CONCORDIA HEALTH PLAN
Schedule Eleven

Coverage for Whole Health 2000

This Schedule describes benefits under Plan Coverage Option Whole Health 2000, for Members and Dependents enrolled in such Option, and replaces Subsections 4.5 through 4.10 of the Concordia Health Plan

Basic medical care and preventive medical care.* This Schedule describes the benefits applicable for Whole Health 2000, which is an HSA-compliant High Deductible Health Plan 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

SERVICES/TREATMENTS		REIMBURSEMENT BENEFITS
		All services and supplies must be provided in the network, except in limited circumstances.
Preventive Medical Care	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%
Outpatient Services (Office or Outpatient Facility)	Office visit	$30 copay, after deductible
	Allergy testing or injection as part of office visit *(includes allergy serum)*	$30 copay, after deductible
	Allergy injection only	100%
	Travel immunization, other non-routine immunization or injection provided during office visit	100%
	Travel immunization, other non-routine immunization or injection – injection only	$30 copay, after deductible *(or cost of administration/materials if less)*
	Infusion services provided during office visit	100%
	Infusion services – injection only	$30 copay, after deductible *(or cost of administration/materials if less)*
	Vision refraction exam	$30 copay, after deductible
	Hearing exam (audiometry)	100%
	Health education *(classes for self-management of asthma, diabetes and coronary disease)*	100%
	Nutrition visits	$30 copay, after deductible
	Biofeedback services *(medical or mental health provider)*	$30 copay, after deductible
	Respiratory/pulmonary therapy	$30 copay, after deductible

SERVICES/TREATMENTS		REIMBURSEMENT BENEFITS
	Cardiac rehabilitation	$30 copay, after deductible
	Chemotherapy services	$30 copay, after deductible
	Radiation therapy	100%
	Dialysis services	$30 copay, after deductible
	Physical, occupational or speech therapy *Maximum 20 visits per calendar year per therapy category; visit limits do not apply for autism treatment*	$30 copay, after deductible
	Diagnostic laboratory and x-ray services	$10 copay, after deductible
	Advanced radiology services *(includes CT, MRI, nuclear medicine and PET)*	$50 copay, after deductible
Hospital and Surgery Services	Room, board, and professional services/supplies *(includes bariatric surgery)*	$250 copay per admission, after deductible
	Outpatient surgery and related expenses *(includes bariatric surgery)*	$150 copay per admission, after deductible
	Emergency services *(copay waived if admitted)*	$100 copay, after deductible
	Ground or air ambulance services *(ambulance services used as non-emergency transportation, other than repatriation transportation, are not covered)*	$100 copay per trip, after deductible *("repatriation" transportation from non-network/network hospital to network hospital is covered 100%)*
	Urgent and after hours care	$30 copay per visit, after deductible
Maternity Services	Routine pre-natal and post-partum care *(pre-natal and first post-partum visit)*	100%
	Hospital inpatient	$250 copay per admission, after deductible
Mental Health and Chemical Dependency Services	Inpatient and residential treatments *(detox treatments provided under medical services)*	$250 copay per admission, after deductible
	Partial hospitalization	100%, after deductible
	Intensive outpatient services	100%, after deductible
	Outpatient/office services	$30 copay per visit, after deductible *($15 copay applies for group session)*

SERVICES/TREATMENTS		REIMBURSEMENT BENEFITS
Skilled Care Services	Skilled nursing facility *Maximum 100 visits per calendar year*	$250 copay per admission, after deductible
	Home health care *Maximum 100 visits per calendar year* *(Includes nurse visits (2 hrs.), aide visits (4 hrs.), therapy visits, and related supplies)*	100%, after deductible
	Home infusion therapy services and related supplies	100%, after deductible
	Respite care *Up to 5 consecutive days for each approved admission*	100%, after deductible
	Hospice care	100%, after deductible
Other Services	House call	$30 copay, after deductible
	Chiropractic care *Maximum of 20 visits per calendar year*	$20 copay, after deductible
	Applied Behavior Analysis (ABA) therapy	$20 copay, after deductible
Supplies & Equipment	Medical supplies, durable medical equipment	100% after deductible
	Prosthetics and orthotics *(includes medically necessary eyewear for diagnoses of aniridia and aphakia; colostomy/ostomy and urological supplies)*	100% after deductible
	Special oral foods *(amino acid modified products)*	100% after deductible

		REIMBURSEMENT BENEFITS	
Prescription Drugs	Up to 30-day supply – KP Pharmacy or Mail Order Pharmacy	**Generic** $10 copay after deductible	**Brand-name** $30 copay after deductible
	Up to 30-day supply – Community network pharmacy *(limited to first fill of prescription in Mid-Atlantic States and Georgia)*	**Generic** $20 copay after deductible	**Brand-name** $40 copay after deductible
	31 – 90* day supply – Mail Order Pharmacy **(31 - 100 day supply in California)*	**Generic** $20 copay after deductible	**Brand-name** $60 copay after deductible
	Certain over-the-counter drugs prescribed by physician *(Limited to aspirin, oral fluoride, folic acid, iron supplements, vitamin D, and preparation drug for colonoscopy)*	100%	

Deductibles	Individual annual deductible*	$2,000
	Family unit** annual deductible	$4,000
Annual Out-of-Pocket Maximums	Individual out-of-pocket maximum	$3,000
	Family unit** out-of-pocket maximum	$6,000

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

*The Individual annual deductible 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.

