CONCORDIA HEALTH PLAN
Schedule A

Coverage for Option A

This Schedule provides the amount of reimbursement for benefits under Plan Coverage Option A, for Members and Dependents enrolled in such Option, and replaces Subsections 4.5 through 4.10 of the Concordia Health Plan

Basic medical care and preventive medical care. There are a variety of Plan Coverage Options for basic medical and preventive medical care. This Schedule describes the benefits applicable for Option A, which is a PPO (Preferred Provider Organization) program. Blue Cross Blue Shield of Minnesota is the network manager for this option (see page 26). Participating BlueCard PPO providers should be used by Members to access care. Greater benefits are provided when BlueCard PPO providers are used for healthcare services, and lower benefits will be applicable if non-network providers are used.

Mental health and substance abuse care. A network manager (Cigna Behavioral Health) has been selected to administer the benefits for eligible Members and their Enrolled Dependents. The care must be provided by an eligible provider and be medically necessary. Greater benefits are provided when network providers are used.

Employee Assistance Program (EAP). Cigna Behavioral Health administers this nationwide employee assistance program for Members and their families. Confidential counseling is avail- able for work/life issues such as marital and family difficulties, parenting challenges, stress and anxiety, and financial and legal concerns.

Prescription drugs. Express Scripts administers the prescription drug coverage. Prescription drugs may be purchased by the Member at a local pharmacy or, for long-term medications, through a participating Smart90® retail pharmacy or Express Scripts' home delivery service, except for specialty drugs which must be purchased through the specialty-drug mail order pharmacy specified by Express Scripts.

Dental care and preventive dental care. A network manager (Cigna Dental) has been selected to administer these benefits. If network providers are used, the Member will normally have lower out-of-pocket costs due to discounted fee agreements between the dentist and the network manager.

Vision care. Vision Service Plan (VSP) administers the vision benefits. Coverage is provided for routine eye exams and purchase of glasses and contact lenses.

Hearing care. HearUSA (also known as National Ear Care Plan) administers this discount program for hearing screenings and testing, as well as purchase of hearing aids.

SECTION I – BASIC MEDICAL CARE AND PREVENTIVE MEDICAL CARE BENEFITS

Network Manager: Blue Cross Blue Shield of Minnesota

Summary of Benefits

SERVICES/TREATMENTS		NETWORK BENEFITS	NON-NETWORK BENEFITS
		All services and supplies must be provided or authorized by a Physician in the network.	Eligible charges are subject to a customary charge limitation.
Preventive Medical Care	Well-child care – routine office visits, standard immunizations, developmental assessments, vision and hearing screenings, and laboratory services *(under age six)*	100%	Not Covered
	Routine preventive medical evaluation, including vision and hearing screenings, and standard immunizations *(age 6 and older)*	100%	Not Covered
	Routine lab tests, including but not limited to, diabetes screening and lipid profile (including total and HDL cholesterol)	100%	Not Covered
	Routine cancer screenings including but not limited to mammograms, Pap smears, flexible sigmoidoscopies, colonoscopies, fecal occult blood testing, Prostate Specific Antigen (PSA) tests, digital rectal exams, and surveillance tests for ovarian cancer	100%	Not Covered
Medical Services in Physician's Office	Primary Care Physician office visits (includes lab tests or x-rays if performed in the office)	100% except $25 Copay per visit	100% except $50 Copay per visit
	Specialist office visits (includes lab tests or x-rays if performed in the office)	100% except $25 Copay per visit	100% except $50 Copay per visit
	Second surgical opinions (not mandatory)	100% except $25 Copay per visit	100% except $50 Copay per visit

SERVICES/TREATMENTS		NETWORK BENEFITS	NON-NETWORK BENEFITS
Medical Services in Physician's Office (cont.)	Obstetrical care--pregnancy (physician's fee only)	100% except for one $25 Copay per pregnancy	100% except for one $50 Copay per pregnancy
	Chiropractic care *(26 visits per calendar year)*	100% except $25 Copay per visit	100% except $50 Copay per visit
	Physical, occupational, or speech therapy	90%	70% after deductible
	Allergy care by specialist	100% except $25 Copay per visit	100% except $50 Copay per visit
	Allergy shots (serum) if no office visit charge	90%	70% after deductible
Hospital Services	Room, board, and other services/supplies	90%	70% after deductible *(Hospital certification required for all hospital admissions, otherwise $500 penalty applied)*
	Newborn care	90%	70% after deductible
	Hospital emergency room	100% except $120 Copay per visit *(Copay waived if admitted into hospital within 24 hours)*	
Medical & Surgical Services While Hospitalized	Surgery and related expenses such as anesthesia, assistant surgeon	90%	70% after deductible
	Physician's expense-- pregnancy delivery charge	Included as part of obstetrical care listed under "Medical Services in Physician's Office"	Included as part of obstetrical care listed under "Medical Services in Physician's Office"
	Physician visit in hospital	90%	70% after deductible
	Blood transfusions	90%	70% after deductible
	Organ transplants or bone marrow/stem cell transplants*	90%	70% after deductible

