CONCORDIA HEALTH PLAN
Schedule One

Coverage for Select 500

This Schedule provides the amount of reimbursement for benefits under Plan Coverage Option Select 500, 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.* There are a variety of Plan Coverage Options for basic medical and preventive medical care. This Schedule describes the benefits applicable for Select 500, which is a PPO (Preferred Provider Organization) program. Blue Cross Blue Shield of Minnesota is the network manager for these services. Participating network providers should be used by Members to access care. Greater benefits are provided when network providers are used for healthcare services, and lower benefits will be applicable if non-network providers are used.

Mental health and substance abuse care.* A network manager (Cigna Behavioral Health) has been selected to administer the benefits for eligible Members and their Enrolled Dependents. The care must be provided by an eligible provider and be medically necessary. Greater benefits are provided when network providers are used.

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

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

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

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

Hearing care. HearUSA (also known as National Ear Care Plan) administers this discount program for hearing screenings and testing, as well as 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, 2016

SECTION I – BASIC MEDICAL CARE AND PREVENTIVE MEDICAL CARE BENEFITS

Network Manager: Blue Cross Blue Shield of Minnesota

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	Well-child care – routine office visits, standard immunizations, developmental assessments, vision and hearing screenings, and laboratory services *(under age 6)*	100%	60% after deductible
	Routine preventive medical evaluation, including vision and hearing screenings, and standard immunizations *(age 6 and older)*	100%	60% after deductible
	Routine lab tests, including but not limited to, diabetes screening and lipid profile (including total and HDL cholesterol)	100%	60% after deductible
	Routine cancer screenings including but not limited to mammograms, Pap smears, flexible sigmoidoscopies, colonoscopies, fecal occult blood testing, Prostate Specific Antigen (PSA) tests, digital rectal exams, and surveillance tests for ovarian cancer	100%	60% after deductible
	Routine outpatient prenatal care (including the initial visit to diagnose pregnancy)	100%	60% after deductible
Medical Services in Physician's Office	Primary Care Physician office visits (includes lab tests or x-rays if performed in the office)	100% except $20 Copay per visit	100% except $40 Copay per visit

BASIC MEDICAL CARE AND PREVENTIVE MEDICAL CARE BENEFITS (continued)

	SERVICES/TREATMENTS	NETWORK BENEFITS	NON-NETWORK BENEFITS
Medical Services in Physician's Office (cont.)	Specialist office visits (includes lab tests or x-rays if performed in the office	100% except $40 Copay per visit	100% except $80 Copay per visit
	Second surgical opinions (not mandatory)	100% except $40 Copay per visit	100% except $80 Copay per visit
	Chiropractic care *(26 visits per calendar year)*	100% except $40 Copay per visit	100% except $80 Copay per visit
	Physical, occupational, or speech therapy	80% after deductible	60% after deductible
	Allergy care by specialist	100% except $40 Copay per visit	100% except $80 Copay per visit
	Allergy shots (serum) if no office visit charge	80% after deductible	60% after deductible
Hospital Services	Room, board, and other services/supplies	80% after deductible *(Hospital certification required for all hospital admissions, otherwise $500 penalty applied)*	60% after deductible
	Newborn care	80% after deductible	60% after deductible
	Hospital emergency room	100% except $150 Copay per visit *(Copay waived if admitted into hospital within 24 hours)*	
Medical & Surgical Services While Hospitalized	Surgery and related expenses such as anesthesia, assistant surgeon	80% after deductible	60% after deductible
	Physician's expense - pregnancy delivery charge and related inpatient services	80% after deductible	60% after deductible
	Physician visit in hospital	80% after deductible	60% after deductible
	Blood transfusions	80% after deductible	60% after deductible

