

EXHIBIT A

GOLD SCHEDULE OF BENEFITS

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM LIFETIME BENEFIT AMOUNT	\$1,000,000	
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
CALENDAR YEAR DEDUCTIBLE		
Per Covered Person	\$750	\$1,500
Per Family Unit	\$2,250	\$4,500
Amounts applied towards the Network Calendar Year deductible will also apply towards the non-Network Calendar Year deductible, and vice versa.		
COPAYMENTS		
Physician Visits	\$25	N/A
Outpatient Diagnostic Testing	\$12.50	N/A
Preventive Care – Routine Well Adult Care and benefits listed as All Other Routine Well Child Care	\$25	N/A
CALENDAR YEAR MAXIMUM OUT-OF-POCKET AMOUNT		
Per Covered Person	\$2,500	\$6,000
Per Family Unit	\$7,500	\$18,000
Amounts applied towards the Network out-of-pocket maximum will also apply towards the non-Network out-of-pocket maximum, and vice versa.		
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.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: Deductibles Copayments Outpatient and inpatient substance abuse treatment Precertification non-compliance penalties		
COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
ALL NON-NETWORK SERVICES ARE SUBJECT TO EME: Eligible Medical Expense (EME) is the maximum allowable amount that will be eligible for a particular Covered Service as determined by the Plan in accordance with the Plan reimbursement schedule. See Eligible Medical Expense in the Defined Terms section.		
Hospital Services		
Room and Board	After deductible, 80% of semiprivate room rate	After deductible, 50% of semiprivate room rate
Intensive Care Unit	After deductible, 80% of Hospital's ICU Charge	After deductible, 50% of Hospital's ICU Charge
Skilled Nursing Facility	After deductible, 80% of facility's semiprivate room rate \$5,000 Calendar Year maximum benefit	After deductible, 50% of facility's semiprivate room rate \$5,000 Calendar Year maximum benefit
Physician Services		
Inpatient Visits	After deductible, 80%	After deductible, 50%
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	After deductible, 50%
Outpatient Diagnostic Procedures	After copayment, 100% up to \$300, then subject to deductible and co-insurance	After deductible, 50%
Allergy testing and injections	After deductible, 80%	After deductible, 50%
Surgery	After deductible, 80%	After deductible, 50%

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Home Health Care	After deductible, 80% 60 visit Calendar Year maximum benefit	After deductible, 50% 60 visit Calendar Year maximum benefit
Outpatient Private Duty Nursing	After deductible, 80%	After deductible, 50%
Hospice Care	After deductible, 80% \$7,500 Calendar Year maximum benefit	After deductible, 50% \$7,500 Calendar Year maximum benefit
Ambulance Services	After deductible, 80%	After deductible, 50%
Occupational Therapy Speech Therapy Physical Therapy	After deductible, 80% Inpatient - \$10,000 Calendar Year maximum benefit Outpatient - \$3,000 Calendar Year maximum benefit Inpatient and Outpatient maximums include the combined charges of Occupational Therapy, Speech Therapy and Physical Therapy	After deductible, 50% Inpatient - \$10,000 Calendar Year maximum benefit Outpatient - \$3,000 Calendar Year maximum benefit Inpatient and Outpatient maximums include the combined charges of Occupational Therapy, Speech Therapy and Physical Therapy
Durable Medical Equipment (Rental up to purchase price) Prosthetics Orthotics	After deductible, 80% \$10,000 Lifetime maximum benefit Maximum applies to charges for Durable Medical Equipment, Prosthetics, and Orthotics combined	After deductible, 50% \$10,000 Lifetime maximum benefit Maximum applies to charges for Durable Medical Equipment, Prosthetics, and Orthotics combined
Diabetic Equipment and Supplies (Includes equipment, immunizations, self-management training and supplies not eligible for coverage under the Prescription Drug plan)	After deductible, 80%	After deductible, 50%
Spinal Manipulation Chiropractic	After deductible, 80%	After deductible, 50%
Mental Disorders		
Includes Serious Mental Illness		
Inpatient	After deductible, 80% 45 days Calendar Year maximum benefit	After deductible, 50% 45 days Calendar Year maximum benefit
Outpatient	After deductible, 80% 60 visit Calendar Year maximum benefit	After deductible, 50% 60 visit Calendar Year maximum benefit
Substance Abuse		
Inpatient	After deductible, 80% 45 days Calendar Year maximum benefit	After deductible, 50% 45 days Calendar Year maximum benefit
Outpatient	After deductible, 80% 60 visit Calendar Year maximum benefit	After deductible, 50% 60 visit Calendar Year maximum benefit
Preventive Care		
Routine Well Adult Care		
Prostate Cancer Screening	After copayment, 100%	Subject to deductible and co-insurance
Cervical Cancer Screening	After copayment, 100%	Subject to deductible and co-insurance
All Other Routine Well Adult Care (Includes office visits, mammogram, gynecological exam, routine physical examination, diagnostic procedures, hearing tests and immunizations/flu shots)	After copayment, 100% up to a \$1,000 Calendar Year maximum benefit	Not covered
Routine Well Newborn Care	After deductible, 80%	After deductible, 50%
Routine Well Child Care		
Immunizations	100%	100%
Childhood Hearing Test	80%	50%
All Other Well Child Care (Includes office visits, routine physical examination and diagnostic procedures)	After copayment, 100% up to a \$1,000 Calendar Year maximum benefit	Not covered
All Other Covered Expenses	After deductible, 80%	After deductible, 50%