* *If using a Blue Distinction Center of Excellence, 100% coverage is provided for hospital charges as well as a travel benefit as described in Subsection 4.2 s) and in administrative guidelines established by Concordia Plan Services.*

SERVICES/TREATMENTS		NETWORK BENEFITS	NON-NETWORK BENEFITS
Medical & Surgical Services While Hospitalized (cont.)	Knee or hip replacement, and spine surgery*	90%	70% after deductible
	** If using a Blue Distinction Center of Excellence, 100% coverage is provided for hospital charges.*		
	Bariatric surgery*	90%	70% after deductible
	** If using a Blue Distinction Center of Excellence, 100% coverage is provided for hospital charges.*		
	Physical, occupational, or speech therapy	90%	70% after deductible
Outpatient Services	Diagnostic x-ray and lab	90%	70% after deductible
	Surgery and related expenses	90%	70% after deductible
	Pre-admission testing	90%	70% after deductible
	Physical, occupational, or speech therapy	90%	70% after deductible
Other Services	Home health care	90%	70% after deductible
	Urgent care	100% except $25 Copay per visit	100% except $50 Copay per visit
	Ambulance and approved emergency air transport services *(if medically necessary)*	90%	90%
	Extended care or skilled nursing facility (up to 100 days per calendar year covered)	90%	70% after deductible
	Hospice care	90%	70% after deductible
	Kidney dialysis (after 12 months, Member must apply for Medicare Part A and Part B)	90%	70% after deductible
	Radiation therapy and chemotherapy	90%	70% after deductible

SERVICES/TREATMENTS		NETWORK BENEFITS	NON-NETWORK BENEFITS
Other Services (cont.)	Tubal ligation or vasectomy	90%	70% after deductible
	Accidental injury to natural teeth (treatment must begin within 12 months after accident, and be completed within 24 months after initial treatment)	90%	70% after deductible
	Temporomandibular joint (TMJ) disorder-only if deemed to be a medical expense by the network's medical review department	90%	70% after deductible
	Telemedicine consultation	100% except $10 Copay per visit	
Supplies and Equipment	Medical supplies, durable medical equipment	90%	70% after deductible
	Prosthetic or orthopedic devices, such as artificial limbs or eyes, braces, etc. (also covers replacement of these devices when required by person's growth to maturity)	90%	70% after deductible
General	**Deductibles:**		
	Individual annual deductible	Not applicable	$500
	Family unit* annual deductible	Not applicable	$1,000
	Annual coinsurance maximums: *(not applicable to Copays or deductibles)*		
	Individual coinsurance maximum	$600	$2,100
	Family unit* coinsurance maximum	$1,200	$4,200
	Maximum benefits:		
	Individual annual maximum benefit for chiropractic care	Combined 26 visits for network and non-network	
	Individual lifetime maximum benefit for all benefits paid by the CHP	Unlimited lifetime limit	

* "Family unit" shall mean a Member and that Member's Enrolled Dependents.

NOTE: Network deductibles, coinsurance maximums, and out-of-pocket maximums can be satisfied only with eligible expenses incurred in the network. Non-network deductibles, coinsurance maximums, and out-of-pocket maximums can be satisfied only with eligible expenses not incurred in the network.

BASIC MEDICAL CARE AND PREVENTIVE MEDICAL CARE BENEFITS

Provisions Outlining Basic Medical Care and Preventive Medical Care Benefits

After satisfaction of any required deductible for a calendar year, the amount of reimbursement for eligible medical charges, except those otherwise included elsewhere in this Schedule, shall be:

a) Network services and supplies.

i) Preventive medical care. One hundred percent (100%) of such eligible charges.

The list of covered procedures, the frequency with which such procedures will be covered in a calendar year, and any applicable age limits may change from time to time as determined by the network manager. If a patient exceeds the frequency limit for any service in a calendar year, and the service was performed for routine checkup purposes, the benefit for basic medical care, with appropriate deductibles and copays, shall be applicable.

ii) Physician office visits and urgent care visits. One hundred percent (100%) of such eligible charges, minus a twenty-five dollar ($25) copay per visit.

iii) Hospital emergency room visits. One hundred percent (100%) of such eligible charges, minus a one hundred twenty dollar ($120) copay per visit; provided, however, that if the person is admitted into a hospital within twenty-four (24) hours of the emergency room visit, the copay shall be waived.

iv) All other eligible charges. Ninety percent (90%) of the first six thousand dollars ($6,000) of such eligible charges, and one hundred percent (100%) of such eligible charges in excess of six thousand dollars ($6,000).