	SERVICES/TREATMENTS	NETWORK BENEFITS	NON-NETWORK BENEFITS
Medical & Surgical Services While Hospitalized (cont.)	Organ transplants or bone marrow/stem cell transplants*	80% after deductible	60% after deductible
	** If using a Blue Distinction Center of Excellence, 100% coverage is provided for hospital charges as well as a travel benefit as described in Subsection 4.2 s) and in administrative guidelines established by Concordia Plan Services.*		
	Knee or hip replacement, and spine surgery*	80% after deductible	60% after deductible
	** If using a Blue Distinction Center of Excellence, 100% coverage is provided for hospital charges.*		
	Bariatric surgery*	80% after deductible	60% after deductible
	** If using a Blue Distinction Center of Excellence, 100% coverage is provided for hospital charges.*		
	Physical, occupational, or speech therapy	80% after deductible	60% after deductible
Outpatient Services	Diagnostic x-ray and lab	80% after deductible	60% after deductible
	Surgery and related expenses	80% after deductible	60% after deductible
	Pre-admission testing	80% after deductible	60% after deductible
	Physical, occupational, or speech therapy	80% after deductible	60% after deductible
Other Services	Home health care	80% after deductible	60% after deductible
	Urgent care	100% except $50 Copay per visit	100% except $100 Copay per visit
	Ambulance and approved emergency air transport services *(if medically necessary)*	80% after deductible	
	Extended care or skilled nursing facility (up to 100 days per calendar year covered)	80% after deductible	60% after deductible

	SERVICES/TREATMENTS	NETWORK BENEFITS	NON-NETWORK BENEFITS
Other Services (cont.)	Hospice care	80% after deductible	60% after deductible
	Kidney dialysis (after 12 months, Member must apply for Medicare Part A and Part B)	80% after deductible	60% after deductible
	Radiation therapy and chemotherapy	80% after deductible	60% after deductible
	Tubal ligation or vasectomy	80% after deductible	60% after deductible
	Accidental injury to natural teeth (treatment must begin within 12 months after accident, and be completed within 24 months after initial treatment)	80% after deductible	60% after deductible
	Temporomandibular joint (TMJ) disorder-only if deemed to be a medical expense by the network's medical review department	80% after deductible	60% after deductible
Supplies and Equipment	Medical supplies, durable medical equipment	80% after deductible	60% after deductible
	Prosthetic or orthopedic devices, such as artificial limbs or eyes, braces, etc. (also covers replacement of these devices when required by person's growth to maturity)	80% after deductible	60% after deductible
General	**Deductibles:**		
	Individual annual deductible (applicable to medical and mental health and substance abuse services)	$500	$1,000
	Family unit* annual deductible** (applicable to medical and mental health and substance abuse services)	$1,000	$2,000

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

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

	SERVICES/TREATMENTS	NETWORK BENEFITS	NON-NETWORK BENEFITS
General (cont.)	**Annual out-of-pocket maximums**:** (deductibles, copays and coinsurance; includes costs for medical, mental health and substance abuse and prescription drug services)		
	Individual out-of-pocket maximum	$2,000	$4,000
	Family unit* out-of-pocket maximum**	$4,000	$8,000

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

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

	Maximum benefits:	
	Individual annual maximum benefit for chiropractic care	Combined 26 visits for network and non-network
	Individual lifetime maximum benefit for all benefits paid by the CHP	Unlimited lifetime limit

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

Provisions Outlining Basic Medical Care and Preventive Medical Care Benefits

After satisfaction of any required deductible for a calendar year, the amount of reimbursement for eligible medical charges, except those otherwise included elsewhere in this Schedule, shall be:

a) Network services and supplies.

i) 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 appropriate deductibles and copays, shall be applicable.

ii) Physician office visits and urgent care visits. One hundred percent (100%) of such eligible charges, minus a twenty dollar ($20) copay per visit for primary care physician office visit; forty dollar ($40) copay per visit for specialist visit; and fifty dollar ($50) copay per visit for urgent care visit.

iii) Hospital emergency room visits. One hundred percent (100%) of such eligible charges, minus a one hundred fifty dollar ($150) copay per visit; provided, however, that if the person is admitted into a hospital within twenty-four (24) hours of the emergency room visit, the copay shall be waived.

iv) Deductible amount. For each calendar year, the deductible for each person for basic medical and mental health and substance abuse charges for network services and supplies not subject to a copay is five hundred dollars ($500). A person may satisfy the deductible for a calendar year through the operation of the following provisions:

A) Normally. The deductible is satisfied by eligible charges incurred within the calendar year. The deductible is satisfied on the date a person incurs an eligible charge which, together with eligible charges previously incurred during the calendar year, equals or exceeds five hundred dollars ($500).

