

# CONCORDIA HEALTH PLAN

## Schedule Nine

### Coverage for Whole Health

**This Schedule describes benefits under Plan Coverage Option Whole Health, 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 Whole Health, which is an Exclusive Provider Organization (EPO) Coverage Option. Kaiser Permanente (KP) is the network manager for these services. Participating network providers must be used to access care since no coverage is available outside the network.

***Mental health and substance abuse care.***\* Kaiser Permanente administers the mental health and substance abuse care benefits for eligible Members and their Enrolled Dependents. Participating network providers must be used to access care.

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

***Prescription drugs.***\* Kaiser Permanente administers the prescription drug coverage. Prescription drugs may be purchased at a local network pharmacy or, for long-term medications, through Kaiser Home Delivery Pharmacy mail order service.

***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: Kaiser Permanente  
 Prescription Drug Network Manager: Kaiser Permanente  
 Mental Health / Substance Abuse Network Manager: Kaiser Permanente**

## ***Summary of Benefits***

<b>SERVICES/TREATMENTS</b>		<b>REIMBURSEMENT BENEFITS</b>
		All services and supplies must be provided in the network, except in limited circumstances.
<b>Preventive Medical Care</b>	Routine preventive medical evaluation, including vision and hearing screenings, preventive immunizations, and laboratory services	100%
	Routine cancer screenings including but not limited to mammograms, Pap smears, Prostate Specific Antigen (PSA) tests	100%
<b>Outpatient Services (Office or Outpatient Facility)</b>	Office visit	100% except \$25 copay per visit
	Allergy testing or injection as part of office visit <i>(includes allergy serum)</i>	100% except for \$25 copay
	Allergy injection only	100%
	Travel immunization, other non-routine immunization or injection provided during office visit	100% except for \$25 copay
	Travel immunization, other non-routine immunization or injection – injection only	100%
	Infusion services provided during office visit	100% except for \$25 copay
	Infusion services – injection only	100%
	Vision refraction exam	100%
	Hearing exam (audiometry)	100%
	Health education <i>(classes for self-management of asthma, diabetes and coronary disease)</i>	100%
	Nutrition visits	100% except for \$25 copay
	Biofeedback services <i>(medical or mental health provider)</i>	100% except for \$25 copay
	Respiratory/pulmonary therapy	100% except for \$25 copay
Cardiac rehabilitation	100% except for \$25 copay	

SERVICES/TREATMENTS		REIMBURSEMENT BENEFITS
	Chemotherapy services	100% except for \$25 copay
	Radiation therapy	100%
	Dialysis services	100% except for \$25 copay
	Physical, occupational or speech therapy <i>Maximum 20 visits per calendar year per therapy category; visit limits do not apply for autism treatment</i>	100% except \$25 copay per visit
	Diagnostic laboratory and x-ray services	100%
	Advanced radiology services <i>(includes CT, MRI, nuclear medicine and PET)</i>	100% except for \$50 copay
<b>Hospital and Surgery Services</b>	Room, board, and professional services/supplies <i>(includes bariatric surgery)</i>	100% except for \$250 copay per admission
	Outpatient surgery and related expenses <i>(includes bariatric surgery)</i>	100% except for \$25 copay
	Emergency services <i>(copay waived if admitted)</i>	100% except for \$100 copay
	Ground or air ambulance services <i>(ambulance services used as non-emergency transportation, other than repatriation transportation, are not covered)</i>	100% except for \$100 copay per trip <i>(“repatriation” transportation from non-network/network hospital to network hospital is covered 100%)</i>
	Urgent and after hours care	100% except for \$25 copay
<b>Maternity Services</b>	Routine pre-natal and post-partum care <i>(pre-natal and first post-partum visit)</i>	100%
	Hospital inpatient	100% except for \$250 copay per admission
<b>Mental Health and Chemical Dependency Services</b>	Inpatient and residential treatments <i>(detox treatments provided under medical services)</i>	100% except for \$250 copay per admission
	Partial hospitalization	100%
	Intensive outpatient services	100% except for \$25 copay
	Outpatient/office services	100% except for \$25 copay <i>(\$12 copay applies for group session)</i>

