

CONCORDIA HEALTH PLAN

Schedule H

Coverage for Option HDHP

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

Basic medical care, preventive medical care, mental health care, and substance abuse care. This Schedule describes the benefits applicable for Option HDHP, which is an HSA-compliant High Deductible Health Plan. Blue Cross Blue Shield of Minnesota (BCBS-MN) is the network manager or, if selected by the adopting Employer, UMR, a UnitedHealthcare company, is the network manager for this option (see page 22). Network providers should be used by Members to access care. Generally, out-of-pocket costs are lower for services from network providers than non-network providers.

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.

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

Dental care and preventive dental care. Cigna Dental administers the dental 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 Cigna Dental.

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 administers a discount program for routine hearing screenings and testing, as well as purchase of hearing aids. Ear Professionals International Corporation (EPIC) Hearing Health Care administers a discount hearing program that is also available to Members in the UMR network.

SECTION I – Benefits for Basic Medical Care, Preventive Medical Care, Prescription Drugs, Mental Health Care, and Substance Abuse Care

**Network Manager: Blue Cross Blue Shield of Minnesota or UMR
Network Manager for Prescription Drugs: Express Scripts**

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.	All 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 (<i>under age six</i>)	100%	80% after deductible
	Routine preventive medical evaluation, including vision and hearing screenings, and standard immunizations (<i>age 6 and older</i>)	100%	80% after deductible
	Routine lab tests, including but not limited to, diabetes screening and lipid profile (including total and HDL cholesterol)	100%	80% after deductible
	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%	80% after deductible
	Routine outpatient prenatal care (including the initial visit to diagnose pregnancy)	100%	80% after deductible

SERVICES/TREATMENTS		NETWORK BENEFITS	NON-NETWORK BENEFITS
Medical Services in Physician's Office	Primary Care Physician office visits (includes lab tests or x-rays performed in the office)	100% after deductible	80% after deductible
	Specialist office visits (includes lab tests or x-rays performed in the office)	100% after deductible	80% after deductible
	Second surgical opinions (not mandatory)	100% after deductible	80% after deductible
	Chiropractic care (26 visits per calendar year)	100% after deductible	80% after deductible
	Physical, occupational, or speech therapy	100% after deductible	80% after deductible
	Allergy care by specialist (including allergy shots)	100% after deductible	80% after deductible
	Mental health or substance abuse counseling	100% after deductible	80% after deductible
Hospital Services	Room, board, and other services/supplies (semi-private room rate)	100% after deductible	80% after deductible <i>(Hospital certification required for all BCBS-MN covered hospital admissions, otherwise \$500 penalty applied)</i>
	Newborn care	100% after deductible	80% after deductible
	Hospital emergency room	100% after deductible	100% after deductible
Medical & Surgical Services While Hospitalized	Surgery and related expenses such as anesthesia, assistant surgeon	100% after deductible	80% after deductible
	Physician's expense – pregnancy delivery charge and related inpatient services	100% after deductible	80% after deductible
	Physician visit in hospital	100% after deductible	80% after deductible
	Blood transfusions	100% after deductible	80% after deductible

SERVICES/TREATMENTS		NETWORK BENEFITS	NON-NETWORK BENEFITS
Medical & Surgical Services While Hospitalized (cont.)	Physical, occupational or speech therapy	100% after deductible	80% after deductible
	Organ transplant or bone marrow/stem cell transplants*	100% after deductible	80% after deductible
<i>*If using a Specialty Care Facility, a travel benefit is provided as described in Subsection 4.2 s) and in administrative guidelines established by Concordia Plan Services.</i>			
Outpatient Services	Diagnostic x-ray and lab	100% after deductible	80% after deductible
	Surgery and related expenses	100% after deductible	80% after deductible
	Pre-admission testing	100% after deductible	80% after deductible
	Physical, occupational, or speech therapy	100% after deductible	80% after deductible
	Applied Behavior Analysis (ABA) therapy	100% after deductible	80% after deductible
Other Services	Prescription drugs	100% after deductible	100% after deductible <i>(limited to network reimbursement amount)</i>
	Home health care	100% after deductible	80% after deductible
	Urgent care or telemedicine	100% after deductible	80% after deductible
	Ambulance and approved emergency air transport services <i>(if medically necessary)</i>	100% after deductible	80% after deductible
	Extended care or skilled nursing facility <i>(up to 100 days per calendar year covered)</i>	100% after deductible	80% after deductible
	Residential treatment facility or hospital day care for mental health or substance abuse care	100% after deductible	80% after deductible
	Hospice care	100% after deductible	80% after deductible

