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

Best Buy – Coupe Health - Option 1

Coverage For: Individual + Family **Plan Type: EPO**

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 Valet 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 calendar year deductible	**Tier 4 Out-of-Network** Yes. There is no overall calendar year deductible	Deductible does not apply for this plan. But a copayment may apply. 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 deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out–of–pocket limit for this plan?	**Tier 1-3 In-Network** Individual / $4,000 Family / $8,000	**Tier 4 Out-of-Network** None	The out-of-pocket limit is the most you could pay in a year for covered services. This limit helps you plan for health care expenses. This plan has a per member out-of-pocket limit. Once a family member reaches his or her out-of-pocket limit, the plan begins to pay 100% of eligible health care expenses for that person for the rest of the year.
What is not included in the out–of–pocket limit?	Premiums, balance billing charges, health care this plan doesn't cover, 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.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay	$55 copay	$90 copay	Not Covered	None
	Specialist visit	$45 copay	$80 copay	$135 copay	Not Covered	None
	Preventive care/screening/ immunization	No Charge	No Charge	No Charge	Not Covered	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 Additional services are available. Please call your Coupe Health Valet at 1-833-749-1969.
If you have a test	Diagnostic test (x-ray, blood work)	Routine Labs: $0 copay Advanced Labs: $250 copay X-ray: $80 copay	Routine Labs: $10 copay Advanced Labs: $350 copay X-ray: $110 copay	Routine Labs: $30 copay Advanced Labs: $700 copay X-ray: $180 copay	Not Covered	Fee listed include facility and physician charges
	Imaging (CT/PET scans, MRIs)	$250 copay	$650 copay	$1,300 copay	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	
If you need drugs to treat your illness or condition A retail pharmacy is any licensed pharmacy that you can physically enter to obtain a **prescription drug**. A mail service pharmacy dispenses **prescription drugs** through the U.S. Mail. More information about **prescription drug coverage** is available at **OptumRx.com**	Tier 1 Prescription Drugs - Your Lowest-Cost Option	Retail: 25% coinsurance Mail Order: 25% coinsurance	Retail: 25% coinsurance Mail Order: 25% coinsurance	Retail: 25% coinsurance Mail Order: 25% coinsurance	Not Covered	Retail: 25% ($25 min/$125 max copay) Mail Order: 25% ($50 min/$250 max copay) Tier 1 contraceptives 100%
	Tier 2 Prescription Drugs - Your Midrange-Cost Option	Retail: 40% coinsurance Mail Order: 40% coinsurance	Retail: 40% coinsurance Mail Order: 40% coinsurance	Retail: 40% coinsurance Mail Order: 40% coinsurance	Not Covered	Retail: 40% ($50 min/$200 max copay) Mail Order: 40% ($100 min/$400 max copay)
	Tier 3 Prescription Drugs - Your Highest-Cost Option	Retail: 50% coinsurance Mail Order: 50% coinsurance	Retail: 50% coinsurance Mail Order: 50% coinsurance	Retail: 50% coinsurance Mail Order: 50% coinsurance	Not Covered	Retail: 50% ($75 min/$300 max copay) Mail Order: 50% ($150 min/$600 max copay)
	Tier 4 Prescription Drugs - Your Additional High-Cost Option	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered; member pays 100%
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay	$600 copay	$1,200 copay	Not Covered	Facility fee listed includes facility and physician charges associated with outpatient facility and surgical services
	Physician/surgeon fees	No Charge	No Charge	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room care	$950 copay	$950 copay	$950 copay	$950 copay	Copay is waived if admitted within 24 hours. Out-of-network emergency room care visit copay applies to the in-network out-of-pocket limit.
	Emergency medical transportation	$1,000 copay	$1,000 copay	$1,000 copay	$1,000 copay	Out-of-network emergency medical transportation copay applies to the in-network out-of-pocket limit.
	Urgent care	$100 copay	$150 copay	$200 copay	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	
If you have a hospital stay	Facility fee (e.g., hospital room)	$2,350 copay	$2,750 copay	$3,350 copay	Not Covered	Prior authorization is required for non-emergency facility admissions and inpatient surgery or there may be no coverage
	Physician/surgeon fees	No Charge	No Charge	No Charge	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$150 copay	$180 copay	$250 copay	Not Covered	Inpatient services includes facility and physician charges EAP Visit Limit 8 per issue
	Inpatient services	$2,350 copay	$2,750 copay	$3,350 copay	Not Covered	
If you are pregnant	Office visits	No Charge	No Charge	No Charge	Not Covered	One copayment is applied for all covered services related to childbirth/delivery, including the newborn, unless discharged after mother Prior authorization is required for inpatient stays beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery or there may be no coverage
	Childbirth/delivery professional services	No Charge	No Charge	No Charge	Not Covered	
	Childbirth/delivery facility services	$1,300 copay	$1,925 copay	$3,225 copay	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	
If you need help recovering or have other special health needs	Home health care	$70 copay	$90 copay	$140 copay	Not Covered	Visit Limit: 120 per person per calendar year Prior authorization is required for certain home health care services or there may be no coverage
	Rehabilitation services	$35 copay	$55 copay	$90 copay	Not Covered	Visit Limit: 120 per person per calendar year for occupational therapy, physical therapy, and speech therapy combined Mental health-related therapies (occupational, physical and speech): Visit limits do not apply
	Habilitation services	$35 copay	$55 copay	$90 copay	Not Covered	
	Skilled nursing care	$2,350 copay	$2,750 copay	$3,350 copay	Not Covered	Prior authorization is required or there may be no coverage
	Durable medical equipment	$130 copay	$170 copay	$285 copay	Not Covered	Diabetic equipment and supplies provided by Omada are covered at $0 copay; other providers will be subject to the applicable Tier copay
	Hospice services	$300 copay	$400 copay	$500 copay	Not Covered	Prior authorization is required or there may be no coverage
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	Not Covered	Not Covered	None