B) Family unit. When one thousand dollars ($1,000) of eligible charges, which may be applied toward satisfying the deductible for a calendar year, has been incurred collectively by persons in the same family unit, the deductible will be deemed satisfied for that calendar year for all enrolled persons in that family unit.

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.

v) Out-of-pocket maximums. For each calendar year, the out-of-pocket maximum for each person (combined deductibles, copays and coinsurance charges) for basic medical, mental health and substance abuse and prescription drug charges for network services and supplies is two thousand dollars ($2,000). For each calendar year, the out-of-pocket maximum for family unit (combined deductibles, copays and coinsurance charges) for basic medical, mental health and substance abuse and prescription drug charges for network services and supplies is four thousand dollars ($4,000).

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

b) Non-network services and supplies.

i) Physician office visits and urgent care visits. One hundred percent (100%) of such eligible charges, minus a forty dollar ($40) copay per visit for primary care physician office visit; eighty dollar ($80) copay per visit for specialist visit; and one hundred dollar ($100) copay per visit for urgent care visit.

ii) Deductible amount. For each calendar year, the deductible for basic medical and mental health and substance abuse charges for non-network services and supplies for each person is one thousand dollars ($1,000). A person may satisfy the deductible for a calendar year through the operation of the following provisions:

A) Normally. The deductible is satisfied by eligible charges incurred within the calendar year. The deductible is satisfied on the date a person incurs an eligible charge which, together with eligible charges previously incurred during the calendar year, equals or exceeds one thousand dollars ($1,000).

B) Family unit. When two thousand dollars ($2,000) of eligible charges, which may be applied toward satisfying the deductible for a calendar year, has been incurred collectively by persons in the same family unit, the deductible will be deemed satisfied for that calendar year for all enrolled persons in that family unit.

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.

iii) Out-of-pocket maximum. For each calendar year, the out-of-pocket maximum for each person (combined deductibles, copays and coinsurance charges) for basic medical, mental health and substance abuse and prescription drug charges for non-network services and supplies is four thousand dollars ($4,000). For each calendar year, the out-of-pocket maximum for each family unit (combined deductibles, copays and coinsurance charges) for basic medical, mental health and substance abuse and prescription drug charges for non-network services and supplies is eight thousand dollars ($8,000).

iv) Preventive medical care. Charges for preventive medical care with a non-network provider are covered at 60% after the deductible.

v) Hospital emergency room and ambulance charges. Eligible charges for a hospital emergency room visit or ambulance transport, if deemed medically necessary, shall be reimbursed as a network service even though provided by a non-network provider.

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

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

d) Extended care or skilled nursing facility care.

i) Annual limit. The amount of reimbursement for extended care or skilled nursing facility room and board (including regular daily nursing services), exclusive of professional services, furnished by the extended care or skilled nursing facility for medical care therein, shall be limited to a maximum of one hundred days (100) days for all confinements during any one calendar year.

ii) Non-network care in special circumstances. If the patient is unable to obtain a bed in an in-network extended care or skilled nursing facility within fifty (50) miles of the patient's home due to full capacity, the Plan will cover a non-network extended care or skilled nursing facility at the network level of benefits.

e) Organ transplants and bone marrow/stem cell transplants. If the surgery is performed at a Blue Distinction Center of Excellence, eligible hospital charges related to the surgery will be covered one hundred percent (100%) with no deductible or coinsurance applied. Also, a travel benefit, not to exceed five thousand dollars ($5,000) per lifetime, 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.

f) Bariatric surgery. If the surgery is performed at a Blue Distinction Center of Excellence, eligible hospital charges as described in Subsection 4.2 a) and b) will be covered one hundred percent (100%) with no deductible or coinsurance applied.

g) Hearing aids for children under age 19. Eligible charges for hearing aids for Enrolled Dependent children and other relatives under age nineteen (19), including hearing aid supplies and hearing aid exam services related to such hearing aids, shall be subject to the deductible and coinsurance applicable for this Plan Coverage Option, except for any physician office visit charges which are subject to the copay; provided, however, that reimbursement for the hearing aids shall not exceed two thousand dollars ($2,000) per aid every three (3) years.

h) Knee replacement, hip replacement, and spine surgery. If the surgery is performed at a Blue Distinction Center of Excellence, eligible hospital charges related to the surgery will be covered one hundred percent (100%) with no deductible or coinsurance applied.

