SCHEDULE OF BENEFITS – PLATINUM PLAN

Effective September 1, 2010

All benefits, unless otherwise specified, are based on Usual, Customary and Reasonable (UCR) charges, or the network contracted amounts, and are subject to the deductibles, benefit percentages and maximum amounts shown below. Please read the more detailed description of benefits, the description of covered expenses, and the Plan limitations and exclusions provided in your Plan booklet. If you have questions, please call the Claim Services Administrator, **Meritain Health, at (800) 844-7979.**

Benefit Maximums				
Lifetime Maximum Benefits	All Medical Expenses - $5,000,000 Inpatient Mental/Nervous Treatment - 50 days Alcohol and Substance Abuse - $25,000 Assisted Reproduction Techniques - $20,000			
Calendar Year Maximum Benefits	Outpatient Mental/Nervous Treatment - 52 visits Outpatient Alcohol and Substance Abuse - $5,000 Skeletal Adjustment - $750 Autism and Autism Spectrum Disorders - $36,000			
Deductible and Out-of-Pocket Maximum	**Tier 1 HealthLink**	**Tier 2 HealthLink**	**Tier 3 Non-Network**	**Tier 4 Non-Network in Metro St. Louis***
Calendar Year Deductible • Individual • Family	 $300 $900	 $500 $1,500	 $500 $1,500	 $500 $1,500
Calendar Year Out-of-Pocket** • Individual • Family	 $900 $1,800	 $1,500 $3,000	 $3,000 $6,000	 $4,700 $9,400
*** The Metro St. Louis area includes St. Charles County, St. Louis County and St. Louis City in Missouri and Madison County, St. Clair County and Monroe County in Illinois.** ****The Calendar Year Out-of-Pocket Maximum does not apply when you travel outside the Designated Area for the purpose of receiving treatment.**				
**** The following expenses do not apply toward satisfaction of the Calendar Year Out-of-Pocket Maximum**: • Coinsurance for all mental/nervous, alcohol and/or substance abuse treatment charges; • Coinsurance for treatment outside the Designated Area; • Charges for transplants outside the network; • Charges for surgical procedures for morbid obesity outside the network; • All copayment amounts; • Spinal adjustment charges; • Penalties for failure to pre-certify when required by the Plan; • Any ineligible expenses; • Any expenses in excess of the Lifetime or Calendar Year Maximums.				

Description of Service	Tier 1 HealthLink	Tier 2 HealthLink	Tier 3 Non-Network	Tier 4 Non-Network in Metro St. Louis*
A Copayment applies for each Inpatient Hospital Admission and Outpatient Surgical Procedure performed at an Outpatient Hospital Facility or Ambulatory Surgical Facility. (maximum of 3 such Copayments per person per calendar year) ***All charges are subject to the Calendar Year Deductible unless otherwise noted.***				
Inpatient Hospital Services for treatment of illness or injury (including mental/nervous, alcohol and/or substance abuse)	$150 then 95%	$150 then 90%	$450 then 75%	$450 then 65%
Outpatient Surgery at a Hospital or Ambulatory Surgical Facility (except Emergency Room treatment)	$150 then 95%	$150 then 90%	$450 then 75%	$450 then 65%
Emergency Room Treatment (hospital and emergency room physician fee only). This does not include ambulance transportation.	$200 then 90%, no deductible	$200 then 90%, no deductible	$200 then 90%, no deductible	$200 then 90%, no deductible
Urgent Care Center/Facility	$40 then 90%, no deductible	$40 then 90%, no deductible	$40 then 90%, no deductible	$40 then 90%, no deductible
Medically Necessary Ambulance Transportation	80%	80%	80%	80%
Medically Necessary Ambulance Transportation - Out of Network Medically Necessary Ambulance Expenses will be subject to the Tier 2 Out-of-Pocket Maximum.				
Pre-admission Testing	100%, no deductible	100%, no deductible	100%, no deductible	100%, no deductible
Physician's Inpatient Visits (includes medical, surgical, mental/nervous, alcohol and/or substance abuse visits)	95%	90%	75%	65%
Second Surgical Opinion	100%, no deductible	100%, no deductible	100%, no deductible	100%, no deductible
Diagnostic Laboratory Expenses	95%	90%	75%	65%
Diagnostic Laboratory Expenses (When using a LabCard provider)	100%, no deductible	100%, no deductible	100%, no deductible	100%, no deductible
Diagnostic Laboratory Expenses - When a covered member uses the services of a LabCard provider, there will be no out-of-pocket expense to the member and covered services will be covered at 100%.				
Diagnostic X-ray Expenses	95%	90%	75%	65%
Organ and Tissue Transplants	100%, no deductible	90%, no deductible	50% up to $50,000	50% up to $50,000
Surgical Treatment of Morbid Obesity	95%	90%	50% up to $50,000	50% up to $50,000
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Description of Service	Tier 1 HealthLink	Tier 2 HealthLink	Tier 3 Non-Network	Tier 4 Non-Network in Metro St. Louis*
All charges are subject to the Calendar Year Deductible unless otherwise noted.				
Physician's Office Visit or Retail Clinic Visit	$25 then 100%, no deductible	$25 then 100%, no deductible	75%	65%
Adjunctive Services in Physician's Office, Retail Clinic or Urgent Care Center/Facility	95%	90%	75%	65%
Physician's Outpatient Mental/nervous, Alcohol and/or Substance Abuse Visits	95%	90%	75%	65%
Skeletal Adjustment	50%	50%	50%	50%
Durable Medical Equipment	95%	90%	75%	65%
Physical, Speech or Occupational Therapy	95%	90%	75%	65%
Home Health Care Home Infusion Skilled Nursing Facility Hospice Care	95%	90%	75%	65%
Covered Prescription Drugs not covered under the Drug Card Benefit	80%	80%	80%	80%
All Other Covered Expenses	95%	90%	75%	65%
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PRESCRIPTION DRUG CARD BENEFIT

