CONCORDIA HEALTH PLAN
Schedule Seven

Coverage for Health Wise 1200

This Schedule describes benefits under Plan Coverage Option Health Wise 1200, 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 Health Wise 1200, a Local Plus (LP) network Coverage Option which is part of an Open Access Plus (OAP) network. Cigna Health and Life Insurance Co. 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 or no benefits will be applicable if non-network providers are used.

Mental health and substance abuse care.* Cigna Behavioral Health administers the mental health and substance abuse care benefits for eligible Members and their Enrolled Dependents. The care must be provided by an eligible provider and be medically necessary. Greater benefits are provided when network providers are used.

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

Prescription drugs.* Cigna Health and Life Insurance Co. administers the prescription drug coverage. Prescription drugs may be purchased at a local network pharmacy or, for long-term medications and specialty drugs, through Cigna Home Delivery Pharmacy mail order service. Certain maintenance drugs may be purchased at select retail network pharmacies specified by Cigna.

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 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.*

January 1, 2018

SECTION I – MEDICAL CARE, PRESCRIPTION DRUG AND MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS

Network Manager: Cigna Health and Life Insurance Co.
Prescription Drug Network Manager: Cigna Pharmacy
Mental Health / Substance Abuse Network Manager: Cigna Behavioral Health

Summary of Benefits

SERVICES/TREATMENTS		NETWORK BENEFITS	NON-NETWORK BENEFITS
		All services and supplies must be provided or authorized by a Physician in the network.	Eligible charges are subject to a customary charge limitation.
Preventive Medical Care	Routine preventive medical evaluation, including immunizations, vision and hearing screenings, and laboratory services	100%	No coverage except immunizations from birth through age 4 are covered 100%
	Routine cancer screenings including but not limited to mammograms, Pap smears, Prostate Specific Antigen (PSA) tests	100%	60% after deductible
Medical Services in Physician's Office	Primary Care Physician (PCP) office visits* *(including allergy treatments, radiology and advanced radiology imaging services and surgery performed in office)*	100% except $35 copay per visit *(or actual charge, if less)*	60% after deductible
	Specialist office visits* *(including allergy treatments, radiology and advanced radiology imaging services and surgery performed in office)*	100% except $50 copay per visit *(or actual charge, if less)*	60% after deductible
	Allergy serum dispensed by physician and targeted infusion therapy drugs administered in physician's office	100%	60% after deductible
	Laboratory tests *(other than routine preventive care services)*	80% after deductible	60% after deductible
	Chiropractic care *(26 visits per calendar year)*	100% except for $50 copay per visit	60% after deductible

**Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist copay depending on how the provider contracts with Cigna.*

SERVICES/TREATMENTS		NETWORK BENEFITS	NON-NETWORK BENEFITS
Medical Services in Physician's Office (continued)	Mental health or substance abuse counseling *(including individual, intensive outpatient, and behavioral telehealth consultation)*	100% except for $35 copay	60% after deductible
Hospital Services	Room, board, and other services/supplies *(semi-private room rate)*	80% after deductible	60% after deductible
	Newborn care	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
	Hospital emergency room/urgent care facility	<u>Life threatening condition</u>: $200 copay per visit then 100% after deductible *(copay waived if admitted)* <u>Non-life threatening condition</u>: $500 copay per visit then 100% after deductible *(copay waived if admitted)*	
	Organ transplants*	80% after deductible	Not covered
	** If using a LifeSource Facility, 100% coverage and a travel benefit of up to $10,000 per transplant is provided as described in Subsection 4.2 s) and in administrative guidelines established by Concordia Plan Services.*		
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 impatient services	80% after deductible	60% after deductible
	Physician visit in hospital	80% after deductible	60% after deductible
	Laboratory, radiology and advanced radiology imaging services	80% after deductible	60% after deductible
	Organ transplants*	80% after deductible	Not covered
	** If using a LifeSource Facility, 100% coverage and a travel benefit of up to $10,000 per transplant is provided as described in Subsection 4.2 s) and in administrative guidelines established by Concordia Plan Services.*		

