



**SMALL GROUP 2020 – SILVER PLAN**  
**PLAN: IL-HMO CO-100 \$7,500 DED.**  
**HIOS NUMBER: 54322IL0060315**

	<b>Network Providers You Pay</b>	<b>Non-Network Providers You Pay</b>
Deductible (Embedded)	\$7,500 Single, \$15,000 Family	N/A
Coinsurance	0 % coinsurance after deductible	N/A
Office visit charge	\$20 Copay	Not Covered
Maximum Out of Pocket (Medical & Rx) (Embedded)	\$7,500 Single, \$15,000 Family	N/A
Preventive Services	\$0	Not Covered
Diagnostic Services (lab and x-ray)	0 % coinsurance after deductible	Not Covered
Hospital inpatient services*	0 % coinsurance after deductible	Not Covered
Hospital outpatient services*	0 % coinsurance after deductible	Not Covered
Emergency room charge	\$300 Copay	\$300 Copay
Ambulance	0 % coinsurance after deductible	0 % coinsurance after deductible
Urgent care charge	\$75 Copay	Not Covered
Mental Health inpatient*	0 % coinsurance after deductible	Not Covered
Mental Health day treatment*	0 % coinsurance after deductible	Not Covered
Mental Health outpatient	\$20 Copay	Not Covered
Durable medical equipment	0 % coinsurance after deductible	Not Covered
Physical, Speech and Occupational therapy	0 % coinsurance after deductible	Not Covered
Chiropractic	0 % coinsurance after deductible	Not Covered
* Prior authorization required for these services		
<b>Prescription drug coverage</b>		
Tier 1	\$20 Copay	Not Covered
Tier 2	0 % coinsurance after deductible	Not Covered
Tier 3	0 % coinsurance after deductible	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.