Family stop loss maximum. When the ten percent (10%) not reimbursed for eligible charges in accordance with this subparagraph iv) equals one thousand two hundred dollars ($1,200) for persons in the same family unit in a calendar year, the amount for reimbursement of eligible charges subject to this subparagraph iv) for the balance of the calendar year for that family unit shall be one hundred percent (100%).

v) Network deductibles, coinsurance maximums, and out-of-pocket maximums can be satisfied only with eligible expenses incurred in the network.

vi) Telemedicine consultation. One hundred percent (100%) of such eligible charges, minus a ten dollar ($10) copay per visit.

b) Non-network services and supplies.

i) Reimbursement. Seventy percent (70%) of the first seven thousand dollars ($7,000) of such eligible charges, and one hundred percent (100%) of such eligible charges in excess of seven thousand dollars ($7,000).

Family stop loss maximum. When the thirty percent (30%) not reimbursed for eligible charges in accordance with this subparagraph equals four thousand two hundred dollars ($4,200) for persons in the same family unit in a calendar year, the amount for reimbursement of eligible charges subject to this subparagraph for the balance of the calendar year for that family unit shall be one hundred percent (100%).

ii) Deductible amount. For each calendar year, the deductible for basic medical charges for non-network services and supplies for each person is five hundred dollars ($500). A person may satisfy the deductible for a calendar year through the operation of the following provisions:

A) Normally. The deductible is satisfied by eligible charges incurred within the calendar year. The deductible is satisfied on the date a person incurs an eligible charge which, together with eligible charges previously incurred during the calendar year, equals or exceeds five hundred dollars ($500).

B) Family unit. When one thousand dollars ($1,000) of eligible charges, which may be applied toward satisfying the deductible for a calendar year, has been incurred collectively by persons in the same family unit, the deductible will be deemed satisfied for that calendar year for all enrolled persons in that family unit.

C) Newborn baby. During a newborn baby's initial hospital confinement immediately following birth, no deductible shall be applied towards the baby's hospital room and board charges or hospital nursery charge, provided that such baby is enrolled as a Dependent by the Member within sixty (60) days after birth. However, a deductible may be applied towards other charges incurred by the baby during the initial hospital confinement immediately following birth, such as, but not limited to, physician charges or laboratory tests. For purposes of this paragraph, the initial hospital confinement shall end when the baby is discharged.

iii) Preventive medical care not covered. Charges for preventive medical care are not considered eligible charges by the Network Manager administering medical care in a Managed Provider Network unless such services are provided by a network provider.

iv) Hospital emergency room and ambulance charges. Eligible charges for a hospital emergency room visit or ambulance transport, if deemed medically necessary, shall be reimbursed as a network service even though provided by a non-network provider.

v) Non-network deductibles, coinsurance maximums, and out-of-pocket maximums can be satisfied only with eligible expenses not incurred in the network.

c) Chiropractic care. The annual calendar-year limit for chiropractic care shall be twenty-six (26) visits.

d) Extended care or skilled nursing facility care.

i) Annual limit. The amount of reimbursement for extended care or skilled nursing facility room and board (including regular daily nursing services), exclusive of professional services, furnished by the extended care or skilled nursing facility for medical care therein, shall be limited to a maximum of one hundred days (100) days for all confinements during any one calendar year.

ii) Non-network care in special circumstances. If the patient is unable to obtain a bed in an in- network extended care or skilled nursing facility within fifty (50) miles of the patient's home due to full capacity, the Plan will cover a non-network extended care or skilled nursing facility at the network level of benefits.

e) Organ transplants and bone marrow/stem cell transplants. If the surgery is performed at a Blue Distinction Center of Excellence, expenses related to the surgery will be covered one hundred percent (100%) with no deductible or coinsurance applied. Also, a travel benefit, not to exceed five thousand dollars ($5,000) per

lifetime, for the patient and one human companion shall be provided, subject to Subsection 4.2 s) of the Plan and administrative guidelines established by the Board of Trustees.

f) Bariatric surgery. If the surgery is performed at a Blue Distinction Center of Excellence, the hospital expenses as described in Subsection 4.2 a) and b) will be covered one hundred percent (100%) with no deductible or coinsurance applied.

g) Hearing aids for children under age 19. Eligible charges for hearing aids for Enrolled Dependent children and other relatives under age nineteen (19), including hearing aid supplies and hearing aid exam services related to such hearing aids, shall be subject to the deductible and coinsurance applicable for this Plan Coverage Option, except for any physician office visit charges which are subject to the copay; provided, however, that reimbursement for the hearing aids shall not exceed two thousand dollars ($2,000) per aid every three (3) years.

h) Knee replacement, hip replacement, and spine surgery. If the surgery is performed at a Blue Distinction Center of Excellence, eligible hospital charges related to the surgery will be covered one hundred percent (100%) with no deductible or coinsurance applied.