SECTION II -- MANAGED MENTAL HEALTH AND SUBSTANCE ABUSE NETWORK BENEFITS

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 provider in the network.	All eligible charges are subject to a customary charge limitation.
Inpatient care: Hospital and Residential Treatment Facility expenses: room and board, drug, X-ray, lab, physician, detox, and other inpatient services and supplies	80% after deductible	60% after deductible
Outpatient care: Individual or group therapy	100% except $20 Copay per visit	100% except $40 Copay per visit
Intensive outpatient services	80% after deductible	60% after deductible
Partial care	80% after deductible	60% after deductible
Applied Behavior Analysis (ABA) therapy	100% no deductible	100% no deductible
Outpatient laboratory tests	80% after deductible	60% after deductible
Outpatient psychological testing	80% after deductible	60% after deductible
General Deductibles per plan year:		
Individual deductible (applicable to medical and mental health and substance abuse services)	$500	$1,000
Family unit* deductible** (applicable to medical and mental health and substance abuse services)	$1,000	$2,000

	NETWORK BENEFITS	NON-NETWORK BENEFITS
Annual out-of-pocket maximums: (deductibles, copays and coinsurance; includes costs for medical, mental health and substance abuse and prescription drug services)		
Individual out-of-pocket maximum	$2,000	$4,000
Family unit* out-of-pocket maximum**	$4,000	$8,000

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

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

Provisions Outlining Mental Health and Substance Abuse Benefits

The amount of reimbursement for eligible charges incurred in connection with mental health care or substance abuse care shall be:

a) Network services and supplies.

i) Inpatient care. For each plan year, eighty percent (80%) of eligible charges for inpatient care after the combined deductible has been met.

ii) Outpatient visits. One hundred percent (100%) of such eligible charges, minus a twenty dollar ($20) copay per visit.

iii) Applied Behavior Analysis (ABA) therapy. One hundred percent (100%) of eligible charges for treatment of autism or autism spectrum disorders. Only ABA therapy provided by an autism service provider, as described in Subsection 4.1 aa) of the Plan, shall be considered eligible.

b) Non-network services and supplies.

i) Inpatient care. For each plan year, sixty percent (60%) of eligible charges for inpatient care after the combined deductible has been met.

ii) Outpatient visits. One hundred percent (100%) of such eligible charges, minus a forty dollar ($40) copay per visit. Eligible providers of non-network outpatient care shall be limited to psychiatrists, psychologists, social workers, nurse practitioners, and professional counselors, all of whom must be licensed for independent practice for mental health care or substance abuse care in the state in which the services are provided.

iii) Applied Behavior Analysis (ABA) therapy. One hundred percent (100%) of eligible charges for treatment of autism or autism spectrum disorders. Only ABA therapy provided by an autism service provider, as described in Subsection 4.1 aa) of the Plan, shall be considered eligible.

SECTION III – EMPLOYEE ASSISTANCE PROGRAM

Network Manager: Cigna Behavioral Health

Summary of Benefits

SERVICES/TREATMENTS	NETWORK BENEFITS
	All services must be pre-certified or authorized by the Network Manager, otherwise there is no coverage.
Confidential, solution-focused counseling and referrals for a variety of work, family, and life issues, such as marital and family difficulties, parenting challenges, child and elder care, stress and anxiety, job enrichment, financial and legal concerns, etc.	Up to six (6) free face-to-face visits per issue each year with a professional licensed counselor. Free 30-minute telephonic or face-to-face consultations with an attorney for legal questions. If legal representation is necessary, additional legal services are provided at a 25% reduction of the attorney's customary fees. Free telephone consultations with a financial planner/adviser.

