CONCORDIA HEALTH PLAN
Schedule HMO-C

Coverage for Option HMO-C

This Schedule provides the amount of reimbursement for benefits under Plan Coverage Option HMO-C, for Members and Dependents enrolled in such Option, and replaces Subsections 4.5 through 4.12 a) 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 HMO-C, which is an HMO (Health Maintenance Organization) program. Cigna HealthCare of California is the network manager for this option, which is available only in California (see page 26). Participating network providers must be used to access care since no coverage is available outside the network.

Mental health and substance abuse care. Cigna Behavioral Health administers the mental health and substance abuse benefits. Participating network providers must be used to access care.

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.

Prescription drugs. Cigna HealthCare administers the prescription drug coverage. Prescription drugs may be purchased by the Member at a local pharmacy or, for long-term medications, through Cigna's mail order service, except for specialty drugs which must be purchased from the Cigna specialty mail order pharmacy.

Dental care and preventive dental care. Cigna Dental administers the dental benefits. If network providers are used, the Member will have lower out-of-pocket costs; however, non-network providers may also be used.

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 routine hearing screenings and testing, as well as purchase of hearing aids.

SECTION I – BASIC MEDICAL CARE AND PREVENTIVE MEDICAL CARE BENEFITS

Network Manager: Cigna HealthCare

Summary of Benefits

SERVICES/TREATMENTS		NETWORK BENEFI	NON-NETWORK BENEFITS
		All services and supplies must be provided or authorized by the Primary Care Physician (except OB/GYN care)	No benefits are available for services or supplies received outside the network or not authorized by the Primary Care Physician
Preventive Medical Care	Periodic routine physical exams	100% after $20 copay per visit	Not Covered
	Well-child care	100% after $20 copay per visit	Not Covered
	Immunizations	100% *	Not Covered
	Mammograms for routine, checkup purposes	100% *	Not Covered
	* *If there is an office visit charge, $20 copay applies.*		
Medical Services in Physician's Office	Primary Care Physician office visits (includes lab tests or x-rays performed in the office)	100% after $20 copay per visit	Not Covered
	Specialist Physician office visits (includes lab tests or x-rays performed in the office)	100% after $20 copay per visit	Not Covered
	Second surgical opinions (not mandatory)	100% after $20 copay per visit	Not Covered
	Gynecological care visits (includes Pap test)	100% after $20 copay per visit	Not Covered
	Obstetrical care--pregnancy (physician's fee only)	100% except for one $20 copay per pregnancy	Not Covered

BASIC MEDICAL CARE AND PREVENTIVE MEDICAL CARE BENEFITS (continued)

SERVICES/TREATMENTS		NETWORK BENEFITS	NON-NETWORK BENEFITS
Medical Services In Physician's Office (cont.)	Chiropractic care *(maximum 20 days per year)*	100% after $15 copay per visit	Not Covered
	Allergy care by specialist	$20 copay or actual charge, whichever is less	Not Covered
	Allergy shots (serum) if no office visit charge	100%	Not Covered
Hospital Services	Room, board, and other services/supplies	100% after $430 copay per admission	Not Covered
	Routine newborn care	100%*	Not covered
	* If baby stays in hospital after mother is discharged, a separate $430 copay may apply.		
	Hospital emergency room *(see page 24 for more information on emergencies)*	100% after $90 copay per visit (no copay if admitted into hospital)	
Medical & Surgical Services While Hospitalized	Surgery and related expenses such as anesthesia, assistant surgeon	100%	Not Covered
	Physician's expense--pregnancy delivery charge	Included as part of obstetrical care listed under "Medical Services in Physician's Office"	Not covered
	Physician visit in hospital	100%	Not Covered
	Blood transfusions	100%	Not Covered
	Physical, occupational, speech, pulmonary, or cognitive therapy	100%	Not Covered
	Advanced radiological imaging (e.g., MRI, MRA, CAT Scan, PET Scan, etc.)	100%	Not Covered

