2024 Surest Standard Plan Designs - Illinois

Case Effective July 01, 2024 through June 30, 2025

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Category	Plan Design Element	Plan A2500	
		In-Network	Out-of-Network
Overall Provisions	Deductible	None	
	Coinsurance (Plan Paid)	100%	
	OOP Limit Individual	$2,500	$8,000
	OOP Limit Family	$5,000	$16,000
Medical Coverage*	**Preventive Care**	$0	$60
	Virtual Care	$0 to $40	Up to $90
	Office Visit	$5 to $40	$120
	Urgent Care	$20	$60
	Emergency Room	$180	$180
	Ambulance	$80	$80
	Observation Stay	$180	$180
	Maternity Delivery	$350 to $1,000	$3,000
	Prenatal and Postnatal Care	$0	$60
	Delivery	$350 to $1,000	$3,000
	Procedures (Office, Outpatient and Inpatient)	$10 to $2,000	Up to $6,000
	Procedures (Inpatient and some Outpatient)	$75 to $2,000	Up to $6,000
	Other outpatient hospital services	$50 to $320	$960
	Other inpatient hospital stay (inc. admission from ER)	$1,000	$3,000
	Bariatric Surgery	Not Covered	Not Covered
	Gender Dysphoria Surgery	Covered	Covered
	Skilled Nursing Facility	$800	$2,400
	Home Health Care	$15	$45
	Rehabilitative Therapies	$5 to $35	Up to $105
	Acupuncture	$20	$60
	Chiropractic	$10	$30
	Occupational Therapy	$5 to $35	$105
	Physical Therapy	$5 to $25	$75
	Speech Therapy	$5 to $35	$105
	Complex Imaging (Ex: MRI, CT, etc.)	$40 to $280	Up to $840
	Routine Diagnostic Test (Ex: X-ray, Lab, Ultrasound)	$0	$0
	Advanced Tests[1]	$5 to $450	Up to $1,350
	Medical Infusions and Chemotherapy	$5 to $1,250	Up to $3,750
	Therapeutic Treatments[2]	$20 to $1,175	Up to $3,525
	Durable Medical Equipment (including hearing aids)	$0 to $500	Up to $1,000
	Fertility Treatment (limits apply)	$100 to $1,500	$200 to $3,000
	Mental Health & Substance Use Disorder		
	In an office setting (inc. ABA therapy)	$5	$60
	Mental Health Telehealth	$5	$60
	Intensive Outpatient Treatment Program	$30	$90
	Partial Hospitalization Program	$50	$150
	In an outpatient setting	$50	$150
	In an inpatient setting	$1,000	$3,000
	Hospice		
	Home Hospice Visit	$15	$45
	Inpatient Hospice Care	$1,000	$3,000
Other Benefit Notes	**OOP Limit Cross Application**	In-Network copays accumulates towards In-Network & Out-of-Network OOP Limit	Out-of-Network copays do not accumulate to In-Network OOP Limit
	OOP Limit Accumulator	ERISA Plan Year accumulator	ERISA Plan Year accumulator
	Out of Network Reimbursement	N/A	100% of Medicare Fee Schedule
	Emergency Services OOP accumulator	In-network copays accumulate to In-Network OOP Limit	Out-of-network copays accumulate to In-Network OOP Limit
	Therapy Visit Limits:		
	Acupuncture	60 visits per plan year; INN; OON; Medical Only**	
	Chiropractic	No visit limit	
	Physical Therapy	No visit limit	
	Occupational Therapy	No visit limit	
	Speech Therapy	No visit limit	
	Home Health Care	No visit limit	
	Skilled Nursing Facility	120 days per plan year; INN; OON; Medical Only**	

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Category	Plan Design Element	Plan A2500	
		In-Network	Out-of-Network
Pharmacy Coverage (OptumRx)***	**Pharmacy Alt Plan 1**		
	Retail and Mail Order Pharmacy - 30 day supply		
	Tier 1	$10	$10
	Tier 2	$35	$35
	Tier 3	$70	$70
	Specialty Retail Pharmacy		
	Tier 1	$10	$10
	Tier 2	$100	$100
	Tier 3	$200	$200
	Pharmacy Alt Plan 2		
	Retail and Mail Order Pharmacy - 30 day supply		
	Tier 1	$10	$10
	Tier 2	$60	$60
	Tier 3	$90	$90
	Specialty Retail Pharmacy		
	Tier 1	$10	$10
	Tier 2	$150	$150
	Tier 3	$300	$300
	Pharmacy Alt Plan 3		
	Retail and Mail Order Pharmacy - 30 day supply		
	Tier 1	$20	$20
	Tier 2	$90	$90
	Tier 3	$150	$150
	Specialty Retail Pharmacy		
	Tier 1	$20	$20
	Tier 2	$200	$200
	Tier 3	$500	$500

*Fertility Treatment is covered. Bariatric Surgery is not covered

*Place of Service - the Price (Copays) for some medical services and procedures are determined by the clinical setting in which the individual actually receives the care ("Place of Service"). For example, minor surgery in an office will incur an Office Visit price (copay), whereas minor surgery received in a hospital will incur an Outpatient Hospital Services and Surgery price (copay).

[1] Advanced Tests are complex medical tests your doctor may order to learn more about your health; typically planned and separately scheduled. Examples include EKG or a Facility Based Sleep Study.

[2] Therapeutic Procedures are treatments for complex diseases and health needs that do not involve surgery. Examples include radiation therapy or dialysis.

**All visit and stay limits are per covered person per plan year and combined in-network and out-of-network.

*** Retail and Mail Order 90 day ratio is 2.5

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This product grid is intended to highlight benefits and should not be used to fully understand exact coverage. If this grid conflicts with the Certificate of Coverage, Schedule of Benefits, Riders, and/or amendments, those documents govern. Review your COC for an exact description of the services and supplies that are not covered,