SECTION IV -- PRESCRIPTION DRUG BENEFITS

Administered by Express Scripts

Summary of Benefits

SERVICES/TREATMENTS	BENEFITS	
	Purchased at a local pharmacy	Purchased through Express Scripts mail order service
Acute/Short-Term Drugs Supply of 30 days or less, limited to 3 refills* when purchased at a local pharmacy	Member pays: ***Generic:*** $15 Copay ***Brand-name formulary:*** $30 Copay ***Brand-name non-formulary:*** $60 Copay	Member pays: ***Generic:*** $15 Copay ***Brand-name formulary:*** $30 Copay ***Brand-name non-formulary:*** $60 Copay
Maintenance/Long-Term Drugs Supply of more than 30 days but no more than 90 days	Member pays: ***Generic:*** $30 Copay or 50% of cost, whichever is greater ***Brand-name formulary:*** $60 Copay or 50% of cost, whichever is greater ***Brand-name non-formulary:*** $120 Copay or 50% of cost, whichever is greater	Member pays: ***Generic:*** $30 Copay ***Brand-name formulary:*** $60 Copay ***Brand-name non-formulary*** $120 Copay
Specialty Drugs**	Member pays: ***Generic:*** $15 Copay ***Brand-name formulary:*** $30 Copay ***Brand-name non-formulary:*** $60 Copay	Member pays: ***Generic:*** $15 Copay ***Brand-name formulary:*** $30 Copay ***Brand-name non-formulary*** $60 Copay

* After four (4) consecutive fills within one hundred twenty (120) days of the same prescription at your local pharmacy, starting with the fifth (5^{th}) fill at the local pharmacy, you will pay 50% of the cost or the appropriate mail order copay or coinsurance, whichever is greater. Some exceptions may apply if the drug (A) is not available for purchase through the Express Scripts' mail order program, (B) cannot be provided through the mail due to state law, or (C) is considered a controlled substance by Express Scripts.

** Specialty drugs will be covered by the Plan only if purchased from the specialty-drug mail order pharmacy specified by Express Scripts. Specialty drugs are high-cost oral or injectable medications used to treat certain complex conditions. Notwithstanding the foregoing, an initial purchase of a thirty (30) day supply of a specialty drug at a local pharmacy will be covered by the Plan as outlined above.

Provisions Outlining Prescription Drug Benefits

The amount of reimbursement for eligible charges incurred in connection with prescription drugs shall be:

a) Acute/short-term therapy drugs. One hundred percent (100%) of all charges in excess of:

   i) fifteen dollars ($15) for each prescription for a generic drug;

   ii) thirty dollars ($30) for each prescription for a brand-name drug listed on the published formulary of the agency designated by the Board of Trustees to administer these benefits; or

   iii) sixty dollars ($60) for each prescription for a brand-name drug which is not listed on the published formulary of the agency designated by the Board of Trustees to administer these benefits

b) Maintenance/long-term therapy drugs.

   i) Mail order pharmacy. For such maintenance/long-term therapy drugs purchased from the mail order pharmacy designated by the Board of Trustees, one hundred percent (100%) of all charges in excess of:

      a) Thirty dollars ($30) per prescription for a generic drug;

      b) Sixty dollars ($60) per prescription for a brand-name drug listed on the published formulary of the mail order pharmacy; or

      c) One hundred twenty dollars ($120) per prescription for a brand-name drug which is not listed on the published formulary of the mail order pharmacy. Each refill shall be deemed to be a new prescription.