SECTION II -- MANAGED MENTAL HEALTH AND SUBSTANCE ABUSE NETWORK BENEFITS

Network Manager: Cigna Behavioral Health

Summary of Benefits

SERVICES/TREATMENTS	NETWORK BENEFITS	NON-NETWORK BENEFITS
	All services and supplies must be provided or authorized by a provider in the network.	Eligible charges are subject to a customary charge limitation.
Inpatient care: Hospital and Residential Treatment Facility expenses: room and board, drug, X-ray, lab, physician, detox, and other inpatient services and supplies	100% no deductible	100% no deductible
Outpatient care: Individual or group therapy	100% except $25 Copay per visit	100% except $50 Copay per visit
Intensive outpatient services	100% no deductible	100% no deductible
Partial care	100% no deductible	100% no deductible
Applied Behavior Analysis (ABA) Therapy	100% no deductible	100% no deductible
Outpatient laboratory tests	100% no deductible	100% no deductible
Outpatient psychological testing	100% no deductible	100% no deductible

General			
General	**Deductibles per plan year:**		
	Individual deductible	None	None
	Family unit* deductible	None	None

SERVICES/TREATMENTS		NETWORK BENEFITS	NON-NETWORK BENEFITS
General (continued)	**Coinsurance maximums per plan year:** *(not applicable to Copays or deductibles)*		
	Individual coinsurance maximum	Not Applicable	Not Applicable
	Family unit* coinsurance maximum	Not Applicable	Not Applicable

* "Family unit" shall mean a Member and that Member's Enrolled Dependents.

Provisions Outlining Mental Health and Substance Abuse Benefits

The amount of reimbursement for eligible charges incurred in connection with mental health care or substance abuse care shall be:

a) Network services and supplies.

  i) Inpatient care. For each plan year, one hundred percent (100%) of eligible charges for inpatient care.

  ii) Outpatient visits. One hundred percent (100%) of such eligible charges, minus a twenty-five dollar ($25) copay per visit.

  iii) Applied Behavior Analysis (ABA) therapy. One hundred percent (100%) of eligible charges for treatment of autism or autism spectrum disorders. Only ABA therapy provided by an autism service provider, as described in Subsection 4.1 aa) of the Plan, shall be considered eligible.

b) Non-network services and supplies.

  i) Inpatient care. For each plan year, one hundred percent (100%) of eligible charges for inpatient care.

  ii) Outpatient visits. One hundred percent (100%) of such eligible charges, minus a fifty dollar ($50) copay per visit. Eligible providers of non-network outpatient care shall be limited to psychiatrists, psychologists, social workers, nurse practitioners, and professional counselors, all of whom must be licensed for independent practice for mental health care or substance abuse care in the state in which the services are provided.

  iii) Applied Behavior Analysis (ABA) therapy. One hundred percent (100%) of eligible charges for treatment of autism or autism spectrum disorders. Only ABA therapy provided by an autism service provider, as described in Subsection 4.1 aa) of the Plan, shall be considered eligible.

SECTION III – EMPLOYEE ASSISTANCE PROGRAM

Network Manager: Cigna Behavioral Health

Summary of Benefits

SERVICES/TREATMENTS	NETWORK BENEFITS
	All services must be pre-certified or authorized by the Network Manager, otherwise there is no coverage.
Confidential, solution-focused counseling and referrals for a variety of work, family, and life issues, such as marital and family difficulties, parenting challenges, child and elder care, stress and anxiety, job enrichment, financial and legal concerns, etc.	Up to six (6) free face-to-face visits per issue each year with a professional licensed counselor. Free 30-minute telephonic or face-to-face consultations with an attorney for legal questions. If legal representation is necessary, additional legal services are provided at a 25% reduction of the attorney's customary fees. Free telephone consultations with a financial planner/adviser.

SECTION IV -- PRESCRIPTION DRUG BENEFITS

Administered by Express Scripts

Summary of Benefits

SERVICES/TREATMENTS	NETWORK BENEFITS
Prescription Drugs	**Member pays:**
30 day supply or less purchased at a retail pharmacy	***Generic:*** $15 Copay ***Brand-name formulary:*** $30 Copay ***Brand-name non-formulary:*** $60 Copay
31-90 day supply purchased from a Smart90® retail pharmacy or the Network Manager home delivery pharmacy	***Generic:*** $25 Copay ***Brand-name formulary:*** $60 Copay ***Brand-name non-formulary:*** $120 Copay

Special Note: Specialty drugs will be covered by the Plan only if purchased from the specialty drug home delivery pharmacy specified by the Network Manager.