SERVICES/TREATMENTS		NETWORK BENEFITS	NON-NETWORK BENEFITS
Outpatient Services	Diagnostic x-ray and lab	100%	Not Covered
	Advanced radiological imaging (e.g., MRI, MRA, CAT Scan, PET Scan, etc.)	100%	Not Covered
	Surgery and related expenses	100%	Not Covered
	Pre-admission testing	100%	Not Covered
	Physical, occupational, speech, pulmonary, or cognitive therapy	100% after $25 copay per visit	Not Covered
	Cardiac rehabilitation	100% after $25 copay per visit	Not Covered
	Outpatient facility charge	100% after $430 copay per visit	Not Covered
	Urgent care facility	100% after $90 copay per visit	
	Outpatient facility charge	100% after $430 Copay per visit	Not Covered
Other Services	Home health care	100%	Not covered
	Ambulance and approved emergency air transport services (only covered if a true emergency)	100%	100%
	Extended care or skilled Nursing facility *(up to 100 days Per calendar year covered)*	100%	Not covered
	Hospice care	100%	Not covered
	Telemedicine consultation	100% after $10 copay	Not covered
Supplies and Equipment	Medical supplies, durable medical equipment	100%	Not covered
	Prosthetic or orthopedic devices (artificial limbs or eyes, braces, etc.)	100%	Not covered

SERVICES/TREATMENTS		NETWORK BENEFITS	NON-NETWORK BENEFITS
General	**Deductibles:**	None	None
	Annual out-of-pocket maximums: *(applies to copays)*		
	Individual out-of-pocket maximum	$1,850	Not applicable
	Family unit* out-of-pocket maximum	$5,550	Not applicable
	NOTE: The annual out-of-pocket maximums are satisfied by a combination of all copays paid by the Member for covered medical expenses (described in this Section I) and covered mental health/substance abuse expenses (described in Section II of this Schedule).		
	Annual maximums:		
	Chiropractic care	20 days** per calendar year	Not applicable
	Extended care facility or skilled nursing facility	100 days per calendar year	Not applicable
	Lifetime maximum:		
	Individual lifetime maximum benefit for all benefits paid by the CHP	Unlimited	Not applicable

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

** If multiple chiropractic services are provided on the same day, they will constitute one day, but a separate copay will apply to the services provided by each provider.

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

Provisions Outlining Basic Medical Care and Preventive Medical Care Benefits

The amount of reimbursement for eligible medical charges, when provided by an eligible network provider and except as otherwise included elsewhere in this Schedule, shall be:

a) Primary Care Physician office visits. One hundred percent (100%) of such eligible charges, minus a twenty dollar ($20) copay per visit.

b) Specialist Physician office visits. One hundred percent (100%) of such eligible charges, minus a twenty dollar ($20) copay per visit.

c) Hospital emergency room visits. At any hospital (including non-network hospitals), one hundred percent (100%) of such eligible charges, minus a ninety dollar ($90) copay per visit; provided, however, that if the person is admitted into the hospital from the emergency room, the copay shall be waived.

d) Inpatient hospital charges. One hundred percent (100%) of such eligible charges, minus a four hundred thirty dollar ($430) copay for each hospital admission.

e) Urgent care facility charges. For urgent care at any urgent care facility (including non-network facilities), one hundred percent (100%) of such eligible charges, minus a ninety dollar ($90) copay per visit.

f) Outpatient facility charges. One hundred percent (100%) of such eligible charges, minus a four hundred thirty dollar ($430) copay.

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

h) Specialized services and supplies.

i) Preventive medical care. One hundred percent (100%) of such eligible charges, minus a twenty dollar ($20) copay per visit; provided, however, that the copay shall be waived for immunizations and mammograms unless there is a physician office visit charge.

ii) Physician's obstetrical care for pregnancy. One hundred percent (100%) of such eligible charges, minus a single twenty dollar ($20) copay per pregnancy.

iii) Allergy care. One hundred percent (100%) of eligible charges minus a twenty dollar ($20) copay per visit, or the actual charge, whichever is less. If there is no office visit charge for allergy shots (serum), one hundred percent (100%) of the eligible charge.

iv) Outpatient physical, occupational, speech, pulmonary, or cognitive therapy. One hundred percent (100%) of such eligible charges, minus a twenty-five dollar ($25) copay per visit.