SERVICES/TREATMENTS		NETWORK BENEFITS	NON-NETWORK BENEFITS
Outpatient Services	Laboratory services performed at national preferred laboratory (i.e., Quest and LabCorp)	90% no deductible	N/A
	Laboratory services not performed at national preferred laboratory	80% after deductible	60% after deductible
	Radiology and advanced radiology imaging services	80% after deductible	60% after deductible
	Surgery and related expenses	80% after deductible	60% after deductible
	Cardiac rehabilitation *(36 days maximum per calendar year)*	100% except for $50 copay	60% after deductible
	Pulmonary rehabilitation, physical*, occupational, cognitive and speech therapy *(40 days maximum per calendar year –combined; 40-day limit does not apply to physical, occupational or speech therapy for treatment of autism, mental health or substance abuse conditions)*	100% except for $50* copay **($35 copay applies for physical therapy or all other therapy categories if provided by Primary Care Physician)*	60% after deductible
	Mental health or substance abuse counseling *(includes individual, intensive outpatient, group therapy and partial hospitalization)*	80% after deductible	60% after deductible
	Applied Behavior Analysis (ABA) therapy	100% no deductible	60% after deductible
Other Services	Home health care *(includes outpatient private duty nursing subject to medical necessity)* · *60 days maximum per calendar year; 60-day limit does not apply for treatment of autism, mental health or substance abuse conditions* · *16 hour maximum per day*	80% after deductible	60% after deductible
	Urgent care	$50 copay per visit then 100% after deductible	
	Telephone or Video Consultation *(including behavioral telehealth consultations)*	100%, except for $10 copay	Not covered
	Ambulance and approved emergency air transport services *(ambulance services used as non-emergency transportation are not covered)*	80% after deductible	
	Extended care or skilled nursing facility *(up to 60 days per calendar year; 60-day limit does not apply for treatment of autism, mental health or substance abuse conditions)*	80% after deductible	60% after deductible

SERVICES/TREATMENTS		NETWORK BENEFITS	NON-NETWORK BENEFITS
Other Services (continued)	Hospice care and bereavement counseling	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
	Family Planning – Men's services *(including surgical services such as vasectomy; reversals excluded; physician's office services will be covered same as office visit)*	80% after deductible	60% after deductible
	Family Planning – Women's services *(including contraceptive devices prescribed by a physician when medically necessary and surgical services such as tubal ligation; reversals excluded)*	100% no deductible	60% after deductible
	Temporomandibular joint (TMJ) disorder-surgical and non-surgical services *(services provided on a case-by-case basis subject to medical necessity; appliances and orthodontic treatment provided under dental benefit)*	80% after deductible *(100%, except for $50 copay for office services)*	60% after deductible
Supplies & Equipment	Medical supplies, durable medical equipment	80% after deductible	60% after deductible
	Breast feeding equipment and supplies *(limited to purchase of manual or electric breast pump or rental of one hospital grade breast pump per birth as prescribed by physician; includes related supplies)*	100%	Not covered
	External prosthetic appliances (EPA) *($200 EPA annual deductible per calendar year)*	80% after deductible	60% after deductible