Provisions Outlining Prescription Drug Benefits

The amount of reimbursement for eligible charges incurred in connection with prescription drugs purchased from a retail pharmacy (limited to a supply of thirty (30) days or less) in the Network Manager network or from the Network Manager home delivery or Smart90® pharmacy (limited to a supply of no more than ninety (90) days) shall be as follows:

a) 30 day supply or less. One hundred percent (100%) of all charges in excess of:

i) fifteen dollars ($15) for each fill of a prescription for a generic drug;

ii) thirty dollars ($30) for each fill of a prescription for a brand-name drug listed on the published formulary of the Network Manager; or

iii) sixty dollars ($60) for each fill of a prescription for a brand-name drug which is not listed on the published formulary of the Network Manager.

b) 31-90 day supply. One hundred percent (100%) of all charges in excess of:

i) twenty-five dollars ($25) per fill of a prescription for a generic drug;

ii) sixty dollars ($60) per fill of a prescription for a brand-name drug listed on the published formulary of the Network Manager; or

iii) one hundred twenty dollars ($120) per fill of a prescription for a brand-name drug which is not listed on the published formulary of the Network Manager.

Eligible charges for maintenance/long-term therapy drugs are limited to no more than a ninety (90) day supply per fill of a prescription.

c) Specialty drugs. Eligible charges for some specialty drugs will be reimbursed only if purchased from the specialty drug home delivery pharmacy specified through the Network Manager. Notwithstanding the foregoing, eligible charges for an initial purchase of a thirty (30) day supply of a specialty drug at a network retail pharmacy will be reimbursed as set forth above.

SECTION V -- DENTAL BENEFITS

Administered by the Cigna Dental PPO through Cigna HealthCare

Summary of Benefits

SERVICES/TREATMENTS		BENEFITS
		Eligible charges are subject to an annual deductible and annual or lifetime maximum.
Preventive and Diagnostic Care	Oral exam (2 per calendar year) Cleaning (2 per calendar year) Bitewing x-rays (2 sets per calendar year) Full mouth or panoramic x-rays (1 complete set every thirty-six (36) calendar months) Fluoride application (1 per calendar year for persons under age 19) Sealants (limited to posterior tooth, only for persons under age 16, one treatment per tooth every thirty-six (36) calendar months) Space maintainers (limited to non-orthodontic treatment) Dental x-rays required for the diagnosis or treatment of a dental defect, injury, or disease Emergency care to relieve pain	100% no deductible
Basic Dental Care	Fillings, extractions, inlays, onlays, crowns*, root canal therapy, bridgework*, initial installation or replacement of complete or partial dentures*, denture adjustments or repairs, periodontal scaling and root planning**, and osseous surgery Temporomandibular joint (TMJ) disorder will be included under Basic Dental Care only if deemed by Cigna Dental to be a dental expense instead of a medical expense	80%
Dental Anesthesia	General anesthesia or sedation	80%
Oral Surgery	Any incision or excision procedure on the gums or tissue of the mouth performed in connection with the extraction or repair of teeth, including related services if otherwise included as an eligible charge under the Plan	80%

DENTAL BENEFITS (continued)

SERVICES/TREATMENTS		BENEFITS
Implant Services	Surgical Implants and Prosthesis over Implants.* If the charges for implant services are not deemed to be medically necessary by Cigna Dental, the Alternate Benefit provision (described below) will be applicable for the prosthetic being placed on the implant and no reimbursement will be made towards the charges for placement of the implant	80%
Orthodontic	Treatment and installation of orthodontic appliances for correction of irregularities in tooth position and jaw relationship	50%

* Replacement of a bridge, crown, denture or prosthetics over implants will be covered once every sixty (60) months, if unserviceable and cannot be repaired.

** Additional services may be covered at 100% for Members and Enrolled Dependents who qualify for the Network Manager's disease management oral health program. Such reimbursement, however, is subject to the annual maximum benefit for basic dental care.

General	Individual annual deductible	$100
	Family unit* annual deductible	$300
	Individual annual maximum benefit for basic dental care	$1,500
	Individual lifetime maximum benefit for orthodontic care	$1,500
Alternative Benefit Provision	When there is a choice of treatment options for dental care, reimbursement will normally be limited to the least expensive, commonly accepted dental standard for adequate and appropriate care for that dental condition, as determined by Cigna Dental. The Plan's reimbursement can be applied by the patient to the treatment of choice.	
Missing Teeth Limitation	Reimbursement for replacement of missing teeth during the first 24 months following enrollment in the Plan will be limited to 50% of the benefit otherwise payable under the Plan.	

* "Family unit" shall mean a Member and that Member's Enrolled Dependents.

Provisions Outlining Dental Benefits

Basic dental care, oral surgery, and orthodontia. After satisfaction of a person's deductible for a calendar year, and subject to the Alternate Benefit limitation under Subsection 4.1 x) of the Plan, the amount of reimbursement for eligible charges incurred in connection with dental care shall be:

a) Basic dental care. In the case of eligible charges for basic dental care:

Eighty percent (80%) of such charges but not to exceed a maximum reimbursement of one thousand five hundred dollars ($1,500) in any one calendar year.