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

vi) Chiropractic care. One hundred percent (100%) of such eligible charges, minus a fifteen dollar ($15) copay per visit, up to twenty (20) days per calendar year. If multiple visits occur on the same day, they will constitute one day, but a separate copay will apply to the services provided by each provider.

vii) Home health care, including private duty nursing when approved as medically necessary. One hundred percent (100%) of such eligible charges.

viii) Extended care or skilled nursing facility care. One hundred percent (100%) of such eligible charges 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, up to a maximum of one hundred days (100) days for all confinements during any one calendar year.

ix) Accidental injury to natural teeth. One hundred percent (100%) of such eligible charges, provided that treatment is started within twelve (12) months after the accident, and completed within twenty-four (24) months of initial treatment, including replacement of such teeth within that period. Accidental injury to teeth does not include injury to teeth while eating.

x) 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 covered one hundred percent (100%), except for any physician office visit charges which are subject to the copay; provided, however, that reimbursement for all such charges shall not exceed four thousand dollars ($4,000) per calendar year.

xi) All other services and supplies. One hundred percent (100%) of such eligible charges.

i) Annual out-of-pocket maximums.

j) Individual. When copays for an individual for (A) eligible medical expenses described in this Section I and (B) eligible mental health and substance abuse expenses described in Section II equal one thousand eight hundred fifty dollars ($1,850) in a calendar year, all remaining copays for that individual for eligible expenses described in Sections I or II of this Schedule for the balance of the calendar year shall be waived by the Plan.

ii) Family unit. When copays for the family unit for (A) eligible medical expenses described in this Section I and (B) eligible mental health and substance abuse expenses described in Section II equal five thousand five hundred fifty dollars ($5,550) in a calendar year, all remaining copays for the family unit for eligible expenses described in Sections I or II of this Schedule for the balance of the calendar year shall be waived by the Plan.

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

Network Manager: Cigna Behavioral Health

Summary of Benefits

SERVICES/TREATMENTS	NETWORK BENEFITS
	All services and supplies must be provided by a provider in the network, otherwise there is no coverage. Some services must be preauthorized by the Network Manager (see below).
Inpatient care Hospital and Residential Treatment Facility expenses: room and board, drug, X-ray lab, physician, detox, and other inpatient services and supplies	100%, except for a $430 copay per admission
Intensive outpatient care	100% after $20 copay per program
Outpatient visits Individual or group therapy	100% after $20 copay per visit
Applied Behavior Analysis (ABA) therapy	100%
Outpatient laboratory tests	100%
Outpatient psychological testing	100%
Behavioral telehealth consultation	100% after $10 copay per visit

Pre-certification: Admission into a hospital or residential treatment facility must be pre-certified (or pre-authorized) by the Network Manager. For emergency admissions, call the Network Manager within 48 hours of admission in order to secure approval. If contact is not made, or if the patient stays in the hospital or facility longer than approved, a $500 penalty will be deducted from the benefits otherwise payable to the Member.

Annual Out-of-pocket Maximums: *(applies to copays)*

Individual out-of-pocket maximum — $1,850**
Family unit* out-of-pocket maximum — $5,550**

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

**The annual out-of-pocket maximums can be satisfied by a combination of all copays paid by the Member for covered medical expenses (described in Section I of this Schedule) and covered mental health/substance abuse expenses (described in this Section II).

Lifetime maximum: Unlimited

Provisions Outlining Mental Health and Substance Abuse Benefits

Subject to the pre-approval requirements outlined in Subsections 4.12 of the Plan, the amount of reimbursement for eligible charges incurred in connection with mental health care or substance abuse care shall be:

a) Hospital confinement or residential treatment facility. For each calendar year, one hundred percent (100%) of eligible charges, minus a four hundred thirty dollar ($430) copay for each admission, for room and board and all other related eligible services and supplies while in a hospital or residential treatment facility.

b) Intensive outpatient care. One hundred percent (100%) of eligible charges, minus a twenty dollar ($20) copay per program.

c) Outpatient individual and group therapy visits. One hundred percent (100%) of eligible charges, minus a twenty dollar ($20) copay per visit.

"Group Therapy" means therapy received in a group setting of unrelated persons. "Individual Therapy" means therapy received by an individual or by an individual along with related family members.

d) 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.

e) Outpatient laboratory tests. For outpatient laboratory tests ordered by a behavioral health provider, one hundred percent (100%) of eligible charges.

f) Outpatient psychological testing. For outpatient psychological testing ordered by a behavioral health provider, one hundred percent (100%) of eligible charges.

