

Exhibit A - 2012 Network Plan Design Summary

Plan A			Plan B			Plan C		
	Single	Family		Single	Family		Single	Family
Deductible	\$300	\$600	Deductible	\$150	\$300	Deductible	\$1,500	\$3,000
Coinsurance	20%	20%	Coinsurance	35%	35%	Coinsurance	20%	20%
Coinsurance Max	\$1,400	\$2,800	Coinsurance Max	\$3,000	\$6,000	Coinsurance Max	\$1,500	\$3,000
Total Deductible & Coinsurance¹	\$1,700	\$3,400	Total Deductible & Coinsurance¹	\$3,150	\$6,300	Total Deductible & Coinsurance	\$3,000	\$6,000
Office Visits	Adult	Child	Office Visits	Adult	Child	Office Visits	Adult	Child
PCP Copay	\$25	\$25	PCP Copay	\$20	\$10	PCP	Ded & Coins ³	
Specialist	\$45	\$45	Specialist	\$40	\$25	Specialist		
Preventive Care	Paid in Full		Preventive Care	Paid in Full		Preventive Care	Paid in Full	
ER Visit	\$100 Copay/Ded/Coins		ER Visit	\$100 Copay/Coins		ER Visit	Ded/Coins ³	
Drug Coinsurance Max²	Coins until member pays out \$2,580 per person (excludes non preferred drugs)		Drug Coinsurance Max²	Coins until member pays out \$2,580 per person (excludes non preferred drugs)		Drugs	Subject to Medical Deductible and Coinsurance.	

1. The Total Deductible and Coinsurance on Plans A and B do not include any copays or prescription drug costs. These amounts are in addition to the Deductible and Coinsurance a member would be responsible to pay.
2. Plans A & B prescription drug costs are subject to a separate Coinsurance maximum of \$2,580 per member per year. There is no Coinsurance maximum on Non Preferred Prescription drugs.
3. Ded/Coins = Deductible and then Coinsurance.
4. The above does not include costs eligible under the dental plan.

Exhibit A - 2012 Network Plan Design Summary

Plans A & B	Plan C
<p>Durable Medical Equipment (DME) Any charges exceeding \$400 require pre-approval by health plan. Limited to \$5,000 per Calendar Year</p>	<p>Durable Medical Equipment (DME) Limited to \$1,000 per Calendar Year</p>
<p>Durable Medical Equipment (DME) Repairs Any charges exceeding \$400 require pre-approval by health plan. Limited to \$2,500 per Calendar Year</p>	
<p>Infertility –</p> <ul style="list-style-type: none"> ○ Office visits, medical evaluation, and counseling; ○ Testing required to establish the etiology of female infertility, which is limited to hysterosalpingogram, diagnostic laparoscopy, and endometrial biopsy; ○ Testing required to establish the etiology of male infertility, which is limited to sperm counts and or semen analysis, scrotal or prostate ultrasound, prostate biopsy, and cystoscopy; ○ Surgical correction of physiological abnormalities causing infertility; ○ Three (3) attempts for artificial insemination, per Member, per Calendar Year; however, laboratory, x-ray, and other testing associated with artificial insemination are not covered. 	<p>Infertility (includes diagnosis and diagnostic surgical treatment only) Limited to \$2,000 per Calendar Year</p>
<p>Prosthetic Devices Any charges exceeding \$1,000 require pre-approval by the health plan</p>	<p>Prosthetic Devices Limited to \$1,000 per Calendar Year</p>