Notwithstanding the foregoing, additional services may be covered at one hundred percent (100%) reimbursement for Members and Enrolled Dependents who qualify for the Network Manager’s disease management oral health program. Such reimbursement, however, shall be subject to the annual maximum reimbursement for basic dental care.

b) Oral surgery and dental implants. In the case of eligible charges for oral surgery and dental implant services:

Eighty percent (80%) of such charges.

Notwithstanding the foregoing, if the oral surgery includes any implant procedure, and if the charges for implant services are not deemed to be medically necessary, as determined by the agency designated by the Board of Trustees to administer the dental benefits, the Alternate Benefit provided in Subsection 4.1 x) of the Plan shall be applicable for the prosthetic being placed on the implant and no reimbursement shall be made towards the charges for placement of the implants.

c) Dental anesthesia. In the case of eligible charges for dental anesthesia:

Eighty percent (80%) of such charges.

d) Orthodontic care. In the case of eligible charges for orthodontic care:

Fifty percent (50%) of such charges, but not to exceed the lifetime maximum under Subsection 4.11 of the Plan.

e) Deductible amount. For each calendar year, the deductible amount for dental charges for each person is one hundred dollars ($100). A person may satisfy the deductible for a calendar year through the operation of the following provisions:

i) Normally. The deductible is satisfied by eligible charges incurred within the calendar year. The deductible is satisfied on the date a person incurs an eligible charge which, together with eligible charges previously incurred during the calendar year, equals or exceeds one hundred dollars ($100).

ii) Family unit. When three hundred dollars ($300) of eligible charges, which may be applied toward satisfying the deductible for a calendar year, has been incurred collectively by persons in the same family unit, the deductible will be deemed satisfied for that calendar year for all enrolled persons in that family unit.

f) Missing teeth limitation. Reimbursement for replacement of missing teeth during the first twenty-four (24) calendar months following enrollment in the Plan shall be limited to fifty percent (50%) of the benefit otherwise payable under the Plan.

g) Preventive and diagnostic care. When provided by an eligible provider, eligible charges for such dental care shall be reimbursed, without a deductible, at the rate of one hundred percent (100%); provided, however, that not more than

i) two (2) oral examinations in any calendar year,
ii) two (2) dental prophylaxes (cleanings) in any calendar year,
iii) two (2) sets of bitewing x-rays in any calendar year,
iv) one (1) panoramic or full mouth x-ray every thirty-six (36) calendar months,
v) one (1) topical application of sealant per tooth every thirty-six (36) calendar months, and
vi) one (1) topical application of fluoride in any calendar year

shall be eligible for reimbursement.

SECTION VI – VISION BENEFITS

Administered by Vision Service Plan (VSP)

Summary of Benefits

SERVICES	NETWORK BENEFITS	NON-NETWORK BENEFITS
For persons age nineteen (19) and older	All services and related products must be received or purchased through network providers.	Reimbursement at a lower level is available if a non-network provider is used.
Eye exams One exam every calendar year	$10 Member Copay	Up to $45
Prescription glasses		
Lenses: Covered once every calendar year		
Single vision	$25 Member Copay	Up to $30
Lined bifocal	$25 Member Copay	Up to $50
Lined trifocal	$25 Member Copay	Up to $65
Progressive (no line)	$25 Member Copay	Up to $50
Lenticular	$25 Member Copay	Up to $100
Frames: Covered once every other calendar year	Covered up to $150, plus 20% discount off any out-of-pocket costs	Up to $70
Contact lenses Covered every calendar year		
Elective contact lenses	$150 allowance applied to the cost of the contacts and the contact lens exam	Up to $105
Medically necessary contact lenses	Covered in full	Up to $210

NOTE: Glasses and contact lenses will not both be covered by the Plan in the same calendar year. At least one calendar year must separate the purchase of glasses and contact lenses in order for coverage to be provided for both.

VISION BENEFITS (continued)

SERVICES	NETWORK BENEFITS	NON-NETWORK BENEFITS
Miscellaneous discounts		
Additional complete set of prescription glasses or sunglasses	20% discount	Not covered
Lens extras, such as scratch resistant and anti-reflective coatings	20% discount	Not covered
Contact lenses exam (fitting and evaluation)	15% discount	Not covered
Laser vision correction	Discount varies	Not covered

Items not covered:

- Non-prescription (plano) lenses
- Two pairs of glasses instead of bifocals
- Replacement/repair of lost/broken lenses or frames
- Medical or surgical treatment
- Services/materials covered under worker's compensation
- Eye exams required as a condition of employment

Items not covered under the contact lens coverage:

- Insurance policies or service agreements
- Artistically painted or non-prescription lenses
- Additional office visits for contact lens pathology
- Contact lens modification, polishing, or cleaning

VISION BENEFITS (continued)