      Each refill shall be deemed to be a new prescription.

   ii) Other pharmacy. For such maintenance/long-term therapy drugs purchased from any other pharmacy, one hundred percent (100%) of all charges in excess of the greater of:

      a) Thirty dollars ($30) or fifty percent (50%) of the cost for each prescription for a generic drug;

      b) Sixty dollars ($60) or fifty percent (50%) of the cost for each prescription for a brand-name drug listed on the published formulary of the mail order pharmacy; or

      c) One hundred twenty dollars ($120) or fifty percent (50%) of the cost for each prescription for a brand-name drug which is not listed on the published formulary of the mail order pharmacy.

   iii) 90-day supply limitation. Eligible charges for maintenance/long-term therapy drugs will be limited to no more than a ninety (90) day supply per prescription.

c) Specialty drugs - Mail order pharmacy. For such maintenance/long-term therapy drugs purchased from the mail order pharmacy designated by the Board of Trustees, one hundred percent 100%) in excess of:

   a) Fifteen dollars ($15) per prescription for a generic drug;

b) Thirty dollars ($30) per prescription for a brand-name drug listed on the published formulary of the mail order pharmacy; or

c) Sixty dollars ($60) per prescription for a brand-name drug which is not listed on the published formulary of the mail order pharmacy.

Eligible charges for specialty drugs will be limited to no more than a thirty (30) day supply per prescription.

Notwithstanding the foregoing, an initial purchase of a thirty (30) day supply of a specialty drug at a local pharmacy will be covered by the Plan as outlined in paragraph a) above.

SECTION V -- DENTAL BENEFITS

Administered by the Cigna Dental PPO
through Cigna HealthCare

Summary of Benefits

	SERVICES/TREATMENTS	BENEFITS
		Eligible charges are subject to an annual deductible and annual or lifetime 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 3 years) 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 3 calendar years) 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 Palliative (emergency) treatment	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 planning**, and osseous surgery Temporomandibular joint (TMJ) disorder will be included under Basic Dental Care only if deemed by Cigna Dental to be a dental expense instead of a medical expense	80%
Dental Anesthesia	General anesthesia or sedation	80%
Oral Surgery	Any incision or excision procedure on the gums or tissues 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%

Oral Surgery (continued)	Implant services will be considered to be oral surgery. 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%
Orthodontic	Treatment and installation of orthodontic appliances for correction of irregularities in tooth position and jaw relationship	50%

* Replacement of a bridge, crown, or denture will be covered only if it has been more than five (5) years since the date originally installed unless (A) such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth, or (B) the bridge, crown, or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while the person was a Member or Enrolled Dependent.

** One hundred percent (100%) reimbursement will be provided for (A) periodontal scaling and root planing, and (B) periodontal maintenance, up to four (4) times per calendar year after periodontal scaling and root planing, for Members and Enrolled Dependents who have been diagnosed with heart disease and/or diabetes and who are actively participating because of either or both conditions, in the Plan's disease management program established under Subsection 4.18. 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
Alternate Benefit Provision	When there is a choice of treatment options for dental care, reimbursement will normally be limited to the least expensive, commonly accepted dental standard for adequate and appropriate care for that dental condition, as determined by Cigna Dental. The Plan's reimbursement can be applied by the patient to the treatment of choice.	
Missing Teeth Limitation	Reimbursement for replacement of missing teeth during the first 24 months following enrollment in the Plan will be limited to 50% of the benefit otherwise payable under the Plan.	

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

Provisions Outlining Dental Benefits

Basic dental care, oral surgery, and orthodontia. After satisfaction of a person's deductible for a calendar year, and subject to the Alternate Benefit limitation under Subsection 4.1 x) of the Plan, the amount of reimbursement for eligible charges incurred in connection with dental care shall be:

a) Basic dental care. In the case of eligible charges for basic dental care:

Eighty percent (80%) of such charges but not to exceed a maximum reimbursement of one thousand five hundred dollars ($1,500) in any one calendar year.

Notwithstanding the foregoing, one hundred percent (100%) reimbursement shall be provided for (i) periodontal scaling and root planing, and (ii) periodontal maintenance, up to four (4) times per calendar year after periodontal scaling and root planing, for Members and Enrolled Dependents who have been diagnosed with heart disease and/or diabetes and who are actively participating because of either or both conditions, in the Plan's disease management program established under Subsection 4.18. Such reimbursement, however, shall be subject to the annual maximum reimbursement for basic dental care.

b) Oral surgery. In the case of eligible charges for oral surgery:

Eighty percent (80%) of such charges.