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.)

- Adult routine vision exam (i.e., refraction)
- Child routine vision exam (i.e., refraction)
- Child dental check-up
- Child glasses
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight Loss Programs

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing Aids
- Fertility Treatment
- Temporomandibular Joint Dysfunction (TMJ)

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: Minnesota Department of Commerce at 1-800-657-3602; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, extension 61565 or www.cciio.cms.gov. For more information on your rights to continue coverage, contact Blue Cross at 1-866-455-8220. 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.mnsure.com or call 1-855-366-7873.

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: Blue Cross at 1-866-455-8220; the Minnesota Department of Commerce at 1-800-657-3602; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. If you are covered under a plan offered by the State Health Plan, a city, county, school district, or Service Cooperative, or church plan you may contact the Department of Health and Human Services Health Insurance team at 1-888-393-2789.

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	$45
Hospital (facility) copayment	$1,300
Other copayment/coinsurance	$1,000/40%

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	$2,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,260

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 copayment	$45
Hospital (facility) copayment	$1,300
Other copayment/coinsurance	$1,000/40%

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	$500
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$1,740

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

The plan's overall deductible	$0
Specialist copayment	$45
Hospital (facility) copayment	$1,300
Other copayment/coinsurance	$1,000/40%

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-903-2583.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-537-7720.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-855-315-4017.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-902-2583.

Notice of Nondiscrimination Practices

Effective July 18, 2016

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  M495
  PO Box 64560
  Eagan, MN 55164-0560
- or by telephone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by telephone at: 1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at: U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F, HHH Building
  Washington, DC 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Access Services:

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိၤကညီကျိာ်ဒီး. တၢ်ကဟ့ဉ်နၤကျိာ်တၢ်မၤစၢၤကလိတဖဉ်နူဉ်လီၤ. ကိး 1-866-251-6744 လၢ TTYအဂိၢ်. ကိး 711 တက့ၢ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jį' béésh bee hodíílnih.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។