SERVICES/TREATMENTS		NETWORK BENEFITS	NON-NETWORK BENEFITS
Prescription Drugs	30 day supply – Retail Pharmacy *(limited to two 30-day fills for specified maintenance medications for which a 90-day prescription filled at either a select network retail pharmacy or by home delivery is necessary; after two 30-day fills, prescription will not be covered by the Plan.)*	**Generic** $10 copay **Preferred Brand** $30 copay **Non-Preferred Brand** $60 copay	Not covered
	90 day supply – Home Delivery (or Select Retail Pharmacy in the case of specified maintenance medications) *(The list of specified maintenance medications and the list of select 90-day network retail pharmacies may be subject to change.)*	**Generic** $25 copay **Preferred Brand** $75 copay **Non-Preferred Brand** $150 copay	Not covered
	Note: Specialty drugs limited to 30-day supply; prior authorization required)		
Deductibles	Individual annual deductible*	$1,200	$2,400
	Family unit** annual deductible	$2,400	$4,800
Annual Out-of-Pocket Maximums *(deductibles and coinsurance)*	Individual out-of-pocket maximum	$5,850	$11,700
	Family unit** out-of-pocket maximum***	$11,700	$23,400

The out-of-pocket maximum is the deductible(s), copays and coinsurance amount(s) combined. It reflects the Member's maximum share during a calendar year for the cost of covered medical care, prescription drugs, mental health care, and substance abuse care.

*The Individual annual deductibles (network and non-network) applies to the "Individual" classification of coverage; as well as to individuals within a family unit coverage classification.

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

***For all classifications of coverage for this Option other than Individual coverage, deductibles and annual out-of-pocket maximums are 'embedded.' See definitions and example at the end of this Schedule.

NOTE: Network deductibles and out-of-pocket maximums can be satisfied with network and non-network eligible expenses. Non-network deductibles and out-of-pocket maximums can be satisfied only with non-network eligible expenses.

Maximum Benefits	Individual annual maximum benefit for chiropractic care	26 visits for network and non-network combined benefits
	Individual annual maximum benefit for extended care and skilled nursing facility care confinements during calendar year*	60 days for network and non-network combined benefits
	Individual annual maximum benefit for home health care*	60 days, (16-hour day maximum) for network and non-network combined benefits
	Individual annual maximum benefit for cardiac rehabilitation	36 days for network and non-network combined benefits
	Individual annual maximum benefit for pulmonary rehabilitation, cognitive therapy, physical therapy*, speech therapy* and occupational therapy* – on a combined basis	Therapy services are limited to 40 days for network and non-network combined benefits
	Individual lifetime maximum benefit for all benefits paid by the CHP	Unlimited lifetime limit

**Maximum benefit limits do not apply for treatment of autism, mental health or substance abuse conditions*

PROVISIONS OUTLINING MEDICAL CARE, PRESCRIPTION DRUG AND MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS

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 medical, prescription drug, and mental health/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, the deductible applied to each enrolled individual for basic medical care, prescription drug, mental health care, and substance abuse charges for eligible network services and supplies is determined through the operation of the following provisions:

A) Individual. The Individual annual deductible applies to the 'Individual' classification of coverage, as well as to each enrolled individual within a family unit coverage classification. The Individual deductible is satisfied by eligible charges for network services and supplies incurred within the calendar year. The Individual deductible is satisfied on the process date of an enrolled individual's incurred eligible charge which, together with eligible charges previously incurred and processed during the calendar year, equals or exceeds one thousand two hundred dollars ($1,200).

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 a 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. When two thousand four hundred dollars ($2,400) of eligible charges, which may be applied toward satisfying the deductible for a calendar year, have been incurred and processed collectively by the family unit, the deductible will be deemed satisfied for that calendar year for all enrolled individuals in that family unit. This type of deductible is referred to as an embedded deductible: when coinsurance applies, either the individual annual deductible must be satisfied by the enrolled individual or the family unit deductible must be satisfied in aggregate by the family unit before charges are reimbursed by the Plan.

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

ii) Reimbursement after deductible is satisfied.

A) Individual. Except as otherwise provided Herein, for each calendar year, the Plan shall pay for an enrolled individual eighty percent (80%) of eligible medical, prescription drugs, mental health care, and substance abuse charges for network services and supplies after the Individual annual deductible is satisfied.

