COUPE HEALTH

Coupe Health Benefits Summary: HSA HDHP

Client Name: Flagstone Foods
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)		$3,400 / $6,800		$6,800 / $13,600
Out-of-Pocket Maximum (Indiv/Family)		$6,800 / $13,600		$13,600 / $27,200
*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	$20	$25	$40	$50
Retail Health Clinic	$20	$25	$40	$50
Specialist	$35	$50	$80	$95
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			
Telehealth Services				
Doctor on Demand		$0		N/A
Maternity				
Initial Prenatal Office Visit	$20	$25	$40	$50
Prenatal Office Visit		No Charge		$50
Delivery & Postnatal Care	$1,640	$2,180	$3,690	$4,425
Hospital Expenses or Long-Term Acute Care Facility/Hospital (Facility Charges)				
Inpatient Hospital	$1,640	$2,180	$3,690	$4,425
Outpatient Hospital	$535	$715	$1,205	$1,445
Skilled Nursing Facility (60 days combined max per plan year)	$1,445	$1,920	$3,250	$3,900
Ambulance Services			$305	
Ambulatory Surgical Center	$535	$715	$1,205	$1,445
Home Health Care (60 visits per plan year)	$35	$50	$80	$95
Home Infusion	$35	$50	$80	$95
Hospice Care	$180	$240	$405	$485

	In-Network			Out-of-Network
Medical Services	✓ **Tier 1**	− **Tier 2**	! **Tier 3**	
Radiology Services				
Diagnostic X-Rays	$50	$65	$105	$125
Advanced Imaging (MRI, MRA, CAT & PET Scans)	$165	$215	$365	$435
Laboratory Services				
Basic Labs	$10	$15	$30	$35
Advanced Diagnostic Labs	$50	$65	$105	$125
Emergency Services/Urgent Care				
Emergency Services/Emergency Room		$305		
Urgent Care Facility		$35		
Mental Disorders & Substance Use Disorders				
Office Visit	$20	$25	$40	$50
Inpatient	$1,640	$2,180	$3,690	$4,425
Outpatient	$535	$715	$1,205	$1,445
Therapy Services				
Chiropractic Care/Spinal Manipulation (20 visits per plan year)	$35	$50	$80	$95
Outpatient Therapies (PT, OT, ST)	$35	$50	$80	$95
Durable Medical Equipment				
Durable Medical Equipment (DME) / Item	$75	$100	$170	$205
Other Healthcare Facilities/Services				
Allergy Injections, Serum & Testing	$35	$50	$80	$95
Acupuncture	$35	$50	$80	$95
Transplants (Travel/lodging $10,000 lifetime maximum)	$1,640	$2,180	$3,690	$4,425

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: FocusRx	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	
Tier 1 -- Preferred Generic Drugs	Deductible then $10 copay
Tier 2 -- Non-Preferred Generic Drugs	Deductible then $10 copay
Tier 3 -- Preferred Brand Drugs	Deductible then $30 copay
Tier 4 -- Non-Preferred Brand Drugs	Deductible then $50 copay
Specialty Drug Program	
Tier 1 -- Specialty Drugs* (Up to a 30-day Supply)	Deductible then $75 copay
Tier 2 -- Specialty Drugs* (Up to a 30-day Supply)	Deductible then $100 copay
*Specialty medications are required to be filled through a Specialty Pharmacy.	
Mail Order (90 Day Supply)	
Tier 1 -- Preferred Generic Drugs	Deductible then $20 copay
Tier 2 -- Non-Preferred Generic Drugs	Deductible then $20 copay
Tier 3 -- Preferred Brand Drugs	Deductible then $60 copay
Tier 4 -- Non-Preferred Brand Drugs	Deductible then $100 copay
Drug Descriptions	
Tier 1 -- Preferred Generic Drugs	All preferred drugs are covered at this copay level.
Tier 2 -- 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.
Tier 3 -- Preferred Brand Drugs	All preferred drugs are covered at this copay level.
Tier 4 -- 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.