

**EXHIBIT A**

**\$750 DEDUCTIBLE PLAN  
SCHEDULE OF BENEFITS**

<b>MAXIMUM BENEFIT AMOUNTS</b>	Calendar Year maximum benefit-None
	Lifetime maximum benefit-None
<b>Your health plan pays all providers based on its Maximum Allowable Charge limitation, which defines its allowed amount. Your health plan may have direct contracts with certain providers but in general your percentage of costs will be the same for any chosen provider.</b>	
<b>CALENDAR YEAR DEDUCTIBLE</b>	<b>PROVIDERS</b>
Per Covered Person	\$750
Per Family Unit	\$2,250
<b>COPAYMENTS</b>	
Physician Visits	\$25
Outpatient Diagnostic Testing	\$12.50
<b>CALENDAR YEAR MAXIMUM OUT-OF-POCKET AMOUNT (including deductible)</b>	
Per Covered Person	\$3,250
Per Family Unit	\$9,750
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.	
Precertification non-compliance penalties do not apply toward the out-of-pocket maximum.	
<b>COVERED SERVICES</b>	<b>BENEFITS</b>
<b>Hospital Services</b>	
Room and Board	After deductible, 80%
Intensive Care Unit	After deductible, 80%
<b>Skilled Nursing Facility</b>	After deductible, 80%
<b>Physician Services</b>	
Inpatient Visits	After deductible, 80%
Office Visits (Includes ancillary charges, such as x-rays, lab work, therapeutic injections and supplies performed/provided and billed by the doctor's office)	After copayment, 100% up to \$500, then subject to deductible and co-insurance
Outpatient Diagnostic Procedures	After copayment, 100% up to \$300, then subject to deductible and co-insurance
Allergy testing and injections	After deductible, 80%
Surgery	After deductible, 80%
<b>Home Health Care</b>	
	After deductible, 80% 60 visit Calendar Year maximum benefit
<b>Outpatient Private Duty Nursing</b>	After deductible, 80%
<b>Hospice Care</b>	After deductible, 80%
<b>Ambulance Services</b>	
Ground Ambulance	After deductible, 80%
Air Ambulance	Air Ambulance Limited to \$10,000 per trip
<b>Occupational Therapy</b>	
<b>Speech Therapy</b>	After deductible, 80%
<b>Physical Therapy</b>	

COVERED SERVICES	BENEFITS
<b>Durable Medical Equipment</b> (Rental up to purchase price) <b>Prosthetics</b> <b>Orthotics</b>	After deductible, 80%
<b>Diabetic Equipment and Supplies</b> (Includes equipment, immunizations, self-management training and supplies not eligible for coverage under the Prescription Drug plan)	After deductible, 80%
<b>Hearing loss, including exam, hearing aids, fitting and follow-up care</b>	After deductible, 80% Limited to \$5,000 per 36 month period
<b>Spinal Manipulation Chiropractic</b>	After deductible, 80%
<b>Mental Health Conditions</b>	
Includes Serious Mental Illness and Substance Use Disorder	Covered as Illness
<b>Child and Adult Preventive Care Services</b>  Immunizations for child age 0 to 6 years  Screening for Hearing Loss for Child from birth to 24 months  All Other Child and Adult Preventive Care	100%  100%  100%
<b>Prostate Cancer Screening</b>	After copayment, 100%
<b>Routine Annual Physical</b>	After copayment, 100% up to a \$1,000 Calendar Year maximum benefit
<b>Routine Well Newborn Care</b>	After deductible, 80%
<b>All Other Covered Expenses</b>	After deductible, 80%