

**EXHIBIT A**

**BRONZE SCHEDULE OF BENEFITS**

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
<b>MAXIMUM LIFETIME BENEFIT AMOUNT</b>	\$1,000,000	
<b>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.</b>		
<b>CALENDAR YEAR DEDUCTIBLE</b>		
Per Covered Person	\$2,000	\$4,000
Per Family Unit	\$6,000	\$12,000
Amounts applied towards the Network Calendar Year deductible will also be applied towards the non-Network Calendar Year deductible, and vice versa.		
<b>COPAYMENTS</b>		
Physician Visits	\$35	N/A
Outpatient Diagnostic Testing	\$17.50	N/A
Preventive Care – Routine Well Adult Care and benefits listed as All Other Routine Well Child Care	\$35	N/A
<b>CALENDAR YEAR MAXIMUM OUT-OF-POCKET AMOUNT</b>		
Per Covered Person	\$4,000	\$10,000
Per Family Unit	\$12,000	\$30,000
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		
	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
<b>COVERED SERVICES</b>		
<b>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.</b>		
<b>Hospital Services</b>		
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
<b>Skilled Nursing Facility</b>	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
<b>Physician Services</b>		
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%

<b>COVERED SERVICES</b>	<b>NETWORK PROVIDERS</b>	<b>NON-NETWORK PROVIDERS</b>
<b>Home Health Care</b>	After deductible, 80% 60 visit Calendar Year maximum benefit	After deductible, 50% 60 visit Calendar Year maximum benefit
<b>Outpatient Private Duty Nursing</b>	After deductible, 80%	After deductible, 50%
<b>Hospice Care</b>	After deductible, 80% \$7,500 Calendar Year maximum benefit	After deductible, 50% \$7,500 Calendar Year maximum benefit
<b>Ambulance Services</b>	After deductible, 80%	After deductible, 50%
<b>Occupational Therapy Speech Therapy Physical Therapy</b>	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
<b>Durable Medical Equipment</b> (Rental up to purchase price) <b>Prosthetics Orthotics</b>	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
<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%	After deductible, 50%
<b>Spinal Manipulation Chiropractic</b>	After deductible, 80%	After deductible, 50%
<b>Mental Disorders</b>		
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
<b>Substance Abuse</b>		
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
<b>Preventive Care</b>		
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
<b>All Other Covered Expenses</b>	After deductible, 80%	After deductible, 50%