SERVICES/TREATMENTS		NETWORK BENEFITS	NON-NETWORK BENEFITS
Other Services (cont.)	Kidney dialysis (after 12 months, Member must apply for Medicare Part A and Part B)	100% after deductible	80% after deductible
	Radiation therapy and chemotherapy	100% after deductible	80% after deductible
	Tubal ligation or vasectomy	100% after deductible	80% after deductible
	Accidental injury to natural teeth (treatment must begin within 12 months after accident, and be completed within 24 months after initial treatment)	100% after deductible	80% after deductible
	Temporomandibular joint (TMJ) disorder – only if deemed to be a medical expense by the network’s medical review department	100% after deductible	80% after deductible
Supplies and Equipment	Medical supplies, durable medical equipment	100% after deductible	80% after deductible
	Prosthetic or orthopedic devices (artificial limbs or eyes, braces, etc.). Also covers replacement of these devices when required by person's growth to maturity.	100% after deductible	80% after deductible

See next page for deductibles, coinsurance maximums, out-of-pocket maximums, and maximum benefits.

SERVICES/TREATMENTS		NETWORK BENEFITS	NON-NETWORK BENEFITS
Deductibles	Individual annual deductible	\$2,850	\$8,550
	Family unit annual deductible	\$5,700	\$17,100
Annual Coinsurance Maximums: <i>(does not include deductibles)</i>	Individual coinsurance maximum	\$-0-	\$5,500
	Family unit coinsurance maximum	\$-0-	\$16,500
<p>“Coinsurance” is the percentage of a charge a Member must pay for covered charges after any applicable deductibles have been satisfied (i.e., normally 20% for non-network charges). Once a coinsurance maximum is reached, the remaining eligible charges normally subject to coinsurance in that year will be covered at 100% by the plan.</p>			
Annual Out-of-Pocket Maximums <i>(deductibles & coinsurance)</i>	Individual out-of-pocket maximum	\$2,850	\$14,050
	Family unit out-of-pocket maximum	\$5,700	\$33,600
<p>The out-of-pocket maximum is the deductible(s) and coinsurance amount(s) added together. It reflects the Member’s maximum share during a calendar year for the cost of covered basic medical care, preventive medical care, prescription drugs, mental health care, and substance abuse care.</p>			
Maximum Benefits <i>(limits apply to network & non-network benefits combined)</i>	Individual <u>annual</u> maximum benefit for chiropractic care	26 visits per calendar year	
	Individual <u>lifetime</u> maximum benefit for all benefits paid by the CHP	Unlimited lifetime limit	

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.

**PROVISIONS OUTLINING BENEFITS FOR BASIC MEDICAL CARE, PREVENTIVE
MEDICAL CARE, PRESCRIPTION DRUGS, MENTAL HEALTH CARE,
AND SUBSTANCE ABUSE CARE**

After satisfaction of any required deductible for a calendar year, the amount of reimbursement for eligible medical charges, which for purposes of this Section I shall include basic medical care, preventive medical care, prescription drugs, mental health care, and substance abuse care, except as otherwise included elsewhere in this Schedule, shall be:

- a) Network services and supplies.
 - i) Annual deductible. For each calendar year, for eligible network services and supplies, the deductible for each person for basic medical charges for network services and supplies is two thousand eight hundred fifty dollars (\$2,850). A person may satisfy the deductible for a calendar year through the operation of the following provisions:
 - A) Individual. 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 two thousand eight hundred fifty dollars (\$2,850).
 - B) Family unit. When five thousand seven hundred dollars (\$5,700) of eligible charges, which may be applied toward satisfying the deductible for a calendar year, has been incurred collectively by the family unit, the deductible will be deemed satisfied for that calendar year for all enrolled persons in that family unit.
 - ii) Reimbursement after deductible is satisfied.
 - A) Individual. For each calendar year, the plan shall pay for a covered person one hundred percent (100%) of eligible medical charges for network services and supplies after the individual deductible is satisfied, up to any annual maximum benefits of the plan.
 - B) Family unit. For each calendar year, for a Member with at least one Enrolled Dependent, the plan shall pay one hundred percent (100%) of eligible medical charges for network services and supplies incurred by the family unit after the family unit deductible is satisfied, up to any annual maximum benefits of the plan.
 - iii) Preventive medical care. Notwithstanding the foregoing, the annual deductible shall be waived for preventive medical care received in network, and the plan shall pay one hundred percent (100%) of eligible charges.
 - iv) Network amounts. Network deductibles, coinsurance maximums, and out-of-pocket maximums can be satisfied only with eligible expenses incurred in the network.
- b) Non-network services and supplies.
 - i) Annual deductible. For each calendar year, for eligible non-network services and supplies, the deductible for each person for basic medical charges for non-network services and supplies is eight thousand five hundred fifty dollars (\$8,550). A person may satisfy the deductible for a calendar year through the operation of the following provisions:

**PROVISIONS OUTLINING BENEFITS FOR BASIC MEDICAL CARE, PREVENTIVE
MEDICAL CARE, PRESCRIPTION DRUGS, MENTAL HEALTH CARE,
AND SUBSTANCE ABUSE CARE**

- A) Individual. 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 eight thousand five hundred fifty dollars (\$8,550).
 - B) Family unit. When seventeen thousand one hundred dollars (\$17,100) of eligible charges, which may be applied toward satisfying the deductible for a calendar year, has been incurred collectively by the family unit, the deductible will be deemed satisfied for that calendar year for all enrolled persons in that family unit.
- ii) Reimbursement after deductible is satisfied.
- A) Individual. For each calendar year after the individual deductible is satisfied, the plan shall pay for a covered person eighty percent (80%) of eligible medical charges for non-network services and supplies until the individual coinsurance maximum of five thousand five hundred dollars (\$5,500) is satisfied, and thereafter one hundred percent (100%) of eligible charges, subject to any annual benefits of the plan.
 - B) Family unit. For each calendar year after the family unit deductible is satisfied, the plan shall pay eighty percent (80%) of eligible medical charges for non-network services and supplies incurred by the family unit until the family unit coinsurance maximum of sixteen thousand five hundred dollars (\$16,500) is satisfied, and thereafter one hundred percent (100%) of eligible charges, up to any annual benefits of the plan. When the family unit coinsurance amount is satisfied by one person in the family unit or collectively by persons in the same family unit, it will be deemed satisfied for all enrolled persons in that family unit.
- iii) 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.
- iv) Non-network amounts. 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.

**PROVISIONS OUTLINING BENEFITS FOR BASIC MEDICAL CARE, PREVENTIVE
MEDICAL CARE, PRESCRIPTION DRUGS, MENTAL HEALTH CARE,
AND SUBSTANCE ABUSE CARE**

- 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) Prescription drugs.
 - i) Eligible charges for maintenance/long-term therapy drugs will be limited to no more than a ninety (90) day supply per prescription.

 - ii) Specialty drugs, as defined in Subsection 4.1 s) iii) will be covered by the plan only if purchased from the mail order pharmacy designated by the prescription drug Network Manager and will be limited to no more than a thirty (30) day supply per prescription.

- f) Hearing aids for children under age 19. Eligible charges for hearing aids for Enrolled Dependent children and other relatives under age 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; provided, however, that reimbursement for the hearing aids shall not exceed two thousand dollars (\$2,000) per aid every three (3) years.

- g) Applied Behavior Analysis (ABA) therapy. Eligible charges for ABA therapy for treatment of autism or autism spectrum disorders must be provided by an autism service provider, as described in Subsection 4.1 aa) of the plan.

SECTION II -- EMPLOYEE ASSISTANCE PROGRAM

Network Manager: Cigna Behavioral Health

Summary of Benefits

EAP 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, identity theft, and bereavement counseling.

