

CONCORDIA HEALTH PLAN

Schedule Five

Coverage for Option Premium Plus

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

There are a variety of Plan Coverage Options for coverage of medical, mental health and substance abuse, employee assistance, prescription drug, dental, vision and hearing care under the Concordia Health Plan. This Schedule describes the benefits applicable for Plan Coverage Option Premium Plus, which is designed to supplement coverage provided under Medicare Part A—Hospital Insurance and Medicare Part B—Medical Insurance for **Medicare Active Members** of the Concordia Health Plan.

Medical care, including mental health and substance abuse care. For medical care, including mental health and substance abuse care, the Centers for Medicare and Medicaid Services administer the Medicare program and determine eligible services and supplies and eligible charges under the Medicare program, and the Plan Coverage Option Premium Plus is designed to supplement Medicare's coverage of only such services and supplies approved under the Medicare program. The services and supplies provided must be preventive or medically necessary for the diagnosis or treatment of illness or injury as determined under the Medicare program. Therefore, greater benefits are available when providers that accept Medicare are utilized. WebTPA, an AmWINS group company, is the claims administrator for this Plan Coverage Option.

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

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

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

Hearing care. HearUSA (also known as National Ear Care Plan) administers this discount program for hearing screenings and testing, as well as the 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 – MEDICAL CARE, INCLUDING MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Claims Administrator: WebTPA, an AmWINS Group Company

Summary of Benefits

SERVICES/TREATMENTS	REIMBURSEMENT
	Reimbursement amounts noted below with an asterisk (*) and \$0 reimbursement are benefits that are covered 100% by Medicare
Preventive Services	\$0*
Hospital inpatient care (Medical, including Mental Health and Substance Abuse) (first 60 days of a benefit period)	Medicare Part A annual deductible amount for each benefit period
Hospital inpatient care (Medical, including Mental Health and Substance Abuse) (days 61-90)	Medicare Part A coinsurance for each benefit period
Hospital inpatient care (Medical, including Mental Health and Substance Abuse) (Days 91 and Beyond)	Medicare Part A coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime)
365 Additional Lifetime Reserve Days	100%
Inpatient care in a Skilled Nursing Facility (not custodial or long term care)	\$0* for Days 1-20 Medicare Part A coinsurance per day for Days 21-100 \$0 for Days 101 and beyond*
Hospice Care	\$0*
Home Health Care	\$0*
Inpatient Respite Care	5% of Medicare-approved charges
Physician Services	20% of Medicare-approved charges, plus 100% of the difference between the Medicare Part B provider charge as allowed by Medicare and the Medicare-approved Part B charge
Durable Medical Equipment	20% of Medicare-approved charges
Foreign Travel Emergency	80% after a \$250 deductible up to a \$50,000 lifetime maximum

SECTION II – EMPLOYEE ASSISTANCE PROGRAM

Administered by 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 – PRESCRIPTION DRUG BENEFITS

Administered by Express Scripts

Summary of Benefits

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

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

PRESCRIPTION DRUG BENEFITS (continued)

Provisions Outlining Prescription Drug Benefits

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

- a) 30-day supply or less. One hundred percent (100%) of all charges in excess of:
 - i) Fifteen dollars (\$15) for each fill of a prescription for a generic drug;
 - ii) Thirty dollars (\$30) for each fill of a prescription for a brand-name drug listed on the published formulary of the agency designated by the Network Manager; or
 - iii) Sixty dollars (\$60) for each fill of a prescription for a brand-name drug which is not listed on the published formulary of the Network Manager.

Notwithstanding the above, after four (4) fills within one hundred twenty (120) days of the same prescription at a network retail pharmacy, starting with the fifth (5th) fill of such drug at a retail pharmacy, the amount of reimbursement shall be the lesser of: a) fifty percent (50%) of the eligible cost, or b) the eligible cost minus the appropriate copay. However, the reimbursement rate set forth in i)-iii) immediately above shall apply if the drug (A) is not available for purchase through the Network Manager home delivery pharmacy, (B) cannot be provided by mail by law, or (C) is considered a controlled substance by the Network Manager.

- b) 31-90 day supply. One hundred percent (100%) of all charges in excess of:
 - i) Thirty dollars (\$30) per fill of a prescription for a generic drug;
 - ii) Sixty dollars (\$60) per fill of a prescription for a brand-name drug listed on the published formulary of the Network Manager; or
 - iii) One hundred twenty dollars (\$120) per fill of a prescription for a brand-name drug which is not listed on the published formulary of the Network Manager.