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

h) Annual out-of-pocket maximums.

i) Individual. When copays for an individual for (A) eligible medical expenses described in Section I and (B) eligible mental health and substance abuse expenses described in this Section II equal one thousand eight hundred fifty dollars ($1,850) in a calendar year, all remaining copays for that individual for eligible expenses described in Sections I or II of this Schedule for the balance of the calendar year shall be waived by the Plan.

ii) Family unit. When copays for the family unit for (A) eligible medical expenses described in Section I and (B) eligible mental health and substance abuse expenses described in this Section II equal five thousand five hundred fifty dollars ($5,550) in a calendar year, all remaining copays for the family unit for eligible expenses described in Sections I or II of this Schedule for the balance of the calendar year shall be waived by the Plan.

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 Cigna HealthCare

Summary of Benefits

SERVICES/TREATMENTS	BENEFITS
Prescription Drugs Purchased at a Participating Retail Pharmacy (typically for acute/short-term drugs, up to 30-day supply per prescription)	Member pays: ***Generic:*** $15 copay ***Brand-Name:*** $25 copay ***Non-Preferred:*** $40 copay
Prescription Drugs Purchased Through Cigna's Mail Order Drug Program "Tel-Drug" (typically for maintenance/long- term drugs, up to 90-day supply per prescription)	Member pays: ***Generic:*** $25 copay ***Brand-Name:*** $50 copay ***Non-Preferred:*** $80 copay
Special Note: As described on the next page, specialty drugs, which are high-cost oral or injectable medications used to treat certain complex conditions, are limited to a 30-day supply and are subject to specific copays.	

Provisions Outlining Prescription Drug Benefits

The amount of reimbursement for eligible charges incurred in connection with prescription drugs shall be:

a) Prescription drugs purchased at a participating retail pharmacy. One hundred percent (100%) of all charges in excess of:

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

   ii) twenty-five dollars ($25) for each prescription for a brand-name drug listed on the published formulary of the agency designated by the Board of Trustees to administer these benefits; or

   iii) forty dollars ($40) for each prescription for a brand-name drug which is not listed on the published formulary of the agency designated by the Board of Trustees to administer these benefits

   Eligible charges for prescription drugs purchased at a participating retail pharmacy will be limited to no more than a thirty (30) day supply per prescription.

b) Prescription drugs purchased through the mail order pharmacy. Maintenance/long-term therapy drugs typically with a supply beyond thirty (30) days are available for purchase from the mail order pharmacy designated by the Board of Trustees and will be reimbursed at one hundred percent (100%) of all charges in excess of:

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

   ii) fifty dollars ($50) per prescription for a brand-name drug listed on the published formulary of the mail order pharmacy; or

   iii) eighty dollars ($80) per prescription for a brand-name drug which is not listed on the published formulary of the mail order pharmacy.

Each refill shall be deemed to be a new prescription.

   Eligible charges for prescription drugs purchased through the mail order pharmacy will be limited to no more than a ninety (90) day supply per prescription.

c) Specialty drugs. One hundred percent (100%) of all charges for specialty drugs, as defined in Subsection 4.1 s) iii) of the Plan, in excess of:

   i) eight dollars ($8) for each prescription for a generic drug;

   ii) sixteen dollars ($16) for each prescription for a brand-name drug listed on the published formulary of the agency designated by the Board of Trustees to administer these benefits; or

   iii) twenty-six dollars ($26) for each prescription for a brand-name drug that is not listed on the published formulary of the agency designated by the Board of Trustees to administer these benefits.

   Eligible charges for specialty drugs will be limited to no more than a thirty (30) day supply per prescription.

d) Prescription drugs are covered only if purchased at a participating pharmacy designated as a network provider or through the mail order pharmacy designated by the Board of Trustees.

e) The second sentence of Subsection 4.1 s) i) of the Plan shall not apply to this Schedule.