Notwithstanding the foregoing, if the oral surgery includes any implant procedure, and if the charges for implant services are not deemed to be medically necessary, as determined by the agency designated by the Board of Trustees to administer the dental benefits, the Alternate Benefit provided in Subsection 4.1 x) of the Plan shall be applicable for the prosthetic being placed on the implant and no reimbursement shall be made towards the charges for placement of the implants.

c) Dental Anesthesia. In the case of eligible charges for dental anesthesia:

Eighty percent (80%) of such charges.

d) Orthodontic care. In the case of eligible charges for orthodontic care:

Fifty percent (50%) of such charges, but not to exceed the lifetime maximum under Subsection 4.11 of the Plan.

e) Deductible amount. For each calendar year, the deductible amount for dental charges for each person is one hundred dollars ($100). A person may satisfy the deductible for a calendar year through the operation of the following provisions:

i) Normally. The deductible is satisfied by eligible charges incurred within the calendar year. The deductible is satisfied on the date a person incurs an eligible charge which, together with eligible charges previously incurred during the calendar year, equals or exceeds one hundred dollars ($100).

ii) Family unit. When three hundred dollars ($300) of eligible charges, which may be applied toward satisfying the deductible for a calendar year, has been incurred collectively by persons in the same family unit, the deductible will be deemed satisfied for that calendar year for all enrolled persons in that family unit.

f) Missing teeth limitation. Reimbursement for replacement of missing teeth during the first twenty-four (24) calendar months following enrollment in the Plan shall be limited to fifty percent (50%) of the benefit otherwise payable under the Plan.

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

a) two (2) oral examinations in any calendar year,
b) two (2) dental prophylaxes (cleanings) in any calendar year,
c) two (2) sets of bitewing x-rays in any calendar year,
d) one (1) panoramic or full mouth x-ray every three (3) calendar years,
e) one (1) topical application of sealant per tooth every three (3) calendar years, and
f) one (1) topical application of fluoride in any calendar year

shall be eligible for reimbursement.

SECTION VI – VISION BENEFITS

Administered by Vision Service Plan (VSP)

Summary of Benefits

SERVICES	NETWORK BENEFITS	NON-NETWORK BENEFITS
For persons age nineteen (19) and older	All services and related products must be received or purchased through network providers.	Reimbursement at a lower level is available if a non-network provider is used.
Eye exams One exam every calendar year	$10 Member Copay	Up to $45
Prescription glasses	$25 Member Copay	
Lenses: Covered once every calendar year		
Single vision		Up to $30
Lined bifocal		Up to $50
Lined trifocal		Up to $65
Progressive (no line)		Up to $50
Lenticular		Up to $100
Frames: Covered once every other calendar year	Covered up to $150, plus 20% discount off any out-of-pocket costs	Up to $70
Contact lenses Covered every calendar year		
Elective contact lenses	$150 allowance applied to the cost of the contacts and the contact lens exam	Up to $105
Medically necessary contact lenses	Covered in full	Up to $210

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

SERVICES	NETWORK BENEFITS	NON-NETWORK BENEFITS
Miscellaneous discounts		
Additional complete set of prescription glasses or sunglasses	20% discount	Not covered
Lens extras, such as scratch resistant and anti-reflective coatings	20% discount	Not covered
Contact lenses exam (fitting and evaluation)	20% discount	Not covered
Laser vision correction	Discount varies	Not covered

Items not covered:

- Non-prescription (plano) lenses
- Two pairs of glasses instead of bifocals
- Replacement/repair of lost/broken lenses or frames
- Medical or surgical treatment
- Services/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

SERVICES	NETWORK BENEFITS	NON-NETWORK BENEFITS
For persons under age nineteen (19)	All services and related products must be received or purchased through network providers.	Reimbursement at 50% coinsurance is available if a non-network provider is used.
Eye exams One exam every calendar year	No Copay	50% coinsurance
Prescription glasses	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	50% coinsurance
Contact lenses Covered once every calendar year		
Elective contact lenses	In lieu of eyeglasses, elective contact lens services and materials are covered in full with the following service limitations: –Standard (one pair annually) –Monthly (six month supply) –Bi-Weekly (three month supply) –Dailies (three month supply)	
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.