SERVICES/TREATMENTS		REIMBURSEMENT BENEFITS
<b>Skilled Care Services</b>	Skilled nursing facility <i>Maximum 100 visits per calendar year</i>	100%
	Home health care <i>Maximum 100 visits per calendar year (Includes nurse visits (2 hrs.), aide visits (4 hrs.), therapy visits, and related supplies)</i>	100%
	Home infusion therapy services and related supplies	100%
	Respite care <i>Up to 5 consecutive days for each approved admission</i>	100%
	Hospice care	100%
<b>Other Services</b>	House call	100% except for \$25 copay
	Chiropractic care <i>Maximum of 20 visits per calendar year</i>	100% except \$20* copay per visit <i>(*Chiropractic care copays do not apply towards the annual out-of-pocket max)</i>
	Applied Behavior Analysis (ABA) therapy	100% except for \$25 copay
<b>Supplies &amp; Equipment</b>	Medical supplies, durable medical equipment	100%
	Prosthetics and orthotics <i>(includes medically necessary eyewear for diagnoses of aniridia and aphakia; colostomy/ostomy and urological supplies)</i>	100%
	Special oral foods <i>(amino acid modified products)</i>	100%

**REIMBURSEMENT  
BENEFITS**

<b>Prescription Drugs</b>	Up to 30-day supply – KP Pharmacy or Mail Order Pharmacy	<u>Generic</u> 100% except for \$10 copay	<u>Brand-name</u> 100% except for \$20 copay
	Up to 30-day supply – Community network pharmacy <i>(limited to first fill of prescription in Mid-Atlantic States and Georgia)</i>	<u>Generic</u> 100% except for \$20 copay	<u>Brand-name</u> 100% except for \$30 copay
	31 – 90* day supply – Mail Order Pharmacy <i>*(31 - 100 day supply in California)</i>	<u>Generic</u> 100% except for \$20 copay	<u>Brand-name</u> 100% except for \$40 copay
	Certain over-the-counter drugs prescribed by physician <i>(Limited to aspirin, oral fluoride, folic acid, iron supplements, vitamin D, and preparation drug for colonoscopy)</i>	100%	

<b>Annual Out-of-Pocket Maximums</b>	Individual out-of-pocket maximum	\$1,500
	Family unit* out-of-pocket maximum	\$3,000

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

NOTE: Each family member has an Individual out-of-pocket maximum amount within the family unit out-of-pocket maximum. The individual cannot contribute to the family unit out-of-pocket maximum more than the amount of an Individual out-of-pocket maximum.

<b>Maximum Benefits</b>	Individual <u>annual</u> maximum benefit for chiropractic care	20 visits
	Individual <u>annual</u> maximum benefit for physical therapy, speech therapy and occupational therapy	Each therapy category is limited to 20 days, excluding treatment for autism - which is unlimited
	Individual <u>lifetime</u> maximum benefit for all benefits paid by the CHP	Unlimited lifetime limit

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

The amount of reimbursement for eligible 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) Preventive medical care. One hundred percent (100%) of such eligible charges.  
  
The list of covered procedures, the frequency with which such procedures will be covered in a calendar year, and any applicable age limits may change from time to time as determined by the network manager. If a patient exceeds the frequency limit for any service in a calendar year, and the service was performed for routine checkup purposes, the benefit for basic medical care, with copays, shall be applicable.
- b) Physician office visits and outpatient care visits. One hundred percent (100%) of such eligible charges, minus a twenty-five dollar (\$25) copay per visit (twelve dollar (\$12) copay per visit for group therapy sessions).
- c) Hospital emergency room visits. At any hospital (including non-network hospital), one hundred percent (100%) of such eligible charges, minus a one hundred dollar (\$100) copay per visit; provided, however, that if the individual is admitted into a hospital within twenty-four (24) hours of the emergency room visit, the copay shall be waived.
- d) Ground or air ambulance services. One hundred percent (100%) of such eligible charges, minus a one hundred dollar (\$100) copay per trip; provided, however, that in the case of repatriation transportation from a network hospital or a non-network hospital to a network hospital, the copay shall be waived.
- e) Inpatient hospital charges. One hundred percent (100%) of such eligible charges, minus a two hundred fifty dollar (\$250) copay per admission. For purposes of this paragraph, eligible charges include medical and prescription drug charges, including room and board or hospital nursery charges, incurred during a newborn baby's initial hospital confinement immediately following birth, regardless of such baby's eligibility for enrollment as a Dependent and regardless of whether or not such baby is enrolled as a Dependent by the Member within sixty (60) days after birth. In addition, for purposes of this paragraph, the initial hospital confinement shall end on the date such baby is discharged, or thirty (30) days following the date of birth, if earlier.
- f) Emergency treatment. Eligible charges for treatment of an Emergency medical Condition shall include Non-Network Services and Supplies provided by a non-Network Provider as such terms are defined in Section VI herein.
- g) Specialized services and supplies.
  - i) Advanced radiology services. One hundred percent (100%) of such eligible charges, minus a fifty dollar (\$50) copay.
  - ii) Outpatient physical, occupational or speech therapy. One hundred percent (100%) of such eligible charges, minus a twenty-five dollar (\$25) copay per visit, up to twenty (20) visits per calendar year for each therapy category. Maximum visit limitations do not apply to treatments for autism.
  - iii) Chiropractic care. One hundred percent (100%) of such eligible charges, minus a twenty dollar (\$20) copay per visit, up to twenty (20) visits per calendar year. The twenty dollar