SECTION V -- DENTAL BENEFITS

Administered by the Cigna Dental PPO

Summary of Benefits

SERVICES/TREATMENTS		NETWORK BENEFITS	NON-NETWORK BENEFITS
		All services and supplies must be provided for a network provider.	Eligible charges are based on reasonable and customary allowances.
CLASS I 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 3 years) Fluoride application (2 per calendar year for persons under age 19) Sealants (limited to posterior tooth, only for persons under age 16, one treatment per tooth every 3 calendar years) 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)	90% (no deductible)
CLASS II Basic Restorative Services	Fillings; root canal therapy; osseous surgery; periodontal scaling and root planing*; denture adjustments or repairs; oral surgery (including tooth extractions); and repairs to bridges, crowns, and inlays	80% (after deductible)	70% (after deductible)
CLASS III Major Restorative Services	Crowns**, inlays, onlays Bridges** Full and partial dentures** Implants	50% (after deductible)	50% (after deductible)

SERVICES/TREATMENTS		NETWORK BENEFITS	NON-NETWORK BENEFITS
CLASS IV Orthodontia	Treatment and installation of orthodontic appliances for correction of irregularities in tooth position and jaw relationship *(for adults and dependent children)*	50%	50%
CLASS V TMJ Treatment	Temporomandibular joint (TMJ) disorder will be covered under dental benefits only if deemed by Cigna Dental to be a dental expense instead of a medical expense	80% (after deductible)	70% (after deductible)
CLASS VI Dental Anesthesia	General anesthesia or sedation	80% (after deductible)	70% (after deductible)

* One hundred percent (100%) reimbursement will be provided for (A) periodontal scaling and root planing, and (B) periodontal maintenance, up to four (4) times per calendar year after periodontal scaling and root planing, for Members and Enrolled Dependents who have been diagnosed with heart disease and/or diabetes and who are actively participating because of either or both conditions, in the Plan's disease management program established under Subsection 4.18. Such reimbursement, however, is subject to the annual maximum benefit for basic dental care.

** Replacement of a bridge, crown, or denture will be covered only if it has been more than five (5) years since the date originally installed unless (A) such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth, or (B) the bridge, crown, or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while the person was a Member or Enrolled Dependent.

General	Individual annual deductible	$50
	Combined individual annual maximum benefit for Class, II, III, and V expenses	$1,500
	Individual lifetime maximum benefit for orthodontic care	$1,250

Alternate 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

After satisfaction of a person's deductible for a calendar year, if applicable, and subject to the Alternate Benefit limitation under Subsection 4.1 x) and any annual or lifetime maximums described in this section, the amount of reimbursement for eligible charges incurred in connection with dental care shall be:

a) Network services and supplies.

i) Class I – Preventive and Diagnostic Care. When provided by an eligible provider, eligible charges for Class I care shall be reimbursed one hundred percent (100%), without a deductible; provided, however, that not more than

A) two (2) oral examinations in any calendar year,
B) two (2) dental prophylaxes (cleanings) in any calendar year,
C) two (2) sets of bitewing x-rays in any calendar year,
D) one (1) panoramic or full mouth x-ray every three (3) calendar years,
E) one (1) topical application of sealant per tooth every three (3) calendar years, and
F) two (2) topical applications of fluoride in any calendar year shall be eligible for

reimbursement.

ii) Class II – Basic Restorative Services. In the case of eligible charges for basic restorative care, eighty percent (80%) of such charges.

Notwithstanding the foregoing, one hundred percent (100%) reimbursement shall be provided for (i) periodontal scaling and root planing, and (ii) periodontal maintenance, up to four (4) times per calendar year after periodontal scaling and root planing, for Members and Enrolled Dependents who have been diagnosed with heart disease and/or diabetes and who are actively participating because of either or both conditions, in the Plan's disease management program established under Subsection 4.18. Such reimbursement, however, shall be subject to the annual maximum reimbursement for basic dental care.

iii) Class III – Major Restorative Services. In the case of eligible charges for major restorative services, fifty percent (50%) of such charges.

iv) Class IV – Orthodontia. In the case of eligible charges for orthodontic care, fifty percent (50%) of such charges, up to a lifetime maximum reimbursement of one thousand two hundred fifty dollars ($1,250) per person.

v) Class V – TMJ Treatment. In the case of eligible charges for treatment of temporomandibular joint (TMJ) disorder, if deemed to be a dental expense instead of a medical expense, eighty percent (80%) of such charges.

vi) Class VI – Dental Anesthesia. In the case of eligible charges for dental anesthesia, eighty percent (80%) of such charges.

b) Non-network services and supplies.

