



**SMALL GROUP 2018 – GOLD PLAN**  
**PLAN: WI-HMO CO-100 \$2,000 DED.**  
**HIOS NUMBER: 58326WI0060308**

|   | <b>Network Providers<br/>You Pay</b> | <b>Non-Network Providers<br/>You Pay</b> |
|---|--------------------------------------|--|
| Deductible (Embedded)                             | \$2,000 Single, \$4,000 Family       | N/A                                      |
| Coinsurance                                       | 0 % coinsurance after deductible     | N/A                                      |
| Office visit charge                               | 0 % coinsurance after deductible     | Not Covered                              |
| Maximum Out of Pocket (Medical & Rx) (Embedded)   | \$2,000 Single, \$4,000 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                             | 0 % coinsurance after deductible     | 0 % coinsurance after deductible         |
| Ambulance   | 0 % coinsurance after deductible     | 0 % coinsurance after deductible         |
| Urgent care charge                                | 0 % coinsurance after deductible     | 0 % coinsurance after deductible         |
| Mental Health inpatient*                          | 0 % coinsurance after deductible     | Not Covered                              |
| Mental Health day treatment*                      | 0 % coinsurance after deductible     | Not Covered                              |
| Mental Health outpatient                          | 0 % coinsurance after deductible     | 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  | 0 % coinsurance after deductible     | 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.