



SMALL GROUP 2020- SILVER PLAN
PLAN: IL-HMO CO-50 \$5000 DEDUCTIBLE
HIOS NUMBER: 54322IL0060307

	Network Providers You Pay	Non-Network Providers You Pay
Deductible	\$5,000 Single, \$10,000 Family	N/A
Coinsurance	50 % coinsurance after deductible	N/A
Office visit charge (PCP/Specialist)	\$50/100 Copay	Not Covered
Maximum Out of Pocket (Medical & Rx)	\$7,900 Single, \$15,800 Family	N/A
Preventive Services	\$0	Not Covered
Diagnostic Services (lab and x-ray)	50 % coinsurance after deductible	Not Covered
Hospital inpatient services*	50 % coinsurance after deductible	Not Covered
Hospital outpatient services*	50 % coinsurance after deductible	Not Covered
Emergency room charge (waived upon admission)	\$300 Copay	\$300 Copay
Ambulance	\$0	\$0
Urgent care charge	\$100 Copay	\$115 Copay
Mental Health inpatient*	50 % coinsurance after deductible	Not Covered
Mental Health day treatment*	50 % coinsurance after deductible	Not Covered
Mental Health outpatient	\$50 Copay	Not Covered
Durable medical equipment	50 % coinsurance after deductible	Not Covered
Physical, Speech and Occupational therapy	\$50 Copay	Not Covered
Chiropractic	\$50 Copay	Not Covered
* Prior authorization required for these services		
Prescription drug coverage		
Tier 1	\$20 Copay	Not Covered
Tier 2	\$50 Copay	Not Covered
Tier 3	\$100 Copay	Not Covered
Tier 4	50% Coinsurance (\$500 Maximum)	Not Covered

These benefits are a partial outline of health services under the Policy. Refer to your Schedule of Benefits for applicable limits to these health services. If differences exist between this Summary and the Certificate of Coverage, the Certificate governs.