CONCORDIA HEALTH PLAN
Schedule Four

Coverage for Choice 2000

This Schedule provides the amount of reimbursement for benefits under Plan Coverage Option Choice 2000, 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.* This Schedule describes the benefits applicable for Choice 2000, which is an HSA-compliant High Deductible Health Plan Coverage Option. Blue Cross Blue Shield of Minnesota is the network manager for these services. Participating network providers should be used by Members to access care. Greater benefits are provided when network 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.

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

**For religious reasons, charges for contraceptive services, drugs or methods will not be paid or reimbursed, regardless of whether they otherwise would be charges that are eligible for reimbursement. Notwithstanding the foregoing, charges for contraceptive services, drugs, or methods may be reimbursed if they are ordered, by a health care provider with prescriptive authority, for medical indications other than to prevent an unintended pregnancy, but such charges only will be reimbursed if, in the sole discretion of Concordia Plan Services or its designee, the services, drugs, or methods are otherwise eligible charges for reimbursement and are not otherwise excluded from coverage under the Concordia Health Plan.*

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
Network Manager for Prescription Drugs: Express Scripts
Network Manager for Mental Health Care and Substance Abuse Care: Cigna Behavioral Health

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 *(under age six)*	100%	60% after deductible
	Routine preventive medical evaluation, including vision and hearing screenings, and standard immunizations *(age 6 and older)*	100%	60% after deductible
	Routine lab tests, including but not limited to, diabetes screening and lipid profile (including total and HDL cholesterol)	100%	60% 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%	60% after deductible
	Routine outpatient prenatal care (including the initial visit to diagnose pregnancy)	100%	60% after deductible

SECTION I (continued)

	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)	80% after deductible	60% after deductible
	Specialist office visits (includes lab tests or x-rays performed in the office)	80% after deductible	60% after deductible
	Second surgical opinions (not mandatory)	80% after deductible	60% after deductible
	Chiropractic care *(26 visits per calendar year)*	80% after deductible	60% after deductible
	Physical, occupational, or speech therapy	80% after deductible	60% after deductible
	Allergy care by specialist (including allergy shots)	80% after deductible	60% after deductible
	Mental health or substance abuse counseling	80% after deductible	60% after deductible
Hospital Services	Room, board, and other services/supplies (semi-private room rate)	80% after deductible	60% after deductible *(Hospital certification required for all hospital admissions, otherwise $500 penalty applied)*
	Newborn care	80% after deductible	60% after deductible
	Hospital emergency room	80% after deductible	
Medical & Surgical Services While Hospitalized	Surgery and related expenses such as anesthesia, assistant surgeon	80% after deductible	60% after deductible
	Physician's expense - pregnancy delivery charge and related inpatient services	80% after deductible	60% after deductible
	Physician visit in hospital	80% after deductible	60% after deductible
	Blood transfusions	80% after deductible	60% after deductible

	SERVICES/TREATMENTS	NETWORK BENEFITS	NON-NETWORK BENEFITS
Medical & Surgical Services While Hospitalized (cont.)	Physical, occupational, or speech therapy	80% after deductible	60% after deductible
	Organ transplants or bone marrow/stem cell transplants*	80% after deductible	60% after deductible
	** If using a Blue Distinction Center of Excellence, a travel benefit is provided as described in Subsection 4.2 s) and in administrative guidelines established by Concordia Plan Services.*		
Outpatient Services	Diagnostic x-ray and lab	80% after deductible	60% after deductible
	Surgery and related expenses	80% after deductible	60% after deductible
	Pre-admission testing	80% after deductible	60% after deductible
	Physical, occupational, or speech therapy	80% after deductible	60% after deductible
	Applied Behavior Analysis (ABA) therapy	80% after deductible	60% after deductible

SERVICES/TREATMENTS	NETWORK BENEFITS	
Prescription Drugs	**Retail pharmacy (30 day supply)**	**Network Manager home delivery or Smart90® pharmacy (31-90 day supply)**
Preventive Drugs - generic, brand-name formulary, brand-name non-formulary, or specialty	100%	100%
Non-Preventive Drugs - generic, brand-name formulary, brand-name non-formulary, or specialty	80%, after deductible (Member pays maximum of $75)	80%, after deductible (Member pays maximum of $150)