B) Family unit. Except as otherwise provided Herein, 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) Waiver of deductible. Notwithstanding the foregoing, the annual deductible shall be waived and the Plan shall pay one hundred percent (100%) of the following eligible charges:

A) preventive care (includes wellness exams, laboratory tests and routine cancer screenings) received in the network;
B) immunizations for birth through age four (4) not received in the network;
C) breast feeding equipment and related supplies (includes purchase of manual or electric breast pump or rental of one hospital grade breast pump per birth prescribed by physician and related supplies) received in the network;
D) women's family planning services such as contraceptive devices prescribed by a physician when medically necessary and tubal ligations (excludes reversals) received in the network;
E) allergy serum dispensed by physician and targeted infusion therapy drugs administered in physician's office received in network;
F) organ transplant services performed at a LifeSource Facility;
G) primary care physician's office visit in excess of a thirty-five dollar ($35) copay per visit;
H) specialist physician's office visit in excess of a fifty dollar ($50) copay per visit;
I) telemedicine or behavioral telehealth consultation in excess of a ten dollar (410) copay per visit;
J) mental health and substance abuse counseling received in a network physician's office in excess of thirty-five dollar ($35) copay; and
K) Applied Behavior Analysis (ABA) therapy, by a network provider. 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.

iv) Out-of-pocket maximums.

A) Individual maximum. For each calendar year, the out-of-pocket maximum for each individual (combined deductibles and coinsurance charges) for basic medical care, prescription drug, mental health care, and substance abuse charges for network services and supplies is five thousand eight hundred fifty dollars ($5,850). Once an enrolled individual meets the individual out-of-pocket maximum, the remaining eligible charges in that year for such individual will be covered 100% by the Plan, subject to any day or visit limits.

B) Family unit maximum. The family unit coverage out-of-pocket maximum of eleven thousand seven hundred dollars ($11,700) is an embedded maximum. Benefits for each enrolled individual 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 an enrolled individual 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 individual 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 with eligible expenses incurred in the network as well as eligible expenses not incurred in the network.

b) Non-network services and supplies.

i) Annual deductible. For each calendar year, the deductible applied to each enrolled individual for basic medical care, prescription drug, mental health care, and substance abuse charges for eligible non-network services and supplies is two thousand four hundred dollars ($2,400). An individual may satisfy the deductible through the operation of the following provisions:

A) Individual. The Individual annual deductible applies to the 'Individual' classification of coverage, as well as to individuals within a family unit coverage classification. The Individual deductible is satisfied by eligible charges incurred within the calendar year. The Individual deductible is satisfied on the date an enrolled individual incurs an eligible charge which, together with eligible charges previously incurred during the calendar year, equals or exceeds two thousand four hundred dollars ($2,400).

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 a separate deductible for each covered individual in the family. All eligible medical care, prescription drug, mental health care, and substance abuse charges for non-network services and supplies apply toward the family unit calendar year deductible. When four thousand eight hundred dollars ($4,800) 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 individuals in that family unit. This type of deductible is referred to as an embedded deductible: when coinsurance applies, either the individual annual deductible must be satisfied by the enrolled individual or the family unit deductible must be satisfied in aggregate by the family unit before charges are reimbursed by the Plan.

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

ii) Reimbursement after deductible is satisfied.

A) Individual. For each calendar year, the Plan shall pay for an enrolled individual sixty percent (60%) of eligible medical care, prescription drug, mental health care, and substance abuse charges for non-network services and supplies after the Individual annual deductible is satisfied.

B) Family unit. For each calendar year, the Plan shall pay sixty percent (60%) of eligible medical care, prescription drug, 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) Out-of-pocket maximums.

A) Individual maximum. The individual out-of-pocket maximum of eleven thousand seven hundred dollars ($11,700) applies to Individual 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 maximum. The family unit coverage out-of-pocket maximum of twenty-three thousand four hundred dollars ($23,400) is an embedded maximum. Benefits for each enrolled individual 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 an enrolled individual 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 individual will be covered 100% by the Plan, subject to any day or visit limits.