NOTE: Each family member has an Individual deductible and out-of-pocket maximum amount within the family unit deductible and out-of-pocket maximum. The individual cannot contribute to the family unit deductible or out-of-pocket maximum more than the amount of an Individual deductible or out-of-pocket maximum. Deductibles and out-of-pocket maximums are 'embedded." See definition and example in Section VI of this Schedule.

Maximum Benefits	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

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, when provided by an eligible network provider and except as otherwise included elsewhere in this Schedule, shall be:

a) 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:

i) 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 date an enrolled individual's incurred eligible charge is processed and which, together with eligible charges previously incurred and processed during the calendar year, equals or exceeds two thousand dollars ($2,000).

ii) 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 four thousand dollars ($4,000) 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.

iii) 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 charges, 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. 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.

b) 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 received in the network:

i) preventive care (includes wellness exams, laboratory tests and routine cancer screenings);
ii) allergy injection or serum, travel immunization and other non-routine immunization, injection or infusion therapy drugs provided during a network office visit;
iii) hearing exam; and
iv) health education classes for self-management of asthma, diabetes or coronary disease.

c) Reimbursement after deductible is satisfied.

i) Individual. Except as otherwise provided herein, for each calendar year, the Plan shall pay for an enrolled individual one hundred percent (100%) of eligible medical, prescription

drugs, mental health care, and substance abuse charges for network services and supplies after the Individual annual deductible is satisfied.

ii) 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 one hundred percent (100%) 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) For each calendar year, after the applicable plan deductible is satisfied, the Plan shall pay for a covered individual one hundred percent (100%) of eligible medical, prescription drug, mental health care, and substance abuse care charges in excess of any applicable copay and subject to day and visit limitations as set forth below:

A) radiation therapy;
B) partial hospitalization or intensive outpatient services for mental health or chemical dependency;
C) hospice care and home infusion therapy services and related supplies;
D) durable medical supplies, prosthetics, orthotics and special oral foods;
E) network physician’s office visit in excess of a thirty dollar ($30) copay per visit;
F) ambulance services in excess of a one hundred dollar ($100) copay per trip;
G) emergency services received from a network or non-network provider, in excess of a one hundred dollar ($100) copay, provided, however, that if the individual is admitted to a hospital, such copay shall be waived;
H) hospital inpatient services in excess of a two hundred fifty dollar ($250) copay per admission (in the case of the birth of a newborn baby (or babies), mother and child(ren) are treated as separate admissions and separate copay(s) applies);
I) outpatient surgery services in excess of a one hundred fifty dollar ($150) copay per admission;
J) skilled nursing facility services in excess of a two hundred fifty dollar ($250) copay per admission, subject to a maximum of 100 days per calendar year;
K) dialysis services in excess of a thirty dollar ($30) copay;
L) urgent care, respiratory or pulmonary therapy, cardiac rehabilitation services, chemotherapy services, biofeedback services, or house calls in excess of a thirty dollar ($30) copay;
M) physical, occupational, or speech therapy in excess of a thirty dollar ($30) copay and subject to a maximum of 20 visits per year for each category, with no maximum visit limit for autism treatment;
N) home health care, subject to a maximum of 100 visits per year for each category;
O) respite care; subject to up to five (5) consecutive days for each approved admission;
P) chiropractic care in excess of a twenty dollar ($20) copay; subject to a maximum of twenty (20) visits per calendar year;
Q) Applied Behavior Analysis therapy in excess of a twenty dollar ($20) copay;
R) diagnostic laboratory and x-ray services in excess of a ten dollar ($10) copay; and
S) advanced radiological services in excess of a fifty dollar ($50) copay.

e) 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.

f) Prescription drugs. For each calendar year, after the applicable plan deductible has been satisfied, 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 network 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 thirty dollars ($30) for up to a thirty (30) day supply of a brand name prescription drug provided by a KP network pharmacy or network mail order pharmacy, except as otherwise provided herein. One hundred percent (100%) of eligible charges in excess of forty dollars ($40) for up to a thirty (30) day supply 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 sixty dollars ($60) 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.

g) 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 three thousand dollars ($3,000). 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 six thousand dollars ($6,000) 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
	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

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 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.
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

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 $1,000 annual individual deductible and a $2,000 annual family unit deductible, with 80% coinsurance. Once you reach your $1,000 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.

“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.

SPECIAL DEFINITIONS

"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.

"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 Eleven
Whole Health 2000

Network Managers

BENEFIT	NETWORK MANAGER	NETWORK AREA	NETWORK
Basic and Preventive Medical Care	Kaiser Permanente *my.kp.org/concordia*	United States	Kaiser Permanente
Mental Health and Substance Abuse Care	Kaiser Permanente *my.kp.org/concordia*	United States	Kaiser Permanente
Prescription Drugs	Kaiser Permanente *my.kp.org/concordia*	United States	Kaiser Permanente Pharmacy
Employee Assistance Program	Cigna Behavioral Health, Inc. 866-726-5267 or *www.cignabehavioral.com*	United States	EAP Network
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

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

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