COUPE HEALTH

Coupe Health Benefits Summary

Client Name: IWCO
Plan Year: January 1st, 2026 - December 31st, 2026
Network: BlueCard® PPO Network

Medical Benefits				
	In-Network			Out-of-Network
	Tier 1	Tier 2	Tier 3	
Calendar Year Deductible (Indiv/Family)		$0		None
Out-of-Pocket Maximum (Indiv/Family) (Includes copays - combine with prescription drug card)		$5,000 / $10,000		Unlimited
OOP Max applies to in-network services only; Out-of-Network OOP Max is unlimited				
	In-Network			Out-of-Network
Medical Services	Tier 1	Tier 2	Tier 3	
Physician Services				
Primary Care Physician	$25	$35	$60	$70
Retail Health Clinic	$25	$35	$60	$70
Specialist	$55	$70	$120	$145
Preventative Services & Routine Care				
Well-Child Care (including exams and immunizations)		No Charge		N/A
Adult Physical Examination (including routine GYN visit)		No Charge		N/A
COVID 19 Vaccine		No Charge		N/A
Breast Cancer Screening (any age)		No Charge		N/A
Pap Test		No Charge		N/A
Prostate Cancer Screening		No Charge		N/A
Colorectal Cancer Screening		See plan document for specific coverage based on age/necessity		
Telehealth Services				
Doctor on Demand (Default)		$0		N/A
Maternity				
Initial Prenatal Office Visit	$25	$35	$60	$70
Prenatal Office Visit		No Charge		
Delivery & Postnatal Care	$2,705	$3,605	$5,000	$7,210
Hospital Expenses or Long-Term Acute Care Facility/Hospital (Facility Charges)				
Inpatient Hospital	$2,705	$3,605	$5,000	$7,210
Outpatient Hospital	$880	$1,170	$1,955	$2,345
Skilled Nursing /Rehabilitation Facility	$2,390	$3,185	$5,000	$6,370
Ambulance Services		$500		
Ambulatory Surgical Center	$880	$1,170	$1,955	$2,345
Home Health Care (120 visits per plan year)	$55	$70	$120	$145
Hospice Care	$295	$390	$650	$780

	In-Network			Out-of-Network
Medical Services	✓ **Tier 1**	**Tier 2**	! **Tier 3**	
Radiology Services				
Diagnostic X-Rays	$75	$100	$170	$205
Advanced Imaging (MRI, MRA, CAT & PET Scans)	$270	$360	$600	$720
Laboratory Services				
Basic Labs	$20	$25	$40	$50
Advanced Diagnostic Labs	$75	$100	$170	$205
Emergency Services/Urgent Care				
Emergency Services/Emergency Room	$500			
Urgent Care Facility	$70			
Mental Disorders & Substance Use Disorders				
Office Visit	$25	$35	$60	$70
Inpatient	$2,705	$3,605	$5,000	$7,210
Outpatient	$880	$1,170	$1,955	$2,345
Therapy Services				
Chiropractic Care/Spinal Manipulation (15 visits per plan year)	$55	$70	$120	$145
Outpatient Therapies (PT, OT, ST) (INN - No visit limit/ OON 15 visits per plan year)	$55	$70	$120	$145
Durable Medical Equipment*				
Durable Medical Equipment (DME) / Item	$120	$160	$270	$325
Other Healthcare Facilities/Services				
Allergy Injections, Serum & Testing	$55	$70	$120	$145
Acupuncture (20 visit limit per plan year)	$55	$70	$120	$145
Transplants (Blue Distinction Centers)* Travel/lodging $10,000 lifetime maximum per transplant)	$2,705	$3,605	$5,000	$7,210

*Please refer to the Blue Distinction Centers (BDCT) Program section of this plan for a more detailed description of this benefit.

Temporomandibular Joint Dysfuntion	See plan document for specific coverages and exclusions.
Weight Control/Bariatric Surgery	See plan document for specific coverages and exclusions.

Pharmacy Drug Vendor: Prime Therapeutics Rx

Pharmacy Benefits	
NOTE: There is no coverage under the plan for prescription drugs obtained from a Non-Participating Partner.	
Rx Network: Select Network Rx Formulary: KeyRx	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.
Pharmacy Plan Feature	
Retail Pharmacy	
Preferred Generic Drugs	$10
Non-Preferred Generic Drugs	$60
Preferred Brand Drugs	$40
Non-Preferred Brand Drugs	$60
Specialty Drug Program	
Specialty Drugs* (Up to a 30-day Supply)	$80
*Specialty medications are required to be filled through Mail Order	
Retail/Mail Order (90 Day Supply)	
Preferred Generic Drugs	$20
Non-Preferred Generic Drugs	$120
Preferred Brand Drugs	$80
Non-Preferred Brand Drugs	$120
Drug Descriptions	
Preferred Generic Drugs	All preferred drugs are covered at this copay level.
Non-Preferred Generic Drugs	All non-preferred generic drugs on this copay level are not on the Preferred Drug List. Discuss using alternatives with your physician or pharmacist.
Preferred Brand Drugs	All preferred drugs are covered at this copay level.
Non-Preferred Brand Drugs	All non-preferred brand drugs on this copay level are not on the Preferred Drug List. Discuss using alternatives with your physician or pharmacist.