

Vantagelinks, Llc

Effective Date: 05/01/2009

ST Louis Group Operations Inc

Blue Access Choice Option 6 with Rx Option P

	Network	Non-Network
Calendar Year Deductible (individual/family)	\$1,500 / \$4,500	\$3,000 / \$9,000
Annual Out-Of-Pocket Limit (individual/family)	\$3,000 / \$6,000	\$6,000 / \$12,000
Physician Home and Office Services (per visit)(PCP/SCP)	\$20 / \$40	50%
Allergy injections	\$5	50%
Mammography	\$20	50%
Emergency Room Services: Facility/Other Covered Services	\$150/20%	\$150/20%
Urgent Care Center	\$50	50%
Inpatient/Outpatient Professional Services	20%	50%
Inpatient Facility Services (per admission)	20%	50%
Outpatient Hospital/Alternative Care Fac: Surgery (per visit)	20%	50%
Outpatient Services: Other (per visit)	20%	50%
Ambulance Services	20%	20%
Hospice Services	20%	50%
Lifetime Maximum	Unlimited Combined	Unlimited Combined

(PCP) means Primary Care Physician. (SCP) means Specialty Care Physician. Flat dollar copayments and Non-Network Human Organ and Tissue Transplants are excluded from the Out-of-pocket limits. Also Prescription Drug deductibles/copayments/coinsurance are excluded from the Out-of-pocket limits. Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other. Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to Emergency Room Services where a copayment and a (%) coinsurance applies. Prescription Drugs do not accumulate toward the Medical Lifetime Maximum (if applicable). However, once the Medical Lifetime Maximum is met (if applicable), no additional Prescription Drug claims will be paid. No Cost Share means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% coinsurance means no coinsurance up to the maximum allowable amount.

Other Network Services:

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| <p>Durable Medical Equipment and Orthotics</p> <ul style="list-style-type: none"> - \$4,000 benefit maximum(excludes Prosthetic Devices and Medical Supplies) - Prosthetic Devices: \$4,000 limit <p>Outpatient Therapies</p> <ul style="list-style-type: none"> - Physical/Manipulation Therapy excluding Chiropractic Services: 20 visit limit - Occupational Therapy: 20 visit limit - Chiropractic Services: 26 visit limit - Speech Therapy: Unlimited visit limit <p>Human Organ / Tissue Transplants</p> <ul style="list-style-type: none"> - No copayment/coinsurance <p>Elective Abortions are excluded</p> | <p>Behavioral Health (Substance Abuse)</p> <ul style="list-style-type: none"> - Inpatient: 21 days, 6 detox - Outpatient: 30 visits - IP & OP Substance Abuse: 10 episodes per lifetime <p>Home Care Services</p> <ul style="list-style-type: none"> - 90 visits excludes Private Duty Nursing and IV Therapy <p>Private Duty Nursing</p> <ul style="list-style-type: none"> - \$50,000 annual/\$100,000 Lifetime Maximum <p>Prescription Drugs (Network Pharmacy)</p> <ul style="list-style-type: none"> - Retail (30-day Supply)
\$8 / \$25 / \$45 / 25% up to \$2,500 - Mail Service (90-day Supply)
\$16 / \$65 / \$115 / 25% up to \$2,500 - Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits. |
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Benefit ID: 96715

This coverage has been selected for employees and eligible dependents; subject to the terms and conditions of this proposal and the application to which this is attached.

Authorized Signature

Date

Your Anthem Benefits



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Blue Access® Choice Option 6 with Rx Option P
Summary of Benefits , Effective 05/01/2009

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	\$1,500/\$4,500	\$3,000/\$9,000
Out-of-Pocket Limit (Single/Family)	\$3,000/\$6,000	\$6,000/\$12,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician(PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: · Allergy injections (PCP and SCP) · Allergy testing · Routine and non-routine mammograms (regardless of outpatient setting) · Diabetic Self Management Training (regardless of outpatient setting) · Certain medical nutritional therapy (regardless of outpatient setting) · MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies and non-maternity related Ultrasounds	\$20/\$40 \$5 20% \$20 \$20 \$20 20%	50% 50% 50% 50% 50% 50%
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams. · Physician Home and Office Visits (PCP/SCP) · Other Outpatient Services @ Hospital/Alternative Care Facility · Immunizations through age 5	\$20/\$40 20% No Copayment/Coinsurance	50% 50% No Copayment/Coinsurance
Emergency and Urgent Care · Emergency Room Services (facility/other covered services) (copayment waived if admitted) · Urgent Care Center Services	\$150/20% \$50	\$150/20% 50%
Inpatient and Outpatient Professional Services Include but are not limited to: · Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	20%	50%
Inpatient Facility Services Unlimited days except for: · 60 days Network/Non-Network combined for physical medicine / rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) · 90 days Network/Non-Network combined for skilled nursing facility	20%	50%
Outpatient Surgery Hospital / Alternative Care Facility · Surgery and administration of general anesthesia	20%	50%
Other Outpatient Services (including but not limited to): · Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. · Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy) · Durable Medical Equipment and Orthotics (Network/Non-network combined) \$4,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies) · Prosthetic Devices \$4,000 benefit maximum · Physical Medicine Therapy Day Rehabilitation programs · Hospice Care · Ambulance Services	20% 20% 20%	50% 50% 20%