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

SECTION I (continued)

	SERVICES/TREATMENTS	NETWORK BENEFITS	NON-NETWORK BENEFITS
Other Services	Home health care	80% after deductible	60% after deductible
	Urgent care	80% after deductible	60% after deductible
	Ambulance and approved emergency air transport services *(if medically necessary)*	80% after deductible	
	Extended care or skilled nursing facility *(up to 100 days per calendar year covered)*	80% after deductible	60% after deductible
	Residential treatment facility or hospital day care for mental health or substance abuse care	80% after deductible	60% after deductible
	Hospice care	80% after deductible	60% after deductible
	Kidney dialysis (after 12 months, Member must apply for Medicare Part A and Part B)	80% after deductible	60% after deductible
	Radiation therapy and chemotherapy	80% after deductible	60% after deductible
	Tubal ligation or vasectomy	80% after deductible	60% after deductible
	Accidental injury to natural teeth (treatment must begin within 12 months after accident, and be completed within 24 months after initial treatment)	80% after deductible	60% after deductible
	Temporomandibular joint (TMJ) disorder-only if deemed to be a medical expense by the network's medical review department	80% after deductible	60% after deductible

	SERVICES/TREATMENTS	NETWORK BENEFITS	NON-NETWORK BENEFITS
Supplies and Equipment	Medical supplies, durable medical equipment	80% after deductible	60% 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.	80% after deductible	60% after deductible
Deductibles	Self Only annual deductible*	$2,000	$4,000
	Family unit** annual deductible	$4,000	$8,000
Annual Out-of-Pocket Maximums *(deductibles & coinsurance)*	Individual out-of-pocket maximum	$4,000	$8,000
	Family unit out-of-pocket maximum***	$8,000	$16,000

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.

* The Self Only annual deductibles (network and non-network) apply to only the 'Self Only' classification of coverage; not to individuals within a family unit coverage classifications.

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

*** For all classifications of coverage for this Option other than Self Only coverage, annual deductibles are 'non-embedded' and annual out-of-pocket maximums are 'embedded.' See further explanation in the Provisions beginning on next page.

NOTE: <u>Network</u> deductibles and network out-of-pocket maximums can be satisfied only with eligible expenses <u>incurred in the network</u>.
<u>Non-network</u> deductibles and non-network out-of-pocket maximums can be satisfied only with eligible expenses <u>not incurred in the network</u>.

Maximum Benefits *(limits apply to network & non-network benefits combined)*	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

<u>Provisions Outlining Benefits for Basic Medical Care, Preventive Medical Care, Prescription Drugs, Mental Health Care, and Substance Abuse Care</u>

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, basic medical, prescription drugs, mental health care, and substance abuse charges for eligible network services and supplies are subject to an annual deductible, which may be satisfied through the operation of the following provisions:

A) Self Only coverage. The Self Only annual deductible applies to only the 'Self Only' classification of coverage, not to individuals within a family unit coverage classification. The Self Only deductible is satisfied by eligible charges incurred within the calendar year. The Self Only deductible is satisfied on the date an enrolled person incurs an eligible charge which, together with eligible charges previously incurred during the calendar year, equals or exceeds two thousand hundred dollars ($2,000).

B) Family unit coverage. Family unit coverage is when an enrollee has one or more covered dependents. If an enrollee has family coverage, there is no separate deductible for each covered individual in the family. All eligible medical, prescription drugs, mental health care, and substance abuse charges for network services and supplies apply toward the family unit calendar year deductible. Network benefits will not be paid until the network family unit deductible for all participants enrolled in the family unit has been satisfied. When four thousand dollars ($4,000) of eligible charges, which may be applied toward satisfying the deductible for a calendar year, have 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. This type of deductible is sometimes referred to as a non-embedded deductible: when coinsurance applies, a single deductible must be satisfied in the aggregate by the family unit before charges are reimbursed by the plan.

ii) Reimbursement after deductible is satisfied.