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

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

SECTION IV – DENTAL BENEFITS

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

Summary of Benefits

SERVICES/TREATMENTS	BENEFITS
	Eligible charges are subject to an annual deductible and annual or lifetime maximums.
Preventive and Diagnostic Care	<p style="text-align: right;">100%</p> <p style="text-align: right;">No deductible</p>
	<p>Oral exam (2 per calendar year)</p> <p>Cleaning (2 per calendar year)</p> <p>Bitewing x-rays (2 sets per calendar year)</p> <p>Full mouth or panoramic x-rays (1 complete set every thirty-six (36) calendar months)</p> <p>Fluoride application (1 per calendar year for persons under age 19)</p> <p>Sealants (limited to posterior tooth, only for persons under age 16, one treatment per tooth every thirty-six (36) calendar months)</p> <p>Space maintainers (limited to non-orthodontic treatment)</p> <p>Dental x-rays required for the diagnosis or treatment of a dental defect, injury, or disease</p> <p>Emergency care to relieve pain</p> <p>Palliative (emergency) treatment</p>
Basic Dental Care	<p style="text-align: right;">80%</p>
	<p>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 planing**, and osseous surgery</p> <p>Temporomandibular joint (TMG) disorder will be included under Basic Dental Care only if deemed by Cigna Dental to be a dental expense instead of a medical expense</p>
Dental Anesthesia	<p style="text-align: right;">80%</p>
	<p>General anesthesia or sedation</p>

DENTAL BENEFITS (continued)

SERVICES/TREATMENTS		BENEFITS
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%
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	
Orthodontic	Treatment and installation of orthodontic appliances for correction of irregularities in tooth position and jaw relationship	50%
<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 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
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.	

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

DENTAL BENEFITS (continued)

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 or Concordia Plan Services 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.

DENTAL BENEFITS (continued)

- 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 V – 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	\$25 Member Copay	
Lenses: Covered once every calendar year		
Single vision		Up to \$30
Lined bifocal		Up to \$50
Lined trifocal		Up to \$65
Progressive (no line)		Up to \$50
Lenticular		Up to \$100
Frames: Covered once every other calendar year	Covered up to \$150, plus 20% discount off any out-of-pocket costs	Up to \$70
Contact Lenses Covered every calendar year		
Elective contact lenses	\$150 allowance applied to the cost of the contacts and the contact lens exam	Up to \$105
Medically necessary contact lenses	Covered in full	Up to \$210

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

VISION BENEFITS (continued)

SERVICES	NETWORK BENEFITS	NON-NETWORK BENEFITS
Miscellaneous discounts		
Additional complete set of prescription glasses or sunglasses	20% discount	Not covered
Lens extras, such as scratch resistant and anti-reflective coatings	20% discount	Not covered
Contact lenses exam (fitting and evaluation)	20% 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/material covered under worker's compensation
- Eye exams required as a condition of employment

Items not covered under the contact lens coverage:

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

VISION BENEFITS (continued)

SERVICES	NETWORK BENEFITS	NON-NETWORK BENEFITS
For persons under age nineteen (19)	All services and related products must be received or purchased through network providers.	Reimbursement at 50% coinsurance is available if 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		
One exam every calendar year		
Elective contact lenses	In lieu of eyeglasses, elective contact lens services and materials are covered in full with the following services 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.

VISION BENEFITS (continued)

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 VI – 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 <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 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 VII – SPECIAL DEFINITIONS

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

“Benefit Period” – is a period determined by Medicare. In general, it begins on the day of admission as an inpatient in a hospital or skilled nursing facility and ends when care has not been received from such facilities for sixty (60) consecutive days.

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

“Coinsurance” – The percentage a Member must pay for covered medical, mental health and substance abuse, prescription drugs or dental services after any applicable deductibles have been satisfied.

“Deductible” – The amount a Member must pay for covered medical, mental health and substance abuse or dental services before the Plan starts to pay.

“Preventive Medical Care” – As determined by Medicare. Additional information available on the Medicare website: www.medicare.gov/coverage/preventive-and-screening-services.html

Schedule Five Option Premium Plus

Claims Administrators

BENEFIT	CLAIMS ADMINISTRATOR	NETWORK
Medical Care, including Mental Health and Substance Abuse Care	WebTPA, AmWINS Group Benefits 1-877-517-1409	Medicare
Employee Assistance Program	Cigna Behavioral Health, Inc. 866-726-5267 or <i>www.cignabehavioral.com</i>	EAP Network
Prescription Drugs	Express Scripts 800-789-7488 or <i>www.express-scripts.com</i>	National Plus
Dental Care	Cigna Dental 800-244-6224 or <i>www.cigna.com</i>	Core Network
Vision Care	Vision Service Plan 800-877-7195 or <i>www.vsp.com</i>	Choice Plan
Hearing Discount Program	HearUSA 800-442-8231 or <i>www.hearusa.com</i>	HearUSA Hearing Care Network

To locate participating providers for each benefit, Members should contact the applicable claims administrator. Phone information is also available at *ConcordiaPlans.org*. Network and contact information for some claims administrators may be accessible on the Member Identification Card or other card provided to Members by the claims administrator.

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