Concept Packaging Group Health Benefits 1/1/2022

The maximums listed below are the total for In Network and Out of Network expenses. For example, if a maximum of 60 days is listed twice under a service, the calendar year maximum is 60 days total which may be split between In Network and Out of Network providers.

Annual Maximum Benefit **Unlimited**

SCHEDULE OF BENEFITS		
CALENDAR YEAR DEDUCTIBLE	**IN NETWORK**	**OUT OF NETWORK**
Individual Plan 8107 Plan 8108 (HSA)	 $3,000 $3,100	 $6,000 $6,200
Family Plan 8107 Plan 8108 (HSA)	 $9,000 $6,200	 $18,000 $12,400
Everyone covered in the family is considered to have satisfied the family deductible once the family maximum has been met. Amounts applied to the deductible for charges from in network providers will be used to satisfy the deductible for charges from out of network providers and vice versa.		
OUT OF POCKET	**IN NETWORK**	**OUT OF NETWORK**
Individual Plan 8107 Plan 8108 (HSA)	 $4,000 $0	 $12,000 $12,000
Family Plan 8107 Plan 8108 (HSA)	 $8,000 $0	 $24,000 $24,000
Copayments, deductibles, cost containment penalties, Physicians' charges for non-surgical TMJ, and out patient care of Spinal Conditions will not apply towards the out-of-pocket, nor will such charges be paid at 100% once that limit has been met. Amounts applied to the Out-of-Pocket maximum for charges from In Network Providers will be used to satisfy the Out-of-Pocket maximum from Out-of-Network Providers and vice versa.		
Co-Insurance (% of covered service paid by Concept Packaging Group) once deductible has been met	 Plan 8107 80% Plan 8108 100%	 Plan 8107 50% Plan 8108 50%

HEALTH PLAN BENEFITS	IN NETWORK	OUT OF NETWORK
Primary Care Physician Office Visit (Includes Labs & X-Rays associated with visit) General/Family Medicine Pediatrician Internist OB-GYN	Plan 8107 $35 co-pay then 100% of covered expenses to a daily maximum of $400, then deductible and co-insurance. Plan 8108 100% after deductible	50% after deductible 50% after deductible
Specialist Office Visit (Includes Labs & X-Rays associated with visit)	Plan 8107 $55 co-pay then 100% of covered expenses to a daily maximum of $400, then deductible and co-insurance. Plan 8108 100% after deductible	50% after deductible 50% after deductible
Office Surgery Plan 8107 Plan 8108	80% after deductible 100% after deductible	50% after deductible 50% after deductible
Preventive Care Immunizations Well Baby Care Mammograms Pap Smears PSA's Routine Physicals (Includes Labs & X-Rays performed and billed at time of visit) **Limited to one routine physical examination in each calendar year**	All Plans: $25 Co-Payment, then 100% of covered expenses to a maximum of $800, then deductible and co-insurance.	Not Covered.

HEALTH PLAN BENEFITS	IN NETWORK	OUT OF NETWORK
Alcohol and Substance Abuse Plan 8107 Plan 8108	 80% after deductible 100 % after deductible	 50% after deductible 50% after deductible
Allergy Injections Plan 8107 Plan 8108	 80% after deductible 100% after deductible	 50% after deductible 50% after deductible
Allergy Services & Supplies Plan 8107 Plan 8108	 80% after deductible 100% after deductible	 50% after deductible 50% after deductible
Ambulance Service Plan 8107 Plan 8108	 80% after deductible 100% after deductible	 50% after deductible 50% after deductible
Birth Control (Injections, IUD)	All Plans: $55 co-pay then 100% of covered expenses to a daily maximum of $1,000, then deductible and co-insurance.	50% after deductible
Chiropractic Services **25 Visit Calendar Year Maximum**	All Plans: $20 per visit maximum benefit. Maximum of $20 payment credited to deductible.	All Plans: $20 per visit maximum benefit. Maximum of $20 payment credited to deductible.
Diagnostic Testing Facility (MRI, CT, etc.) **Precertification required** Plan 8107 Plan 8108	 80% after deductible 100% after deductible	 50% after deductible 50% after deductible
Durable Medical Equipment Plan 8107 Plan 8108	 80% after deductible 100% after deductible	 50% after deductible 50% after deductible
Educational Diabetic Nutrition Counseling **10 Visit Calendar Year Maximum** Plan 8107 Plan 8108	Plan 8107 $35 co-pay then 100% of covered expenses to a daily maximum of $400, then deductible and co-insurance. 100% after deductible	 50% after deductible 50% after deductible

HEALTH PLAN BENEFITS	IN NETWORK	OUT OF NETWORK
Emergency Room Visit (Co-pay waived if admitted) Plan 8107 Plan 8108	 $150 co-pay, then 80% after deductible $150 co-pay, then 100% after deductible	 $150 co-pay, then 50% after deductible $150 co-pay, then 50% after deductible
Home Health Care Plan 8107 Plan 8108 **40 Visit Calendar Year Maximum**	 80% after deductible 100% after deductible	 50% after deductible 50% after deductible
Hospice Care **180 days Calendar Year Maximum**	All Plans: 100% of covered expenses, Deductible waived.	All Plans: 100% of covered expenses, Deductible waived.
Inpatient/Outpatient Anesthesia Plan 8107 Plan 8108	80% after deductible 100% after deductible	50% after deductible 50% after deductible
Inpatient/Outpatient Hospital Services Plan 8107 Plan 8108	 80% after deductible 100% after deductible	 50% after deductible 50% after deductible
Inpatient/Outpatient Laboratory Services and X-Ray Services Plan 8107 Plan 8108	 80% after deductible 100% after deductible	 50% after deductible 50% after deductible
Inpatient/Outpatient Nursery Room Charges Plan 8107 Plan 8108	 80% after deductible 100% after deductible	 50% after deductible 50% after deductible
Inpatient/Outpatient Physician Services Plan 8107 Plan 8108	 80% after deductible 100% after deductible	 50% after deductible 50% after deductible