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

c) Other annual limits. Notwithstanding anything contained herein to the contrary, certain eligible charges are subject to annual day or visit limits as set forth herein:

i) Chiropractic care. The annual calendar year limit for chiropractic care shall be twenty-six (26) visits per enrolled individual.

ii) Extended care or skilled nursing facility care. 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 extended care or skilled nursing facility for medical care therein, shall be limited to a maximum of sixty (60) days for all confinements during any one calendar year. Sixty-day (60-day) limit does not apply for treatment of autism, mental health or substance abuse conditions.

iii) Home health care. The annual calendar year limit on home health care, which includes outpatient private duty nursing if medically necessary, shall be sixty (60) days, with a sixteen (16) hour maximum per day. Sixty-day (60-day) limit does not apply for treatment of autism, mental health or substance abuse conditions.

iv) Cardiac Rehabilitation. The annual calendar year limit for cardiac rehabilitation shall be thirty-six (36) days.

v) Other short-term outpatient rehabilitation therapies. The annual calendar year limit for pulmonary rehabilitation, cognitive therapy, physical therapy, speech therapy and occupational therapy shall be forty (40) days combined for all therapies. Limit does not apply to physical therapy, speech therapy or occupational therapy services for the treatment of autism, mental health or substance abuse conditions.

d) Organ transplants and bone marrow/stem cell transplants. If the surgery is performed at a LifeSource facility, a travel benefit, not to exceed ten thousand dollars ($10,000) per transplant,

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

e) Preferred laboratory services. The Plan shall pay ninety percent (90%) of eligible charges for laboratory services provided by a preferred laboratory, as specified on the published list of national preferred laboratories by the network provider.

f) Ambulance charges. Eligible charges for ambulance transport, if deemed medically necessary, shall be reimbursed as a network service even though provided by a non-network provider. The Plan will pay eighty percent (80%) of such eligible charges, provided by a network or non-network provider. Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.

g) Emergency care. Eligible charges for emergency care shall be reimbursed as a network service even though provided by a non-network provider. After satisfaction of the deductible, the Plan will pay one hundred percent (100%) of eligible charges incurred for an emergency room or urgent care facility in excess of the applicable copay ($200 copay for a life-threatening condition/$500 copay for a non-life-threatening condition). After satisfaction of the deductible, the Plan will pay one hundred percent (100%) of eligible charges incurred for outpatient professional emergency care services provided by a network or non-network provider.

h) 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 agency designated by the Board of Trustees to administer these benefits, or a brand-name drug which is not listed on the published formulary of such agency) purchased from a local network pharmacy (supply of thirty (30) days or less), or from a select network pharmacy (in the case of specified maintenance medications) or network mail order home delivery pharmacy shall be as follows:

i) Generic drugs. One hundred percent (100%) of charges in excess of ten dollars ($10) for a thirty (30) day supply of generic prescription drugs provided by a retail network pharmacy and in excess of twenty-five dollars ($25) for a ninety (90) day supply of generic prescription drugs provided by either (1) the network mail order home delivery pharmacy, or (2) in the case of a maintenance medication specified on the published list of maintenance medications by the network provider, provided by a select retail network pharmacy specified on the published list of select retail network pharmacies by the network provider.

ii) Preferred-Brand Drugs. One hundred percent (100%) of charges in excess of thirty dollars ($30) for a thirty (30) day supply of preferred brand prescription drugs provided by a retail network pharmacy and in excess of seventy-five dollars ($75) for a ninety (90) day supply of preferred brand prescription drugs provided by either (1) the network mail order home delivery pharmacy, or (2) in the case of a maintenance medication specified on the published list of maintenance medications by the network provider, provided by a select retail network pharmacy specified on the published list of select retail network pharmacies by the network provider

iii) Non-Preferred Brand Drugs. One hundred percent (100%) of charges in excess of sixty dollars ($60) for a thirty (30) day supply of non-preferred brand prescription drugs provided by a retail network pharmacy and in excess of one hundred fifty dollars ($150) for a ninety (90) day supply of preferred brand prescription drugs provided by either (1) the network mail order home delivery pharmacy, or (2) in the case of a maintenance medication specified on the published list of maintenance medications by the network

provider, provided by a select retail network pharmacy specified on the published list of select retail network pharmacies by the network provider.

iv) Specialty Drugs. Specialty drugs will be limited to no more than a thirty (30) day supply per prescription.