A) Self Only. For each calendar year, the Plan shall pay for a covered person eighty percent (80%) of eligible medical, prescription drugs, mental health care, and substance abuse charges for network services and supplies after the Self Only annual deductible is satisfied.

B) Family unit. For each calendar year, for a family unit (Member with at least one Enrolled Dependent), the Plan shall pay eighty percent (80%) of eligible medical, prescription drugs, mental health care, and substance abuse charges for network services and supplies incurred by the family unit after the family unit annual deductible is satisfied.

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) Out-of-pocket maximums.

A) Self Only coverage. The individual out-of-pocket maximum of four thousand dollars ($4,000) applies to Self Only coverage. Once the individual out-of-pocket maximum is reached, the remaining eligible charges in that year will be covered 100% by the Plan, subject to any day or visit limits.

B) Family unit coverage. The family unit coverage out-of-pocket maximum of eight thousand dollars ($8,000) is an embedded maximum. Benefits for each covered person in the family unit are subject to the individual out-of-pocket maximum until satisfied or until the aggregate of all eligible amounts incurred by the family unit as a whole meets the family unit out-of-pocket annual maximum. Once a covered person in the family unit meets the individual out-of-pocket maximum or the family unit as a whole meets the family unit annual out-of-pocket maximum, the remaining eligible charges for network services and supplies in that year for such person will be covered 100% by the Plan, subject to any day or visit limits.

v) Network deductibles and network 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, basic medical, prescription drugs, mental health care, and substance abuse charges for eligible non-network services and supplies are subject to an annual deductible, which may be satisfied through the operation of the following provisions:

A) Self Only coverage. The Self Only annual deductible applies to only the ‘Self Only’ classification of coverage, not to individuals within a family unit coverage classification. The Self Only deductible is satisfied by eligible charges incurred within the calendar year. The Self Only deductible is satisfied on the date an enrolled person incurs an eligible charge which, together with eligible charges previously incurred during the calendar year, equals or exceeds four thousand dollars ($4,000).

B) Family unit coverage. Family unit coverage is when an enrollee has one or more covered dependents. If an enrollee has family coverage, there is no separate deductible for each covered individual in the family. All eligible medical, prescription drugs, mental health care, and substance abuse charges for non-network services and supplies apply toward the family unit calendar year deductible. Non-network benefits will not be paid until the non-network family unit deductible for all participants enrolled in the family unit has been satisfied. When eight thousand dollars ($8,000) of eligible charges, which may be applied toward satisfying the deductible for a calendar year, have 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. This type of deductible is sometimes referred to as a non-embedded deductible: when coinsurance applies, a single deductible must be satisfied in the aggregate by the family unit before charges are reimbursed by the Plan.

ii) Reimbursement after deductible is satisfied.

A) Self Only coverage. For each calendar year, the Plan shall pay for a covered person sixty percent (60%) of eligible medical, prescription drugs, mental health care, and substance abuse charges for non-network services and supplies after the Self Only annual deductible is satisfied.

B) Family unit. For each calendar year, the Plan shall pay sixty percent (60%) of eligible medical, prescription drugs, mental health care, and substance abuse charges for non-network services and supplies incurred by the family unit after the family unit annual deductible is satisfied.

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) Out-of-pocket maximums.

A) Self Only coverage. The individual out-of-pocket maximum of eight thousand dollars ($8,000) applies to Self Only coverage. Once the individual out-of-pocket maximum is reached, the remaining eligible charges in that year will be covered 100% by the Plan, subject to any day or visit limits.

B) Family unit coverage. The family unit coverage out-of-pocket maximum of sixteen thousand dollars ($16,000) is an embedded maximum. Benefits for each covered person in the family unit are subject to the individual out-of-pocket maximum until satisfied or until the aggregate of all eligible amounts paid by the family unit as a whole meets the family unit annual out-of-pocket maximum. Once a covered person in the family unit meets the individual out-of-pocket maximum amount or the family unit as a whole meets the family unit annual out-of-pocket maximum amount, the remaining eligible charges for non-network services and supplies in that year for such person will be covered 100% by the Plan, subject to any day or visit limits.

