

**2024 Surest Standard Plan Designs - Illinois**

Case Effective July 01, 2024 through June 30, 2025

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Category	Plan Design Element	Plan F7000	
		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*	<b>Preventive Care</b>	\$0	\$235
	<b>Virtual Care</b>	\$0 to \$155	Up to \$330
	<b>Office Visit</b>	\$45 to \$155	\$465
	<b>Urgent Care</b>	\$110	\$330
	<b>Emergency Room</b>	\$1,000	\$1,000
	<b>Ambulance</b>	\$500	\$500
	<b>Observation Stay</b>	\$1,000	\$1,000
	<b>Maternity Delivery</b>	\$2,500 to \$4,500	\$13,000
	Prenatal and Postnatal Care	\$0	\$235
	Delivery	\$2,500 to \$4,500	\$13,000
	<b>Procedures (Office, Outpatient and Inpatient)</b>	\$80 to \$5,500	Up to \$13,000
	Procedures (Inpatient and some Outpatient)	\$400 to \$5,500	Up to \$13,000
	Other outpatient hospital services	\$300 to \$1,300	\$3,900
	Other inpatient hospital stay (inc. admission from ER)	\$4,500	\$13,000
	Bariatric Surgery	Not Covered	Not Covered
	Gender Dysphoria Surgery	Covered	Covered
	<b>Skilled Nursing Facility</b>	\$3,500	\$10,500
	<b>Home Health Care</b>	\$50	\$100
	<b>Rehabilitative Therapies</b>	\$35 to \$150	Up to \$450
	Acupuncture	\$70	\$210
	Chiropractic	\$40	\$120
	Occupational Therapy	\$35 to \$140	\$420
	Physical Therapy	\$35 to \$110	\$330
	Speech Therapy	\$35 to \$140	\$420
	<b>Complex Imaging (Ex: MRI, CT, etc.)</b>	\$200 to \$1,150	Up to \$3,450
	<b>Routine Diagnostic Test (Ex: X-ray, Lab, Ultrasound)</b>	\$0	\$0
	<b>Advanced Tests<sup>1</sup></b>	\$40 to \$1,800	Up to \$5,400
	<b>Medical Infusions and Chemotherapy</b>	\$70 to \$4,200	Up to \$12,600
	<b>Therapeutic Treatments<sup>2</sup></b>	\$110 to \$4,800	Up to \$13,000
	<b>Durable Medical Equipment (including hearing aids)</b>	\$0 to \$1,000	Up to \$2,000
	<b>Fertility Treatment (limits apply)</b>	\$100 to \$1,500	\$200 to \$3,000
	<b>Mental Health &amp; Substance Use Disorder</b>		
	In an office setting (inc. ABA therapy)	\$45	\$235
Mental Health Telehealth	\$45	\$235	
Intensive Outpatient Treatment Program	\$110	\$330	
Partial Hospitalization Program	\$200	\$600	
In an outpatient setting	\$200	\$600	
In an inpatient setting	\$4,500	\$13,000	
<b>Hospice</b>			
Home Hospice Visit	\$90	\$270	
Inpatient Hospice Care	\$4,500	\$13,000	
Other Benefit Notes	<b>OOP Limit Cross Application</b>	In-Network copays accumulates towards In-Network & Out-of-Network OOP Limit	Out-of-Network copays do not accumulate to In-Network OOP Limit
	<b>OOP Limit Accumulator</b>	ERISA Plan Year accumulator	ERISA Plan Year accumulator
	<b>Out of Network Reimbursement</b>	N/A	100% of Medicare Fee Schedule
	<b>Emergency Services OOP accumulator</b>	In-network copays accumulate to In-Network OOP Limit	Out-of-network copays accumulate to In-Network OOP Limit
	<b>Therapy Visit Limits:</b>		
	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 F7000		
		In-Network	Out-of-Network	
Pharmacy Coverage (OptumRx)**	<b>Pharmacy Alt Plan 1</b>			
	<b>Retail and Mail Order Pharmacy - 30 day supply</b>			
	Tier 1		\$10	\$10
	Tier 2		\$35	\$35
	Tier 3		\$70	\$70
	<b>Specialty Retail Pharmacy</b>			
	Tier 1		\$10	\$10
	Tier 2		\$100	\$100
	Tier 3		\$200	\$200
	<b>Pharmacy Alt Plan 2</b>			
	<b>Retail and Mail Order Pharmacy - 30 day supply</b>			
	Tier 1		\$10	\$10
	Tier 2		\$60	\$60
	Tier 3		\$90	\$90
	<b>Specialty Retail Pharmacy</b>			
	Tier 1		\$10	\$10
	Tier 2		\$150	\$150
	Tier 3		\$300	\$300
	<b>Pharmacy Alt Plan 3</b>			
	<b>Retail and Mail Order Pharmacy - 30 day supply</b>			
	Tier 1		\$20	\$20
Tier 2		\$90	\$90	
Tier 3		\$150	\$150	
<b>Specialty Retail Pharmacy</b>				
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,