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

(\$20) copay for chiropractic care is not included in satisfying annual out-of-pocket maximums.

- iv) Home health care. One hundred percent (100%) of such eligible charges, up to one hundred (100) visits per calendar year. For purposes of determining maximum visit limitations, nurse visit equals two (2) hours and aide visit equals four (4) hours of services.
- v) Respite care. One hundred percent (100%) of such eligible charges; up to five (5) consecutive days for each approved admission.
- vi) Prosthetic or orthopedic devices. One hundred percent (100%) of such eligible charges, including medically necessary eyewear for diagnoses of aniridia and aphakia, as well as colostomy/ostomy and urological supplies.
- vii) Extended care or skilled nursing facility care. One hundred percent (100%) of such eligible charges for extended care or skilled nursing facility room and board (including regular daily nursing services), inclusive of professional services, furnished by the extended care or skilled nursing facility for medical care therein, up to a maximum of one hundred days (100) days for all confinements during any one calendar year.
- h) Prescription drugs. The amount of reimbursement for eligible charges incurred in connection with prescription drugs (whether a generic drug or a brand-name drug listed on the published formulary of the network provider) purchased from a KP network pharmacy or community network pharmacy (supply of thirty (30) days or less), or from the network mail order home delivery pharmacy shall be as follows:
  - i) Generic drugs. One hundred percent (100%) of eligible charges in excess of ten dollars (\$10) for up to a thirty (30) day supply of a generic prescription drug provided by a KP pharmacy or network mail order pharmacy, except as otherwise provided herein. One hundred percent (100%) of eligible charges in excess of twenty dollars (\$20) for up to a thirty (30) day supply of a generic prescription drug provided by a community network pharmacy (in the Mid-Atlantic States and Georgia, limited to a first time fill of a generic prescription drug). One hundred percent (100%) of eligible charges in excess of twenty dollars (\$20) for a thirty-one (31) to ninety (90) day supply of a generic prescription drug from the network mail order delivery pharmacy. Prescription drugs obtained from the network mail order pharmacy delivered to addresses within the state of California will be limited to supplies of one hundred (100) days.
  - ii) Brand name drugs. One hundred percent (100%) of eligible charges in excess of twenty dollars (\$20) for up to a thirty (30) day supply of a brand name prescription drug provided by a KP pharmacy or network mail order pharmacy, except as otherwise provided herein. One hundred percent (100%) of eligible charges in excess of thirty dollars (\$30) for up to a thirty (30) day supply of a brand name prescription drug provided by a community network pharmacy (in the Mid-Atlantic States and Georgia, limited to a first time fill of a brand name prescription drug). One hundred percent (100%) of eligible charges in excess of forty dollars (\$40) for a thirty-one (31) to ninety (90) day supply of a brand name prescription drug from the network mail order delivery pharmacy. Prescription drugs obtained from the network mail order pharmacy delivered to addresses within the state of California will be limited to supplies of one hundred (100) days.

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

- i) Out-of-pocket maximums. Out-of-pocket maximums can be satisfied only with eligible expenses incurred in the network, and in the case of emergency medical treatment, eligible expenses not incurred in the network.
  - i) Individual maximum. For each calendar year, the out-of-pocket maximum for each individual basic medical care, prescription drug, mental health care, and substance abuse charges for network services and supplies is one thousand five hundred dollars (\$1,500). 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.
  - ii) Family unit maximum. The family unit coverage out-of-pocket maximum of three thousand dollars (\$3,000) 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.