SERVICES

Items not covered:

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

Items not covered under the contact lens coverage:

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

SECTION VII -- HEARING DISCOUNT PROGRAM

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

Summary of Benefits

SERVICES/TREATMENTS	BENEFITS
	All services and related products must be pre-certified or authorized by the Network Manager, otherwise there is no coverage.
Comprehensive Audiometry Air & Bone Conduction Thresholds Word Recognition Measures	Member pays $49. *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 VIII -- SPECIAL DEFINITIONS

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

“Blue Distinction Center of Excellence” – A hospital or other facility that has been selected by Blue Cross Blue Shield to be a member of a specialized network that provides organ transplants, bone marrow/stem cell transplants, cardiac care, bariatric surgery, hip or knee replacement surgery, or spine surgery. Facilities have been selected after a rigorous evaluation of clinical data that provide insight into the facility’s structures, processes, and outcomes of care. Nationally established evaluation criteria were developed with input from medical experts and organizations. These evaluation criteria support the consistent objective assessment of specialty care capabilities.

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

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

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

"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 $500 annual individual deductible and a $1,000 annual family unit deductible, with 80% coinsurance. Once you reach your $500 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.

"Hospital Certification" – The network manager must be contacted in advance by the Plan Member or Enrolled Dependent for pre-certification of any hospital admission and ongoing stay in a hospital which is authorized or ordered by a non-network physician. For emergency admissions, call within 48 hours. If contact is not made, a $500 penalty will be imposed against the benefits otherwise payable to the Member. Also, if the patient stays in the hospital longer than approved, a $500 penalty is applicable.

"Network provider" – Hospitals, physicians, laboratories, and other licensed health care providers who have contracted with the network manager to provide services and supplies to eligible Members.

"Network services and supplies" – All covered services and supplies received by eligible Members or their Enrolled Dependents which are directed, provided, or authorized by a primary care physician or a network specialty care physician and provided by a network provider.

"Non-network services and supplies" – All covered services and supplies received by eligible Members or their Enrolled Dependents which are <u>not</u> directed, provided, or authorized by a primary care physician or network specialty care physician, or which are not obtained from a network provider.

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

"Out-of-pocket maximum" – The aggregate total of a Member's and Enrolled Dependents, if any, deductible(s), coinsurance and 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 One
Select 500
Network Managers

BENEFIT	NETWORK MANAGER	NETWORK AREA	NETWORK
Basic and Preventive Medical Care	Blue Cross Blue Shield of Minnesota 800-793-6922 or *www.bluecrossmn.com/concordia*	United States*	BlueCard PPO
	Blue Cross Blue Shield of Minnesota 800-793-6922 or *www.bluecrossmn.com/concordia*	St. Louis, MO metropolitan areas*	Blue Access Choice
		Kansas City, KS and Kansas City, MO metropolitan areas*	PreferredCare Blue
		Wisconsin*	Blue Preferred POS
	Blue Cross Blue Shield of Minnesota 800-810-BLUE or *www.bluecrossmn.com/concordia*	Outside United States	BlueCard Worldwide
Mental Health and Substance Abuse Care	Cigna Behavioral Health, Inc. 866-726-5267 or *www.cignabehavioral.com*	United States	CBH Network of Participating Providers
Employee Assistance Program	Cigna Behavioral Health, Inc. 866-726-5267 or *www.cignabehavioral.com*	United States	EAP Network
Prescription Drugs	Express Scripts 800-789-7488 or *www.express-scripts.com*	United States	National Plus
Dental Care	Cigna Dental 800-244-6224 or *www.cigna.com*	United States	Core Network
Vision Care	Vision Service Plan 800-877-7195 or *www.vsp.com*	United States	Choice Plan
Hearing Discount Program	HearUSA 800-442-8231 or *www.hearusa.com*	United States	HearUSA Hearing Care Network

* The state of Wisconsin and certain counties in the St. Louis, Missouri, Kansas City, Kansas and Kansas City, Missouri metropolitan areas are covered by separate managed provider networks and are not covered by the BlueCard network. Please contact Blue Cross Blue Shield of Minnesota for more information about providers in these areas.

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

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