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 III -- DENTAL BENEFITS

**Administered by the Cigna Dental PPO
through Cigna HealthCare**

Summary of Benefits

DENTAL SERVICES/TREATMENTS	BENEFITS
	Eligible charges are subject to an annual deductible and annual or lifetime maximums.
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 <i>(1 complete set every thirty-six (36) calendar months)</i> 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
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
Dental Anesthesia	General anesthesia or sedation
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

DENTAL SERVICES/TREATMENTS		BENEFITS
Implant Services	Surgical Implants and Prosthesis Over Implants* <i>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</i>	80% after deductible
Orthodontic	Treatment and installation of orthodontic appliances for correction of irregularities in tooth position and jaw relationship	50% after deductible
<p>* Replacement of a bridge, crown, denture or prosthetics over implants will be covered once every sixty (60) months, if unserviceable and cannot be repaired.</p> <p>** Additional services may be covered at one hundred percent (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.</p>		
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
* "Family unit" shall mean a Member and that Member's Enrolled Dependents.		
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.	

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%) 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.

PROVISIONS OUTLINING DENTAL BENEFITS

- 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 IV – VISION BENEFITS

Administered by Vision Service Plan (VSP)

Summary of Benefits

VISION 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 SERVICES	NETWORK BENEFITS	NON-NETWORK BENEFITS
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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.
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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 for persons age nineteen (19) and older:

- 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 for persons age nineteen (19) and older:

- 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 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	No Copay	50% coinsurance
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:	50% coinsurance
	–Standard (one pair annually)	
	–Monthly (six month supply)	
	–Bi-Weekly (three month supply)	
	–Dailies (three month supply)	
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 for persons under age nineteen (19):

- 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 for persons under age nineteen (19):

- 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 V -- HEARING DISCOUNT PROGRAM

Network Manager: HearUSA*

Summary of Program

HEARING SERVICES/TREATMENTS	MEMBER'S COST
	All services and related products must be authorized by the Network Manager, otherwise there is no coverage.
Comprehensive Audiometry Air & Bone Conduction Thresholds Word Recognition Measures	Member pays \$49 <i>Additional charges may apply if under age 5.</i>
Acoustic Immittance Testing Tympanometry Acoustic Reflex Thresholds Acoustic Reflex Decay	Member pays \$35
Digital Hearing Aids	Member pays discounted price
Related Products, Replacement Ear Molds, and Repairs	Member pays discounted price
Annual Cleaning and Check (for any hearing aid purchased through HearUSA)	No charge

**Members in the UMR network also receive discounted services through EPIC Hearing Health Care.*

SECTION VI -- SPECIAL DEFINITIONS

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

“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” – If coverage is with network manager Blue Cross Blue Shield of Minnesota, 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 that 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.

“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 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.

“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 Specialty Care Facility 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 the applicable network manager. (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.

“Specialty Care Facility” – A hospital or other facility that has been selected by the network manager to be a member of a network that provides specialized care for certain services such as organ transplants. In the case of network manager Blue Cross Blue Shield of Minnesota, the specialty care facility program is known as the Blue Distinction Center of Excellence program and for network manager UMR, the Optum Centers for Excellence program. The list of specialized services and network facilities is subject to modification by the network manager.

“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 H
Option HDHP**

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
		St. Louis, MO Metropolitan areas*	BlueAccess Choice
		Kansas City, KS and Kansas City, MO metropolitan areas*	PreferredCare Blue
		Wisconsin*	Blue Preferred POS
	BlueCross Blue Shield of Minnesota 800-810-BLUE or www.bluecrossmn.com/concordia	Outside United States	BlueCard Worldwide
	United Medical Resources 800-207-3172 or www.umar.com	United States	Choice Plus Network
Mental Health and Substance Abuse Care	Cigna Behavioral Health 866-726-5267 or www.cignabehavioral.com	United States	CBH Network of Participating Providers
	United Medical Resources 800-207-3172 or www.umar.com	United States	Choice Plus Network
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 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
	EPIC Hearing Health Care 877-606-3742 or www.epichearing.com	United States	EPIC 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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