i) Class I – Preventive and Diagnostic Care. When provided by an eligible provider, eligible charges for Class I care shall be reimbursed ninety percent (90%), without a deductible; provided, however, that not more than

A) two (2) oral examinations in any calendar year,
B) two (2) dental prophylaxes (cleanings) in any calendar year,
C) two (2) sets of bitewing x-rays in any calendar year,
D) one (1) panoramic or full mouth x-ray every three (3) calendar years,
E) one (1) topical application of sealant per tooth every three (3) calendar years, and
F) two (2) topical applications of fluoride in any calendar year shall be eligible for reimbursement.

ii) Class II – Basic Restorative Services. In the case of eligible charges for basic restorative care, seventy percent (70%) of such charges.

Notwithstanding the foregoing, one hundred percent (100%) reimbursement shall be provided for (i) periodontal scaling and root planing, and (ii) periodontal maintenance, up to four (4) times per calendar year after periodontal scaling and root planing, for Members and Enrolled Dependents who have been diagnosed with heart disease and/or diabetes and who are actively participating because of either or both conditions, in the Plan's disease management program established under Subsection 4.18. Such reimbursement, however, shall be subject to the annual maximum reimbursement for basic dental care.

iii) Class III – Major Restorative Services. In the case of eligible charges for major restorative services, fifty percent (50%) of such charges.

iv) Class IV – Orthodontia. In the case of eligible charges for orthodontic care, fifty percent (50%) of such charges, up to a lifetime maximum reimbursement of one thousand two hundred fifty dollars ($1,250) per person..

v) Class V – TMJ Treatment. In the case of eligible charges for treatment of temporomandibular joint (TMJ) disorder, if deemed to be a dental expense instead of a medical expense, seventy percent (70%) of such charges.

vi) Class VI – Dental Anesthesia. In the case of eligible charges for dental anesthesia, seventy percent (70%) of such charges.

c) Deductible amount. For each calendar year, the deductible amount for Class II, III, V, and VI combined dental charges for each person is fifty dollars ($50). The deductible must be satisfied by eligible charges incurred within the calendar year. No deductible shall be applicable to Class I and IV charges.

d) Annual maximum. For each calendar year, reimbursement for Class II, III, and V combined charges shall be limited to one thousand five hundred dollars ($1,500) per person.

e) 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.

SECTION VI – VISION BENEFITS

Administered by Vision Service Plan (VSP)

Summary of Benefits

SERVICES/TREATMENTS	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 lwnawa: 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.

SERVICES/TREATMENTS	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

SERVICES/TREATMENTS	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% insurance
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: –Standard (one pair annually) –Monthly (six month supply) –Bi-Weekly (three month supply) –Dailies (three month supply)	50% coinsurance
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:

"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, up to the lifetime maximum benefit.

"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.

"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 the absence of immediate medical attention would put the individual's life in jeopardy.

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

"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 specialist 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 specialist physician, or which are not obtained from a network provider.

"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.

"Participating retail pharmacy" – A pharmacy that is designated as a network provider by the agency selected by the Board of Trustees to administer the prescription drug benefits.

"Preventive medical care" – When not performed in connection with an illness, preventive medical care will include the following: routine physical examination, school physical examination, sports physical examination, well-baby checkup, immunization, mammogram, 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, or PCP" – 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, and general practice.

"Specialist Physician" – A physician other than a Primary Care Physician.

"Urgent care facility" – A selected medical facility, listed as a network provider, which may be used in lieu of a hospital emergency room for minor emergency care. Normally, however, the Plan Member should make contact with his/her Primary Care Physician for assessment of the appropriateness of using an urgent care facility.

SCHEDULE HMO-C
Option HMO-C

Network Managers

BENEFIT	NETWORK MANAGER	NETWORK AREA	NETWORK
Basic and Preventive Medical Care	Cigna HealthCare 800-244-6224 or *www.cigna.com*	State of California	Cigna HealthCare of California
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	Cigna HealthCare 800-244-6224 or *www.cigna.com*	United States	Cigna HealthCare of California
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

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 grand-fathered 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***.

Some of the benefits provided under this Schedule HMO-C are required by state law in California.

Concordia Plan Services
The Lutheran Church—Missouri Synod
P.O. Box 229007
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