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

c) Prescription drugs. The amount of reimbursement for eligible charges incurred in connection with prescription drugs (whether a generic drug, a brand-name drug listed on the published formulary of the prescription drug Network Manager, a brand-name drug which is not listed on the published formulary or a specialty drug) purchased from a network retail pharmacy (limited to a supply of thirty (30) days or less) or from the prescription drug Network Manager home delivery pharmacy or a Smart90® (limited to a supply of no more than ninety (90) days) shall be:

i) Preventive drugs. One hundred percent (100%) of the eligible charges for such drugs. Preventive drugs are the drugs on a list of preventive drugs published by the prescription drug Network Manager. Prescription drugs are generally considered “preventive” if they satisfy any of the following three conditions: (1) they are taken by an individual with risk factors for a condition that has not yet manifested itself or not yet become clinically apparent, (2) they are taken by an individual to prevent the recurrence of a disease from which the individual has recovered, or (3) they are taken as part of a preventive care program. Notwithstanding anything herein to the contrary, preventive drug eligible charges are not subject to an annual deductible.

ii) Non-Preventive Drugs.

A) Network Retail Pharmacy. After satisfaction of the deductible, the greater of eighty percent (80%) of the eligible charge for such drug or the amount of the eligible charge minus seventy-five dollars ($75).

B) Network Manager Home Delivery or Smart90® pharmacy. After satisfaction of the deductible, the greater of eighty percent (80%) of the eligible charge for such drug or the amount of the eligible charge minus one hundred fifty dollars ($150).

iii) Specialty Drugs. Eligible charges for specialty drugs will be reimbursed only if purchased from the specialty drug home delivery pharmacy specified by the prescription drug 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 by the Plan as set forth above.

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

e) 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.

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 ($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

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 III -- 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%
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% after deductible
Dental Anesthesia	General anesthesia or sedation	80% after deductible
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% after deductible

SECTION III (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% after deductible
Orthodontic	Treatment and installation of orthodontic appliances for correction of irregularities in tooth position and jaw relationship	50% after deductible

* 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 IV – 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.

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

SECTION IV (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

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 V -- HEARING DISCOUNT PROGRAM

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

Summary of Program

SERVICES/TREATMENTS	MEMBER'S COST
	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 VI -- 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.

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

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

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

“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.

“Eligible Member” – Any Plan Member whose coverage is provided through a participating 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.

“Emergency medical condition” – 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 who possesses an average knowledge of health and medicine) could reasonably expect the absence of immediate medical attention to put the individual’s (or, with respect to a pregnant woman, the health of the woman or her unborn child’s) life in serious jeopardy, cause serious impairment to bodily functions, or cause serious dysfunction to any bodily organ or part.

“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 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. Also, if the patient stays in the hospital longer than approved, a $500 penalty is applicable.

“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 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 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 aggregate total amount of a Member's and Enrolled Dependents' deductible(s) and coinsurance. The out-of-pocket maximum does not include amounts above the customary charge limit, applicable penalties, 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 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 Four
Choice 2000
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 800-793-6922 or *www.bluecrossmn.com/concordia*	St. Louis, MO metropolitan areas*	Blue Access Choice
		Kansas City, KS and Kansas City, MO metropolitan areas*	PreferredCare Blue
		Wisconsin*	Blue Preferred POS
	Blue Cross Blue Shield of Minnesota 800-810-BLUE or *www.bluecrossmn.com/concordia*	Outside United States	BlueCard Worldwide
Mental Health and Substance Abuse Care	Cigna Behavioral Health, Inc. 866-726-5267 or *www.cignabehavioral.com*	United States	CBH Network of Participating Providers
Employee Assistance Program	Cigna Behavioral Health, Inc. 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

*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.

Concordia Plan Services
The Lutheran Church—Missouri Synod
P.O. Box 229007
St. Louis, Missouri 63122-9007
Telephone 314-965-7580 Fax 314-996-1127