SCHEDULE OF BENEFITS – BRONZE PLAN

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

Effective January 1, 2011

This Plan is a High Deductible Health Plan (HDHP), designed to qualify for use with a Health Savings Account (HSA). All charges except charges for preventive care (as defined under IRS rules) are subject to the Calendar Year Deductible. 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	$1,200 $2,400	$1,600 $3,200	$1,600 $3,200	$1,600 $3,200
Calendar Year Out-of-Pocket*** • Individual • Family	$3,600 $7,200	$4,800 $9,600	$5,950 $11,900	Unlimited Unlimited

*** 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.**

**** If any dependents are covered, the Family Calendar Year Deductible must be satisfied before the Plan will pay expenses for any covered family member, except expenses for preventive care.**

***** 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;
- 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;
- Charges for services by Tier 4 providers.

In this Plan all other Copayments, Coinsurance and Calendar Year Deductibles apply toward satisfaction of the Calendar Year Out-of-Pocket Maximum.

Description of Service	Tier 1 HealthLink	Tier 2 HealthLink	Tier 3 Non-Network	Tier 4 Non-Network in Metro St. Louis*
After the Deductible, 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.***				
Inpatient Hospital Services for treatment of illness or injury (including mental/nervous, alcohol and/or substance abuse)	$150 then 80%	$150 then 75%	$450 then 60%	$450 then 50%
Outpatient Surgery at a Hospital or Ambulatory Surgical Facility (except Emergency Room treatment)	$150 then 80%	$150 then 75%	$450 then 60%	$450 then 50%
Emergency Room Treatment (hospital and emergency room physician fee only). This does not include ambulance transportation.	$200 then 80%	$200 then 80%	$200 then 80%	$200 then 80%
Urgent Care Center/Facility	$40 then 80%	$40 then 80%	$40 then 80%	$40 then 80%
Medically Necessary Ambulance Transportation	80%	80%	80%	80%
Pre-admission Testing	80%	75%	60%	50%
Physician's Inpatient Visits (includes medical, surgical, mental/nervous, alcohol and/or substance abuse visits)	80%	75%	60%	50%
Second Surgical Opinion	80%	75%	60%	50%
Diagnostic Laboratory Expenses	80%	75%	60%	50%
Diagnostic Laboratory Expenses (When using a LabCard provider)	100%	100%	100%	100%
Diagnostic Laboratory Expenses - When a covered member uses the services of a LabCard provider, after satisfaction of the calendar year deductible, there will be no out-of-pocket expense to the member and covered services will be covered at 100%.				
Diagnostic X-ray Expenses	80%	75%	60%	50%
Organ and Tissue Transplants	85%	75%	50% up to $50,000	50% up to $50,000
Surgical Treatment of Morbid Obesity	80%	75%	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.				
Physician's Office Visit or Retail Clinic Visit	$25 then 80%	$25 then 75%	60%	50%
Adjunctive Services in Physician's Office, Retail Clinic or Urgent Care Facility	80%	75%	60%	50%
Physician's Outpatient Mental/nervous, Alcohol and/or Substance Abuse Visits	80%	75%	60%	50%
Skeletal Adjustment	50%	50%	50%	50%
Durable Medical Equipment	80%	75%	60%	50%
Physical, Speech or Occupational Therapy	80%	75%	60%	50%
Home Health Care Home Infusion Skilled Nursing Facility Hospice Care	80%	75%	60%	50%
Covered Prescription Drugs not covered under the Drug Card Benefit	80%	80%	80%	80%
All Other Covered Expenses	80%	75%	60%	50%
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PRESCRIPTION DRUG CARD BENEFIT

Mail Order and Participating Retail Pharmacies

Under an HDHP, most prescription drug charges are subject to the Calendar Year Deductible. For covered drugs classified under IRS guidelines as preventive drugs you will pay the Copayments shown below. However, for drugs prescribed to treat an existing illness or medical condition you must pay 100% of the discounted charge for each prescription until you satisfy the Individual Calendar Year Deductible (if you have individual coverage), or until you and all covered family members satisfy the Family Calendar Year Deductible (if you are enrolled for Employee + Spouse, Employee + Child(ren) or Employee + Family coverage). After you satisfy the applicable Calendar Year Deductible, you will pay the Copayments shown in the following table until your out-of-pocket expenses satisfy the appropriate Calendar Year Out-of-Pocket Maximum. The Plan will then pay 100% of the cost of your covered prescription drugs for the remainder of the year. A list of preventive drugs can be found on Express Scripts' web site at **www.express-scripts.com**.

Beginning January 1, 2011 all maintenance medications may be filled on a 90 day basis through Home Delivery or the Express Scripts Maintenance Drug Network (MDN) of pharmacies. You will continue to have the option to fill the first two months of a maintenance medication at any local retail pharmacy for the normal 30 day co-pay. After the first two fills of a maintenance medication each fill afterward will be required to be a 90 day fill at either an MDN pharmacy or through Home Delivery. You can continue to buy up to a 30 day supply of any covered medication that is not a maintenance medication and is not a specialty medication at any retail pharmacy.

Also, you are 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	MDN Retail 90 day supply Maintenance drugs after first 2 fills	Home Delivery up to 90 day supply
Generic	$12	$36	$30
Preferred Brand	$30	$85	$70
Non-Preferred Brand	$45	$130	$110
Injectables	Copay plus 3%	Copay plus 3%	Copay plus 3%

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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. Copayments and Deductibles will apply towards satisfaction of your Calendar Year Out-of-Pocket Maximum.				
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 - 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 80%	$150 then 75%	$450 then 60%	$450 then 50%
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