Mail Order and Participating Retail Pharmacies

Beginning September 1, 2010 you may not purchase more than a 30 day supply of any prescription drug at a retail pharmacy. You may purchase a 30 day supply of maintenance drugs at a retail pharmacy, but after the first two fills, if you continue to choose to fill maintenance drugs at a retail pharmacy (rather than Home Delivery), you will pay double the normal copay for a 30 day supply, as shown below.

Also, beginning September 1, 2010 you will be required to purchase specialty drugs through CuraScript Specialty Pharmacy. Specialty drugs are very high cost biologic and injectable drugs that are not typically stocked by retail pharmacies. **If a member tries to fill a specialty script at retail, the pharmacy will notify the member that the drug must be ordered from Curascript**. You may begin using CuraScript for those specialty medications at any time by calling **866-848-9870.**

Prescription Drug Copayments	Retail 30 day supply	Retail- Maintenance Drugs after first 2 fills 30 day supply	Home Delivery up to 90 day supply
Generic	$12	$24	$30
Preferred Brand	$25	$50	$55
Non-Preferred	$40	$80	$100
Injectables	Copay plus 3%	Copay plus 3%	Copay plus 3%

WELLNESS BENEFIT

Routine services are not typically a covered benefit under this Plan. However, services for the prevention of illness or for the promotion of health are covered on a limited basis as provided below.

Description of Wellness Service	Tier 1 HealthLink	Tier 2 HealthLink	Tier 3 Non-Network	Tier 4 Non-Network in Metro St. Louis*
Charges are not subject to the Calendar Year Deductible except as noted.				
Wellness Office Visit for Infants from birth to 1 year (limited to 6 visits per calendar year)	$25 then 100%	$25 then 100%	75%, after deductible	65%, after deductible
Wellness Office Visit for Children ages 1 to 2 years (limited to 2 visits per calendar year)	$25 then 100%	$25 then 100%	75%, after deductible	65%, after deductible
Wellness Office Visit for Covered Persons over age 2 (limited to 1 visit per calendar year)	$25 then 100%	$25 then 100%	75%, after deductible	65%, after deductible
Childhood Immunizations and Vaccinations that are required by law or by schools	100%	100%	100%	100%
Wellness Office Visit for Routine Gynecological Examination (limited to 1 visit per calendar year)	$25 then 100%	$25 then 100%	75%, after deductible	65%, after deductible
Mammogram (limited to 1 per calendar year paid under the Wellness Benefit)	100%	100%	100%	100%
Routine Pap Smear (limited to 1 test per calendar year paid under the Wellness Benefit)	100%	100%	100%	100%
Routine PSA Test (limited to 1 test per calendar year paid under the Wellness Benefit)	100%	100%	100%	100%
Routine Diagnostic Laboratory and X-ray Testing (limited to $500 calendar year maximum benefit)	100%	100%	100%	100%
Routine Diagnostic Laboratory and X-ray Testing - This $500 benefit may also be used for the HPV vaccine, Gardasil and for the Shingles vaccine, Zostavax (over age 60).				
Routine Diagnostic Colonoscopy and all related expenses for Covered Persons age 50 and over (limited to 1 routine procedure every 10 years). The copayment will only apply in the case where a facility fee is billed.	$150 then 95%, no deductible	$150 then 90%, no deductible	$450 then 75%, no deductible	$450 then 65%, no deductible
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