Anthem Blue Cross and Blue Shield is the trade name RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC) and HMO Missouri, Inc. use to do business in most of Missouri. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. Life and disability benefits are underwritten by Anthem Life Insurance Company (ALIC). RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. RIT, HMO Missouri, Inc., HALIC and ALIC are independent licensees of the Blue Cross and Blue Shield Association.

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Summary of Benefits , Effective 05/01/2009

Covered Benefits	Network	Non-Network
Outpatient Therapy Services (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> · Physician Home and Office Visits (PCP/SCP) · Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: <ul style="list-style-type: none"> · Physical / Manipulation therapy excludes Chiropractic Services: 20 visits · Occupational therapy: 20 visits · Chiropractic Services: 26 visits (Network) Non-Network Not Covered · Speech therapy: Unlimited visits 	\$20/\$40 20%	50% 50%
Behavioral Health Services:(Network and Non-Network) Mental Health and Substance Abuse <ul style="list-style-type: none"> · Inpatient Facility Services · Physician Home and Office Visits (PCP/SCP) · Other Outpatient Services @ Hospital/Alternative Care Facility Substance Abuse Limits <ul style="list-style-type: none"> · Inpatient: 21 days, 6 separate days for detox · Outpatient Facility: 30 visits · Outpatient Office Visits: 30 visits (Substance abuse rehabilitation programs are limited to 10 episodes per lifetime Network and Non-Network combined.)	20% \$20/\$40 20%	50% 50% 50%
Human Organ and Tissue Transplants(1) <ul style="list-style-type: none"> · Acquisition and transplant procedures, harvest and storage. 	No Copayment/Coinsurance	30%
Prescription Drugs:(2) Network Tier structure equals 1/2/3 (and 4 if applicable) <ul style="list-style-type: none"> · Network Retail Pharmacies: (30 day supply) Includes diabetic test strip · Anthem Mail Service: (90 day supply) Includes diabetic test strip *Member may be responsible for additional cost when not selecting the available generic drug. Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits.	\$8/\$25/\$45* 25% up to \$2,500 out of pocket maximum \$16 /\$65 /\$115* 25% up to \$2,500 out of pocket maximum	50% , min \$45(3) Not Covered
Lifetime Maximum (Combined Network and Non-Network) (4)	Unlimited	Unlimited

Notes:

- Flat dollar copayments and Non Network Human Organ and Tissue Transplants are excluded from the out-of-pocket limits. Also Prescription Drug deductibles/copayments/coinsurance are excluded from the out-of-pocket limits.
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to Emergency Room Services where a copayment and a percentage(%) coinsurance applies
- Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent age: to the end of the calendar year in which the child attains age 25.
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYN's and Geriatrics or any other Network Provider as allowed by the plan.
- Physicians Home and office visit copayment applies if the office visit is billed with allergy injections.
- No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

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- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.
- Benefit period = Calendar Year
- (1) Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.
- (2) If applicable, all prescription drug expenses except tier 1, (Network/Non-Network, Retail/Mail-service combined) apply to the per individual RX deductible. Once the RX deductible is met, the appropriate copayment/coinsurance applies. Also, if applicable, the Prescription Drug out of pocket maximum applies to Network Retail and Mail-Service combined.
- (3) Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
- (4) Prescription Drugs do not accumulate toward the Medical Lifetime Maximum (if applicable). However, once the Medical Lifetime Maximum is met (if applicable), no additional Prescription Drug claims will be paid.

Precertification:

- Members are encouraged to always obtain prior approval when using Non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-Existing Exclusion Period:

We will not provide benefits for services, supplies, or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements):

12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical), which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date