Eligible charges for specified maintenance/long-term drugs will be limited to no more than two 30-day supply fills per prescription from a local retail network pharmacy. Prescription drugs provided by a non-network pharmacy will not be covered by the Plan.

SECTION II – EMPLOYEE ASSISTANCE PROGRAM

Network Manager: Cigna Behavioral Health

Summary of Benefits

EAP SERVICES/TREATMENTS	NETWORK BENEFITS
	All services must be pre-certified or authorized by the Network Manager, otherwise there is no coverage.
Confidential, solution-focused counseling and referrals for a variety of work, family, and life issues, such as marital and family difficulties, parenting challenges, child and elder care, stress and anxiety, job enrichment, financial and legal concerns, 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

DENTAL SERVICES/TREATMENTS		BENEFITS
		Eligible charges are subject to an annual deductible and annual or lifetime maximums.
Preventive and Diagnostic Care	Oral exam *(2 per calendar year)* Cleaning *(2 per calendar year)* Bitewing x-rays *(2 sets per calendar year)* Full mouth or panoramic x-rays *(1 complete set every thirty-six (36) calendar months)* Fluoride application *(1 per calendar year for persons under age 19)* Sealants *(limited to posterior tooth, only for persons under age 16, one treatment per tooth every thirty-six (36) calendar months)* Space maintainers *(limited to non-orthodontic treatment)* Dental x-rays required for the diagnosis or treatment of a dental defect, injury, or disease Emergency care to relieve pain	100% No deductible
Basic Dental Care	Fillings, extractions, inlays, onlays, crowns*, root canal therapy, bridgework*, initial installation or replacement of complete or partial dentures*, denture adjustments or repairs, periodontal scaling and root planing**, 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

DENTAL 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% after deductible
Dental 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
	* "Family unit" means a Member and that Member's Enrolled Dependents.	
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

Basic dental care, oral surgery, and orthodontia. After satisfaction of an individual'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 individual is one hundred dollars ($100). An individual 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 an individual 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 individuals in the same family unit, the deductible will be deemed satisfied for that calendar year for all enrolled individuals 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

VISION SERVICES	NETWORK BENEFITS	NON-NETWORK BENEFITS
For persons age nineteen (19) and older	All services and related products must be received or purchased through network providers.	Reimbursement at a lower level is available if a non-network provider is used.
Eye exams One exam every calendar year	$10 Member Copay	Up to $45
Prescription glasses		
Lenses: Covered once every calendar year		
Single Vision	$25 Member Copay	Up to $30
Lined bifocal	$25 Member Copay	Up to $50
Lined trifocal	$25 Member Copay	Up to $65
Progressive (no line)	$25 Member Copay	Up to $50
Lenticular	$25 Member Copay	Up to $100
Frames: Covered once every other calendar year	Covered up to $150, plus 20% discount off any out-of-pocket costs	Up to $70
Contact Lenses One exam 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
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 lens exam *(fitting and evaluation)*	15% discount	Not covered
Laser vision correction	Discount varies	Not covered

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.*

PROVISIONS OUTLINING VISION BENEFITS

Items not covered for persons age nineteen (19) and older:

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

Items not covered under the contact lens coverage:

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

VISION SERVICES	NETWORK BENEFITS	NON-NETWORK BENEFITS
For persons under age nineteen (19)	All services and related products must be received or purchased through network providers.	Reimbursement at 50% coinsurance is available if 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: -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.*

PROVISIONS OUTLINING VISION BENEFITS

Items not covered for persons under age nineteen (19):

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

Items not covered under the contact lens coverage for persons under age nineteen (19):

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

SECTION V – HEARING DISCOUNT PROGRAM

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

Summary of Benefits

HEARING 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 VI – SPECIAL DEFINITIONS

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

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

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

"Deductible" – The amount a Member must pay for covered medical, mental health and substance abuse 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.

