### Annual Deductible
- **$2,000/$4,000** (Single/Family)

### Coinsurance
- 0% Coinsurance

### Annual Maximum Out of Pocket
- **$3,000/$6,000** (Single/Family)

### Lifetime Maximum
- Unlimited

### Annual Maximum for Essential Benefits
- Unlimited

### Preventive Services
- Unlimited

### Dependent Age
- 26/26

### Physician Services
- Subject to Deductible and Coinsurance
- **Office Visit**
- **Chiropractor Visits**
- **Hearing Examination**
- **Podiatry Services**
- **Vision Services**
- **Weight Loss/Nutritional Counseling**

### Hospital Services
- Subject to Deductible and Coinsurance
- **General Inpatient**
- **Delivery & Newborn Charges**
- **Outpatient Services**

### Emergency Services
- $100 Copayment
- **Emergency Room**
- $25 Copayment
- **Urgent Care**
- Subject to Deductible and Coinsurance
- **Ambulance**
- **Pharmacy Benefits**
- $5/$20/$40 Copay
- **Tier 1/Tier 2/Tier 3**
- **Value Tier**
- **Max Out-of-Pocket (Single/Family)**
- **$2,000/$4,000**

### Behavioral Health
- Subject to Deductible and Coinsurance
- **Inpatient**
- **Transitional**
- **Outpatient**
- **Psychiatrist or Psychologist**
- **Other Mental Health Professional**

### Diagnostic Services
- Subject to Deductible and Coinsurance
- **Lab**
- **X-Ray**
- **MRI/MRA Scan**
- **PET Scan**
- **CAT Scan**

### Other Services
- Subject to Deductible and Coinsurance
- **Anesthesia for Dental**
- **Autism Spectrum Disorder**
- **Durable Medical Equipment**
- **Home Health Care Services**
- **Hospice Services**
- **Kidney Disease Treatment**
- **Oral Surgery**
- **Skilled Nursing Care Facility**
- **Therapy Services**
- **TMJ Benefits**

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This Benefits Summary is intended to highlight the benefits provided in policy listed above. Please see your policy, including the Certificate of Coverage and Schedule of Benefits (SOB), for limitations and exclusions.