	• Routine foot care
• Dental care (Adult)	• Weight Loss Programs	• Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Infertility Treatment (limitations apply)	• Hearing Aids (limited to children age 18 and younger, additional limitations apply)
• Chiropractic care	• Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult)
• Bariatric surgery		

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	$4,000
Specialist copay/coinsurance	$30/0%
Hospital (facility) copay/coinsurance	$1,425/0%
Other copay/coinsurance	$1,425/0%

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	$4,000
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$5,460

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

The plan's overall deductible	$4,000
Specialist copay/coinsurance	$30/0%
Hospital (facility) copay/coinsurance	$1,425/0%
Other copay/coinsurance	$1,425/0%

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	$4,000
Copayments	$230
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$4,270

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

The plan's overall deductible	$4,000
Specialist copay/coinsurance	$30/0%
Hospital (facility) copay/coinsurance	$1,425/0%
Other copay/coinsurance	$1,425/0%

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	$2,550
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,650

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.