EXHIBIT A

$1,000 DEDUCTIBLE PLAN
SCHEDULE OF BENEFITS

MAXIMUM BENEFIT AMOUNTS	Calendar Year maximum benefit-None
	Lifetime maximum benefit-None
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.	
CALENDAR YEAR DEDUCTIBLE	**PROVIDERS**
Per Covered Person	$1,000
Per Family Unit	$3,000
COPAYMENTS	
Physician Visits	$30
Outpatient Diagnostic Testing	$15
CALENDAR YEAR MAXIMUM OUT-OF-POCKET AMOUNT (including deductible)	
Per Covered Person	$5,000
Per Family Unit	$13,200
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.	

COVERED SERVICES	**BENEFITS**
Hospital Services	
Room and Board	After deductible, 80%
Intensive Care Unit	After deductible, 80%
Skilled Nursing Facility	After deductible, 80%
Physician Services	
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%
Home Health Care	After deductible, 80% 60 visit Calendar Year maximum benefit
Outpatient Private Duty Nursing	After deductible, 80%
Hospice Care	After deductible, 80%
Ambulance Services **Ground Ambulance** **Air Ambulance**	After deductible, 80% Air Ambulance Limited to $10,000 per trip
Occupational Therapy **Speech Therapy** **Physical Therapy**	After deductible, 80%

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