SERVICES	NETWORK BENEFITS	NON-NETWORK BENEFITS
For persons under age nineteen (19)	All services and related products must be received or purchased through network providers.	Reimbursement at 50% coinsurance is available if a non-network provider is used.
Eye exams One exam every calendar year	No Copay	50% coinsurance
Prescription glasses		
Lenses: Covered once every calendar year		
Single vision	Covered in full	50% coinsurance
Lined bifocal	Covered in full	50% coinsurance
Lined trifocal	Covered in full	50% coinsurance
Polycarbonate, plastic or glass lenses	Covered in full	50% coinsurance
Scratch and UV	Covered in full	50% coinsurance
Frames: Covered once every calendar year	Frames from a Pediatric Exchange Collection are covered in full, or frames from any other collection are covered up to $150	50% coinsurance
Contact lenses Covered once every calendar year		
Elective contact lenses	In lieu of eyeglasses, elective contact lens services and materials are covered in full with the following service limitations: -Standard (one pair annually) -Monthly (six month supply) -Bi-Weekly (three month supply) Dailies (three month supply)	50% coinsurance

VISION BENEFITS (continued)

SERVICES	NETWORK BENEFITS	NON-NETWORK BENEFITS
Medically necessary contact lenses	Covered in full for Members who have specific conditions for which contact lenses provide better visual correction	50% coinsurance

NOTE: Glasses and contact lenses will not both be covered by the Plan in the same calendar year. At least one calendar year must separate the purchase of glasses and contact lenses in order for coverage to be provided for both.

Items not covered:

- Two pairs of glasses instead of bifocals
- Replacement/repair of lost/broken lenses, frames, or contacts
- Medical or surgical treatment
- Orthoptics, vision training, supplemental testing

Items not covered under the contact lens coverage:

- Insurance policies or service agreements
- Artistically painted or non-prescription lenses
- Additional office visits for contact lens pathology
- Contact lens modification, polishing, or cleaning

SECTION VII -- HEARING DISCOUNT PROGRAM

Network Manager: HearUSA (also known as National Ear Care Plan)

Summary of Benefits

SERVICES/TREATMENTS	BENEFITS
	All services and related products must be pre-certified or authorized by the Network Manager, otherwise there is no coverage.
Comprehensive Audiometry Air & Bone Conduction Thresholds Word Recognition Measures	Member pays $49 *Additional charges may apply if under age 5.*
Acoustic Immittance Testing Tympanometry Acoustic Reflex Thresholds Acoustic Reflex Decay	Member pays $35
Digital Hearing Aids	Member pays total discounted price of hearing aids.
Hearing Aid Dispensing	No additional charge for fitting and dispensing fees.
Related Products, Replacement Ear Molds, and Repairs	Member pays total cost minus 20% discount (based on usual and customary fees charged by provider). Member pays total cost less 10% discount for accessories, warranties, and related products at www.hearingshop.com.
Annual Cleaning and Check (for any hearing aid purchased through HearUSA)	No charge

SECTION VIII -- SPECIAL DEFINITIONS

As used in this Schedule, the following terms, whether or not capitalized, shall mean:

"Blue Distinction Center of Excellence" – A hospital or other facility that has been selected by Blue Cross Blue Shield to be a member of a specialized network that provides organ transplants, bone marrow/stem cell transplants, cardiac care, bariatric surgery, hip or knee replacement surgery, or spine surgery. Facilities have been selected after a rigorous evaluation of clinical data that provide insight into the facility's structures, processes, and outcomes of care. Nationally established evaluation criteria were developed with input from medical experts and organizations. These evaluation criteria support the consistent objective assessment of specialty care capabilities.

"Coinsurance" – The percentage a Member must pay for covered medical or dental services after any applicable deductibles have been satisfied.

"Coinsurance maximum" – The maximum share (not including the deductible) that Members have to pay towards their covered basic medical care, preventive medical care, mental health care, and substance abuse care. Once the limit is reached, the Plan pays 100% of covered expenses that are subject to coinsurance for the remainder of the calendar year.

"Copay" – The Member's share for certain services and supplies.

"Deductible" – The amount a Member must pay for covered medical or dental services before the Plan starts to pay.

"Family unit" – A Member and that Member's Enrolled Dependents.

"Hospital Certification" – The network manager must be contacted in advance by the Plan Member or Enrolled Dependent for pre-certification of any hospital admission and ongoing stay in a hospital which is authorized or ordered by a non-network physician. For emergency admissions, call within 48 hours. If contact is not made, a $500 penalty will be imposed against the benefits otherwise payable to the Member. Also, if the patient stays in the hospital longer than approved, a $500 penalty is applicable.

"Life-threatening Emergency" – An Illness or injury that without immediate medical care could put the patient's life in danger or cause serious harm to the patient's bodily functions. Examples include possible heart attack (severe chest pain or pressure), severe bleeding, breathing problems, convulsions, sudden loss of consciousness, severe or multiple injuries, and apparent poisonings. A condition is considered to be a medical emergency if a prudent layperson (a person with an average knowledge of health and medicine) could reasonably expect that the absence of immediate medical attention would put the individual's life in jeopardy.

