COUPE HEALTH

# Coupe Health Benefits Summary

Client Name: BrightSpring
Plan Year: January 1st, 2027 - December 31st, 2027
Network: BlueCard® PPO Network

| Medical Benefits | | | | |
|---|---|---|---|---|
| | In-Network | | | Out-of-Network |
| | Tier 1 | Tier 2 | Tier 3 | |
| Calendar Year Deductible (Indiv/Family) | | $0 | | N/A |
| Out-of-Pocket Maximum (Indiv/Family) | | $8,000 / $16,000 | | N/A |

*OOP Max applies to in-network services only

| | In-Network | | | Out-of-Network |
|---|---|---|---|---|
| **Medical Services** | **Tier 1** | **Tier 2** | **Tier 3** | |
| **Physician Services** | | | | |
| Primary Care Physician | $65 | $85 | $145 | $175 |
| Retail Health Clinic | $65 | $85 | $145 | $175 |
| Specialist | $145 | $195 | $325 | $390 |
| Telehealth Services | $65 | $85 | $145 | $175 |
| **Preventative Services & Routine Care** | | | | |
| Well-Child Care (including exams and immunizations) | No Charge | | | |
| Adult Physical Examination (including routine GYN visit) | No Charge | | | |
| Routine Eye Care | No Charge | | | |
| COVID 19 Vaccine | No Charge | | | |
| Breast Cancer Screening (any age) | See plan document for specific coverage based on age/necessity | | | |
| Pap Test | See plan document for specific coverage based on age/necessity | | | |
| Prostate Cancer Screening | See plan document for specific coverage based on age/necessity | | | |
| Colorectal Cancer Screening | See plan document for specific coverage based on age/necessity | | | |
| **Maternity** | | | | |
| Initial Prenatal Office Visit | $65 | $85 | $145 | $175 |
| Prenatal Office Visit | | No Charge | | $175 |
| Delivery & Postnatal Care | $4,370 | $5,815 | $8,000 | $11,800 |
| **Hospital Expenses or Long-Term Acute Care Facility/Hospital (Facility Charges)** | | | | |
| Inpatient Hospital | $4,370 | $5,815 | $8,000 | $11,800 |
| Outpatient Hospital | $1,725 | $2,295 | $3,885 | $4,660 |
| Skilled Nursing /Rehabilitation Facility (120 days combined max per plan year) | $3,910 | $5,200 | $8,000 | $10,560 |
| Ambulance Services | | $1,725 | | |
| Ambulatory Surgical Center | $1,725 | $2,295 | $3,885 | $4,660 |
| Home Health Care (120 visits per plan year) | $145 | $195 | $325 | $390 |
| Home Infusion | $145 | $195 | $325 | $390 |
| Hospice Care | $460 | $615 | $1,035 | $1,245 |

| | In-Network | | | Out-of-Network |
|---|---|---|---|---|
| **Medical Services** | **Tier 1** | **Tier 2** | **Tier 3** | |
| **Radiology Services** | | | | |
| Diagnostic X-Rays | $260 | $345 | $585 | $700 |
| Advanced Imaging<br>(MRI, MRA, CAT & PET Scans) | $405 | $535 | $910 | $1,090 |
| **Laboratory Services** | | | | |
| Basic Labs | $205 | $270 | $455 | $545 |
| Advanced Diagnostic Labs | $230 | $310 | $520 | $625 |
| **Emergency Services/Urgent Care** | | | | |
| Emergency Services/Emergency Room | | $1,725 | | |
| Urgent Care Facility | | $115 | | |
| **Mental Disorders & Substance Use Disorders** | | | | |
| Office Visit | $65 | $85 | $145 | $175 |
| Inpatient | $4,370 | $5,815 | $8,000 | $11,800 |
| Outpatient | $1,725 | $2,295 | $3,885 | $4,660 |
| **Therapy Services** | | | | |
| Chiropractic Care/Spinal Manipulation<br>(30 visits per plan year) | $145 | $195 | $325 | $390 |
| Outpatient Therapies (PT, OT, ST)<br>(90 combined visits per plan year) | $145 | $195 | $325 | $390 |
| **Durable Medical Equipment*** | | | | |
| Durable Medical Equipment (DME) / Item | $260 | $345 | $585 | $700 |
| **Other Healthcare Facilities/Services** | | | | |
| Allergy Injections, Serum & Testing | $145 | $195 | $325 | $390 |
| Acupuncture | $145 | $195 | $325 | $390 |
| Transplants<br>(Travel/lodging $10,000 per plan year) | $4,370 | $5,815 | $8,000 | $11,800 |