## SECTION II – EMPLOYEE ASSISTANCE PROGRAM

Network Manager: Cigna Behavioral Health

### *Summary of Benefits*

EAP SERVICES/TREATMENTS	NETWORK BENEFITS
<p><b>Confidential, solution-focused counseling and referrals for a variety of work, family, and life issues</b>, such as marital and family difficulties, parenting challenges, child and elder care, stress and anxiety, job enrichment, financial and legal concerns, etc.</p>	<p>All services must be pre-certified or authorized by the Network Manager, otherwise there is no coverage.</p> <p>Up to six (6) free face-to-face visits per issue each year with a professional licensed counselor.</p> <p>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.</p> <p>Free telephone consultations with a financial planner/adviser.</p>



<b>DENTAL SERVICES/TREATMENTS</b>		<b>BENEFITS</b>
<b>Dental Anesthesia</b>	General anesthesia or sedation	80% after deductible
<b>Oral Surgery and Dental Implant Services</b>	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
	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
<b>Orthodontic</b>	Treatment and installation of orthodontic appliances for correction of irregularities in tooth position and jaw relationship	50% after deductible
<b>General</b>	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.	
<b>Alternate Benefit Provision</b>	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.	
<b>Missing Teeth Limitation</b>	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.

## PROVISIONS OUTLINING DENTAL BENEFITS

- 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.
<b>Eye exams</b> One exam every calendar year	\$10 Member Copay	Up to \$45
<b>Prescription glasses</b> <b>Lenses:</b> 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
<b>Frames:</b> Covered once every other calendar year	Covered up to \$150, plus 20% discount off any out-of-pocket costs	Up to \$70
<b>Contact Lenses</b> One exam every calendar year		
<b>Elective contact lenses</b>	\$150 allowance applied to the cost of the contacts and the contact lens exam	Up to \$105
<b>Medically necessary contact lenses</b>	Covered in full	Up to \$210
NOTE: <i>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.</i>		

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.
<b>Miscellaneous discounts</b>		
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 <i>(fitting and evaluation)</i>	15% discount	Not covered
Laser vision correction	Discount varies	Not covered

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

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

**Items not covered under the contact lens coverage:**

- 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.
<b>Eye exams</b> One exam every calendar year	No Copay	50% coinsurance
<b>Prescription glasses</b> <b>Lenses:</b> Covered once every calendar year	No Copay	50% coinsurance
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
<b>Frames:</b> 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
<b>Contact Lenses</b> One exam every calendar year		
<b>Elective contact lenses</b>	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
<b>Medically necessary contact lenses</b>	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.
<b>Comprehensive Audiometry</b> Air & Bone Conduction Thresholds Word Recognition Measures	Member pays \$49 <i>Additional charges may apply if under age 5</i>
<b>Acoustic Immittance Testing</b> Tympanometry Acoustic Reflex Thresholds Acoustic Reflex Decay	Member pays \$35
<b>Digital Hearing Aids</b>	Member pays total discounted price of hearing aids
<b>Hearing Aid Dispensing</b>	No additional charge for fitting and dispensing fees
<b>Related Products, Replacement Ear Molds, and Repairs</b>	Member pays total cost minus 20% discount <i>(based on usual and customary fees charged by provider).</i>  Member pays total cost less 10% discount for accessories, warranties, and related products at <a href="http://www.hearingshop.com">www.hearingshop.com</a>
<b>Annual Cleaning and Check</b> <i>(for any hearing aid purchased through HearUSA)</i>	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 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.

**“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”** – For emergency admissions to a non-network facility, 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.

**“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.

## SPECIAL DEFINITIONS

**“Out-of-Pocket Maximum”** –The aggregate total of a Member’s and Enrolled Dependents, if any, copays 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 Nine Whole Health

### Network Managers

<b>BENEFIT</b>	<b>NETWORK MANAGER</b>	<b>NETWORK AREA</b>	<b>NETWORK</b>
<b>Basic and Preventive Medical Care</b>	Kaiser Permanente <i>my.kp.org/concordia</i>	United States	Kaiser Permanente
<b>Mental Health and Substance Abuse Care</b>	Kaiser Permanente <i>my.kp.org/concordia</i>	United States	Kaiser Permanente
<b>Prescription Drugs</b>	Kaiser Permanente <i>my.kp.org/concordia</i>	United States	Kaiser Permanente Pharmacy
<b>Employee Assistance Program</b>	Cigna Behavioral Health, Inc. 866-726-5267 or <i>www.cignabehavioral.com</i>	United States	EAP Network
<b>Dental Care</b>	Cigna Dental 800-244-6224 or <i>www.myCigna.com</i>	United States	Total Cigna DPPO
<b>Vision Care</b>	Vision Service Plan 800-877-7195 or <i>www.vsp.com</i>	United States	Choice Plan
<b>Hearing Discount Program</b>	HearUSA 800-442-8231 or <i>www.hearusa.com</i>	United States	HearUSA Hearing Care Network

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

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