"Network-eligible employer" – A participating Employer with a physical address deemed by the Board of Trustees and the network manager to be within a network area.

"Network-eligible Member" – Any Plan Member whose coverage is provided through a participating network-eligible employer, and other members participating on an individual basis in the Plan who are deemed by the Board of Trustees (based on their postal ZIP code of their primary home residence) to have adequate access to network providers.

"Network provider" – Hospitals, physicians, laboratories, and other licensed health care providers who have contracted with the network manager to provide services and supplies to eligible Members.

"Network services and supplies" – All covered services and supplies received by network-eligible Members or their Enrolled Dependents which are directed, provided, or authorized by a primary care physician or a network specialty care physician and provided by a network provider.

SPECIAL DEFINITIONS (continued)

"Non-network services and supplies" – All covered services and supplies received by network-eligible Members or their Enrolled Dependents which are not directed, provided, or authorized by a primary care physician or network specialty care physician, or which are not obtained from a network provider.

"Organ and bone marrow/stem cell transplants" – Transplants covered by the Blue Distinction Center of Excellence program are: heart; lung; combination of heart/bilateral lung; liver; simultaneous pancreas and kidney (SPK); pancreas (PAK/PTA); combination liver and kidney; and bone marrow/stem cell (autologous and allogeneic). This list is subject to modification by Blue Cross Blue Shield. (NOTE: Kidney and cornea transplants are not considered organ or bone marrow/stem cell transplants, but are covered by the Plan like other medical services if considered medically necessary.)

"Out-of-pocket maximum" – The combined total of a Member's deductible(s) and coinsurance maximum(s). The out-of-pocket maximum does not include amounts above the customary charge limit, applicable penalties, flat dollar copays, and charges not covered or otherwise limited.

"Preventive medical care" – When not performed in connection with an Illness, preventive medical care will include the following: routine preventive medical evaluation, school physical examination, sports physical examination, well-baby checkup, standard immunization, cancer screening, lab test required for checkup purposes, and blood pressure check. Non-routine tests for certification (such as sports insurance, etc.) are not covered unless medically necessary.

"Primary Care Physician" – The Physician, selected by the network-eligible Member from a list of network providers, who provides medical care in one or more of the following areas: internal medicine, pediatrics, family practice, general practice, or, in some network areas, obstetrics/gynecology.

"Urgent care" – Care provided in an outpatient facility or clinic, in lieu of a hospital emergency room, to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention. It is recommended that the Plan Member make contact with his/her network physician prior to seeking such care to assess the appropriateness of the treatment location.

Schedule A
Option A

Network Managers

BENEFIT	NETWORK MANAGER	NETWORK AREA	NETWORK
Basic and Preventive Medical Care	Blue Cross Blue Shield of Minnesota 800-793-6922 or *www.bluecrossmn.com/concordia*	United States*	BlueCard PPO
	Blue Cross Blue Shield of Minnesota 800-810-BLUE or *www.bluecrossmn.com/concordia*	Outside United States	BlueCard Worldwide
	BlueCross Blue Shield of Minnesota 800-793-6922 or www.bluecrossmn.com/concordia	St. Louis, MO Metropolitan areas*	BlueAccess Choice
		Kansas City, KS and Kansas City, MO metropolitan areas*	PreferredCare Blue
		Wisconsin*	Blue Preferred POS
Mental Health and Substance Abuse Care	Cigna Behavioral Health 866-726-5267 or *www.cignabehavioral.com*	United States	CBH Network of Participating Providers
Employee Assistance Program (EAP)	Cigna Behavioral Health 866-726-5267 or *www.cignabehavioral.com*	United States	EAP Network
Prescription Drugs	Express Scripts 800-789-7488 or *www.express-scripts.com*	United States	National Plus
Dental Care	Cigna Dental 800-244-6224 or *www.cigna.com*	United States	Core Network
Vision Care	Vision Service Plan Call 800-877-7195 or *www.vsp.com*	United States	Choice Plan
Hearing Discount Program	HearUSA 800-442-8231 or *www.hearusa.com*	United States	HearUSA Hearing Care Network

*The state of Wisconsin and certain counties in the St. Louis, Missouri, Kansas City, Kansas and Kansas City, Missouri metropolitan areas are covered by separate managed provider networks and are not covered by the BlueCard network. Please contact Blue Cross Blue Shield of Minnesota for more information about providers in these areas.

To locate participating providers for each network manager, members should contact the applicable network manager. Phone and website information is also available at *ConcordiaPlans.org*. Network and contact information for some network managers may be accessible on the member Identification Card or other card provided to members by the Network Manager.

Grandfathered Status

Concordia Plan Services believes the Concordia Health Plan (CHP) is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the CHP may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement to provide an internal and external appeal review process. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Concordia Plan Services at 888-927-7526. You may also contact the U.S. Department of Health and Human Services at ***www.healthreform.gov***.

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