

2024 Surest Standard Plan Designs - Illinois

Case Effective July 01, 2024 through June 30, 2025

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Category	Plan Design Element	Plan E7000	
		In-Network	Out-of-Network
Overall Provisions	Deductible	None	
	Coinsurance (Plan Paid)	100%	
	OOP Limit Individual	\$7,000	\$14,000
	OOP Limit Family	\$14,000	\$28,000
Medical Coverage*	Preventive Care	\$0	\$210
	Virtual Care	\$0 to \$140	Up to \$300
	Office Visit	\$35 to \$140	\$420
	Urgent Care	\$90	\$270
	Emergency Room	\$850	\$850
	Ambulance	\$400	\$400
	Observation Stay	\$850	\$850
	Maternity Delivery	\$1,850 to \$3,500	\$10,500
	Prenatal and Postnatal Care	\$0	\$210
	Delivery	\$1,850 to \$3,500	\$10,500
	Procedures (Office, Outpatient and Inpatient)	\$70 to \$4,500	Up to \$11,000
	Procedures (Inpatient and some Outpatient)	\$600 to \$4,500	Up to \$11,000
	Other outpatient hospital services	\$300 to \$1,150	\$3,450
	Other inpatient hospital stay (inc. admission from ER)	\$3,500	\$10,500
	Bariatric Surgery	Not Covered	Not Covered
	Gender Dysphoria Surgery	Covered	Covered
	Skilled Nursing Facility	\$2,750	\$8,250
	Home Health Care	\$50	\$100
	Rehabilitative Therapies	\$30 to \$140	Up to \$420
	Acupuncture	\$70	\$210
	Chiropractic	\$35	\$105
	Occupational Therapy	\$30 to \$125	\$375
	Physical Therapy	\$30 to \$100	\$300
	Speech Therapy	\$30 to \$125	\$375
	Complex Imaging (Ex: MRI, CT, etc.)	\$200 to \$1,050	Up to \$3,150
	Routine Diagnostic Test (Ex: X-ray, Lab, Ultrasound)	\$0	\$0
	Advanced Tests¹	\$35 to \$1,650	Up to \$4,950
	Medical Infusions and Chemotherapy	\$60 to \$3,600	Up to \$10,800
	Therapeutic Treatments²	\$100 to \$3,600	Up to \$10,800
	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)	\$35	\$210
Mental Health Telehealth	\$35	\$210	
Intensive Outpatient Treatment Program	\$100	\$300	
Partial Hospitalization Program	\$180	\$540	
In an outpatient setting	\$180	\$540	
In an inpatient setting	\$3,500	\$10,500	
Hospice			
Home Hospice Visit	\$80	\$240	
Inpatient Hospice Care	\$3,500	\$10,500	
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 E7000		
		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,