HEALTH PLAN BENEFITS	IN NETWORK	OUT OF NETWORK
Maternity Services (Pregnancy for employee or dependent spouse only) Routine Prenatal Delivery Postnatal Care		
Plan 8107	80% after deductible	50% after deductible
Plan 8108	100% after deductible	50% after deductible
Breast Pumps	All Plans: $250	
Mental Health Services Inpatient		
Plan 8107	80% after deductible	50% after deductible
Plan 8108	100% after deductible	50% after deductible
Mental Health Services Outpatient		
Plan 8107	$55 co-pay then 100% of covered expenses to a daily maximum of $400, then deductible and co-insurance.	50% after deductible
Plan 8108	100% after deductible	50% after deductible
Newborn Services		
Plan 8107	80% after deductible	50% after deductible
Plan 8108	100% after deductible	50% after deductible
Outpatient Therapy Cardiac Rehab Chemotherapy Speech Occupational Radiation Renal Dialysis		
Plan 8107	80% after deductible	50% after deductible
Plan 8108	100% after deductible	50% after deductible
Physical Therapy		
Plan 8107	$25 Co-pay per visit, 12 visit maximum, then deductible and co- insurance.	50% after deductible
Plan 8108	100% after deductible	50% after deductible

HEALTH PLAN BENEFITS	IN NETWORK	OUT OF NETWORK
Prosthetic Devices Plan 8107 Plan 8108	 80% after deductible 100% after deductible	 50% after deductible 50% after deductible
Second Surgical Opinion Benefits payable only if second opinion requested and approved by UR.	All Plans: 100% of covered expenses, Deductible waived.	All Plans: 100% of covered expenses, Deductible waived.
Skilled Nursing Facility Plan 8107 Plan 8108 **120 Day Calendar Year Maximum**	 80% after deductible 100% after deductible	 50% after deductible 50% after deductible
Urgent Care Facility (Not ER Room) Plan 8107 Plan 8108	 $35 co-pay then 100% of covered expenses to a daily maximum of $400, then deductible and co-insurance. 100% after deductible	 50% after deductible 50% after deductible
Transplant Services Plan 8107 Plan 8108 Bone Marrow Cornea Heart Kidney Liver Lung Pancreas **$500,000 Calendar Year Maximum** Donor **$10,000 Calendar Year Maximum**	 80% after deductible 100% after deductible 80% after deductible	 50% after deductible 50% after deductible 50% after deductible
Pre-Certification Penalty	All Plans: No coverage for any services requiring pre-certification if pre-cert is not obtained prior to service or within 48 hours after service in the case of an emergency. Upon request, at plan discretion a retroactive pre cert may be issued but in no case more than 90 days after date of service.	All Plans: No coverage for any services requiring pre-certification if pre-cert is not obtained prior to service or within 48 hours after service in the case of an emergency. Upon request, at plan discretion a retroactive pre cert may be issued but in no case more than 90 days after date of service.

HEALTH PLAN BENEFITS	IN NETWORK	OUT OF NETWORK
All Other Covered Expenses Plan 8107 Plan 8108	 80% after deductible 100% after deductible	 50% after deductible 50% after deductible
Precertification is required for the following services: CT Scan Home Health Care Injectable Specialty Medications Inpatient Hospitalization MRI/MRA Tests Pet Scan Sleep Studies Outpatient Surgery per Plan Guidelines Precert with Medical Management 877-276-7198		
Prescription Drug Benefit Retail 30 day supply Plan 8107 Generic – Tier 1 Preferred Brand – Tier 2 Non-Preferred Brand – Tier 3 Specialty - Tier 4 Plan 8108 Generic – Tier 1 Preferred Brand - Tier 2 Non Preferred Brand – Tier 3 Specialty - Tier 4	 $15 co-pay $35 co-pay $55 co-pay 50% co-pay Prescriptions are discounted & applied to deductible	 Not Covered Not Covered
Prescription Drug Benefit Mail Order RX: 2 times copay for 90 day supply Plan 8107 Generic – Tier 1 Preferred Brand – Tier 2 Non-Preferred Brand – Tier 3 Specialty - Tier 4 Plan 8108 Generic – Tier 1 Preferred Brand – Tier 2 Non Preferred Brand – Tier 3 Specialty - Tier 4	 $30 co-pay $70 co-pay $110 co-pay 50% co-pay Prescriptions are discounted & applied to deductible	 Not Covered Not Covered
Prescriptions handled through Phoenix Pharmacy Benefits Management, www.phoenixpbm.com. **877-643-2067.** Mail Order through Magnolia Pharmacy pharmacy@mymagnoliarx.com **800-476-2273**		
Vision Benefit Plan 8107 & 8108 (Vision exam, frames, lenses, contact lenses, contact lens exam or fitting.)	All Plans $200 maximum calendar year benefit	