"Embedded Deductible" – If you have family coverage, each covered individual's annual deductible is embedded within the family unit annual deductible, such that once an enrolled individual satisfies his or her individual annual deductible amount, his or her benefits are then covered at the coinsurance level (even if the family unit annual deductible has not been met), and benefits for each other family unit member remain subject to their individual annual deductible until satisfied or until the aggregate of all annual deductibles paid by the family unit meets the family unit deductible.

> For example, you have a family plan with a $1,200 annual individual deductible and a $2,400 annual family unit deductible, with 80% coinsurance. Once you reach your $1,200 deductible, you will have coverage at the 80% coinsurance level even though other family members do not until they satisfy their individual deductible or the family deductible has been met in the aggregate.

"Embedded Out-of-Pocket Maximum" – If you have family coverage, each covered individual's annual out-of-pocket maximum is embedded within the family unit annual out-of-pocket maximum, such that once an enrolled individual satisfies his or her individual annual out-of-pocket maximum amount, he or she shall have no further liability for covered services for the plan year (even if the family unit annual out-of-pocket maximum has not been met), and benefits for each other family unit member remain subject to their 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.

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

"Hospital Certification" – The network manager must be contacted in advance of any inpatient admission. The Plan Member or Enrolled Dependent must contact the network manager for pre-certification of any non-network hospital admission or ongoing stay in a hospital. In the case of emergency admissions, the network manager must be contacted within 48 hours. While there is no dollar penalty for failure to obtain pre-certification, the Plan will not cover benefits reviewed by the network manager and not certified.

"LifeSource Facility" – A hospital or other facility that has been selected by Cigna to be a member of a specialized network that provides organ transplants.

SPECIAL DEFINITIONS

"Life Threatening Condition" – A condition not included on the list of diagnosis codes of non-life threatening conditions which is maintained by the network manager, and subject to modification periodically.

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

"Out-of-Pocket Maximum" –The aggregate total of a Member's and Enrolled Dependents, if any, deductible(s) and coinsurance for medical, mental health and substance abuse and prescription drugs. 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 Seven
Health Wise 1200

Network Managers

BENEFIT	NETWORK MANAGER	NETWORK AREA	NETWORK
Basic and Preventive Medical Care	Cigna HealthCare 866-302-7578 or *www.myCigna.com*	Arizona and certain areas in: Florida* Illinois* Texas*	Local Plus
		Florida** *(excluding Orlando, Tampa and certain South Florida counties)*	Open Access Plus
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	Cigna HealthCare 866-302-7578 or *www.myCigna.com*	United States	Cigna Value Pharmacy
Dental Care	Cigna Dental 800-244-6224 or *www.myCigna.com*	United States	Total Cigna DPPO
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

**Only certain areas in Florida (Orlando, Tampa metropolitan areas as well as Broward, Martin, Miami-Dade, Monroe, Palm Beach and St. Lucie counties in south Florida), Illinois (Chicago metropolitan area) and Texas (Austin, Brazo Valley, Dallas, Fort Worth and Houston metropolitan areas) are covered by Cigna's Local Plus network.*

***The state of Florida, except for the Orlando and Tampa metropolitan areas and certain counties in south Florida (Broward, Martin, Miami-Dade, Monroe, Palm Beach and St. Lucie), are covered by Cigna's Open Access Plus 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.

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