BRONZE

Plan Year Deductible	Out-of-Pocket Maximum	Lifetime Maximum
$1,000 *per Individual* $2,000 *per Family*	$4,000 *per Individual* $8,000 *per Family*	$2,000,000 *per Person*

		Co-Pay *	Deductible	Plan Cost Sharing
Professional Office Visits	*These charges are billed by the physician for time spent with the patient. Coverage includes Preventive Check-Ups & Physicals, Maternity: Pre & Post natal care. Office visits do not include charges for diagnostic, surgical or medical procedures performed by the physician. Medication Management limited to 4 visits per year.*			
Well Child Care (Up to 24 Months)		$10	N/A	100%
Primary Care		$20	N/A	100%
Specialist		$40	N/A	100%
Outpatient Diagnostic Tests, Lab & X-Ray	*Includes diagnostic tests performed in a physician's office or a free standing non-hospital based facility only.*	$20	N/A	100%
Vision	*Maximum annual benefit of $60 after Copayment. Covered Person must submit claim for reimbursement.*	$40	N/A	100%
Short Term Rehabilitation Services	*Physical, Chiropractic, Speech and Occupational Therapy; Up to 30 visits per condition, per Plan Year.*	$40	N/A	100%
Emergency Services	*ER Copayment waived if admitted; $500 penalty for non-emergency use of a hospital emergency room.*			
Hospital Emergency Room (Facility Charge Only)		$150	N/A	100%
Urgent Care/Physician		$20	N/A	100%
Ambulance		$40	N/A	100%
Allergy Treatment				
Testing and Injections		$20	N/A	100%
Serum		$100	N/A	100%
Inpatient Hospitalization	*Organ Transplant Benefits are subject to specific procedures and limitations as indicated in the Organ Transplant Benefits section of the SPD.*			
Medical Services and Facility		N/A	APPLIES	70%
Anesthiologist and Surgeon Fees		N/A	APPLIES	70%
Outpatient Services	*Includes outpatient services or procedures at a freestanding surgery center or hospital (when approved), miscellaneous medical services and supplies. Including, but not limited to Surgical, Diagnostic and Therapeutic Procedures. Surgical/invasive procedures done in a physician's office also included.*			
Medical Services		N/A	APPLIES	70%
Facility Charges		N/A	APPLIES	70%
Home Health Care & Skilled Nursing Facility	*Up to 60 days or visits in a Plan Year.*	N/A	APPLIES	70%
Hospice Care		N/A	APPLIES	70%
Mental Health & Substance Abuse	*Excludes counseling for behavioral disorders.*			
Inpatient Hospitalization		N/A	APPLIES	70%
Outpatient Office Visits		$40	N/A	100%
Durable Medical Equipment	*Maximum annual benefit of $5,000 per person, per Plan Year.*	N/A	APPLIES	70%

* *Copayments never apply to the Plan Year Deductible or Out-of-Pocket Maximum.*

Pre-Certification Penalty: Certain procedures or medical care require pre-certification in order to qualify for full benefits. Failure to pre-certify will result in a $250 penalty per service, procedure or confinement. Please refer to the Pre-Certification section in your SPD for details.

Please Note: This schedule applies as indicated in the Summary Plan Description. This schedule must be read in conjuntion with the entire Summary Plan Description and has no full meaning by itself.