2024 Surest Standard Plan Designs - Illinois

Case Effective July 01, 2024 through June 30, 2025

Category	Plan Design Element	Plan D6500	
		In-Network	Out-of-Network
Overall Provisions	Deductible	None	
	Coinsurance (Plan Paid)	100%	
	OOP Limit Individual	$6,500	$13,000
	OOP Limit Family	$13,000	$26,000
Medical Coverage*	**Preventive Care**	$0	$190
	Virtual Care	$0 to $125	Up to $240
	Office Visit	$20 to $125	$375
	Urgent Care	$80	$240
	Emergency Room	$750	$750
	Ambulance	$350	$350
	Observation Stay	$750	$750
	Maternity Delivery	$1,300 to $2,750	$8,250
	Prenatal and Postnatal Care	$0	$190
	Delivery	$1,300 to $2,750	$8,250
	Procedures (Office, Outpatient and Inpatient)	$50 to $3,500	Up to $10,000
	Procedures (Inpatient and some Outpatient)	$300 to $3,500	Up to $10,000
	Other outpatient hospital services	$150 to $1,000	$3,000
	Other inpatient hospital stay (inc. admission from ER)	$2,750	$8,250
	Bariatric Surgery	Not Covered	Not Covered
	Gender Dysphoria Surgery	Covered	Covered
	Skilled Nursing Facility	$2,000	$6,000
	Home Health Care	$50	$100
	Rehabilitative Therapies	$15 to $120	Up to $360
	Acupuncture	$60	$180
	Chiropractic	$30	$90
	Occupational Therapy	$15 to $110	$330
	Physical Therapy	$20 to $90	$270
	Speech Therapy	$15 to $110	$330
	Complex Imaging (Ex: MRI, CT, etc.)	$125 to $900	Up to $2,700
	Routine Diagnostic Test (Ex: X-ray, Lab, Ultrasound)	$0	$0
	Advanced Tests[1]	$20 to $1,400	Up to $4,200
	Medical Infusions and Chemotherapy	$40 to $2,900	Up to $8,700
	Therapeutic Treatments[2]	$60 to $2,800	Up to $8,400
	Durable Medical Equipment (including hearing aids)	$0 to $1,000	Up to $2,000
	Fertility Treatment (limits apply)	$100 to $1,500	$200 to $3,000
	Mental Health & Substance Use Disorder		
	In an office setting (inc. ABA therapy)	$20	$190
	Mental Health Telehealth	$20	$190
	Intensive Outpatient Treatment Program	$80	$240
	Partial Hospitalization Program	$150	$450
	In an outpatient setting	$150	$450
	In an inpatient setting	$2,750	$8,250
	Hospice		
	Home Hospice Visit	$70	$210
	Inpatient Hospice Care	$2,750	$8,250
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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		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

Insurance coverage is provided by All Savers Insurance Company (for FL, GA, OH, UT and VA), by UnitedHealthcare Insurance Company of IL (for IL), by United Healthcare of Kentucky, Ltd. (for KY), or by UnitedHealthcare Insurance Company (for AL, AR, AZ, CO, DC, DE, GA, IA, ID, IN, KS, LA, MI, MN, MO, MS, MT, NC, NE, NH, NV, OK, PA, RI, SC, SD, TN, TX, UT, VA, WV, and WY). These policies have exclusions, limitations, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact either your broker or the insuring company. Administrative services provided by Bind Benefits, Inc. d/b/a Surest, its affiliate United HealthCare Services, Inc., or by Bind Benefits, Inc. d/b/a Surest Administrators Services, in CA.

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,