2025 Surest Standard Plan Designs - Nevada

Category	Plan Design Element	Plan B4000	
		In-Network	Out-of-Network
Overall Provisions	Deductible	None	
	Coinsurance (Plan Paid)	100%	
	OOP Limit Individual	$4,000	$8,000
	OOP Limit Family	$8,000	$16,000
Medical Coverage*	**Preventive Care**	$0	$100
	Virtual Care	$0 to $65	Up to $195
	Office Visit	$10 to $65	$195
	Urgent Care	$35	$105
	Emergency Room	$350	$350
	Ambulance	$160	$160
	Observation Stay	$350	$350
	Maternity Delivery	$625 to $1,600	$4,800
	Prenatal and Postnatal Care	$0	$100
	Delivery	$625 to $1,600	$4,800
	Procedures (Office, Outpatient and Inpatient)	$15 to $2,500	Up to $7,000
	Procedures (Inpatient and some Outpatient)	$150 to $2,500	Up to $7,000
	Other outpatient hospital services	$75 to $525	$1,575
	Other inpatient hospital stay (inc. admission from ER)	$1,600	$4,800
	Bariatric Surgery	Not Covered	Not Covered
	Gender Dysphoria Surgery	Covered	Covered
	Skilled Nursing Facility	$1,200	$3,600
	Home Health Care	$30	$90
	Rehabilitative Therapies	$5 to $60	Up to $180
	Acupuncture	$30	$90
	Chiropractic	$15	$45
	Occupational Therapy	$10to $55	$165
	Physical Therapy	$5 to $45	$135
	Speech Therapy	$10to $55	$165
	Complex Imaging (Ex: MRI, CT, etc.)	$60 to $450	Up to $1,350
	Routine Diagnostic Test (Ex: X-ray, Lab, Ultrasound)	$0	$0
	Advanced Tests'	$10 to $750	Up to $2,250
	Medical Infusions and Chemotherapy	$15 to $1,850	Up to $5,550
	Therapeutic Treatments'	$30 to $1,750	Up to $5,250
	Durable Medical Equipment (including hearing aids)	$0 to $500	Up to $1,000
	Fertility Treatment	Not Covered	Not Covered
	Mental Health & Substance Use Disorder		
	In an office setting (inc. ABA therapy)	$10	$100
	Mental Health Telehealth	$10	$100
	Intensive Outpatient Treatment Program	$40	$120
	Partial Hospitalization Program	$75	$225
	In an outpatient setting	$75	$225
	In an inpatient setting	$1,600	$4,800
	Hospice		
	Home Hospice Visit	$30	$90
	Inpatient Hospice Care	$1,600	$4,800
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	60 visits per plan year; **INN;** OON; Medical Only**	
	Physical Therapy	60 visits per plan year; **INN;** OON; Medical Only**, not combined with other therapies	
	Occupational Therapy	60 visits per plan year; **INN;** OON; Medical Only**, not combined with other therapies	
	Speech Therapy	60 visits per plan year; **INN;** OON; Medical Only**, not combined with other therapies	
	Home Health Care	120 visits per plan year; **INN;** OON; Medical Only**	
	Skilled Nursing Facility	120 days per plan year; **INN;** OON; Medical Only**	

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Category	Plan Design Element	Plan B4000	
		In-Network	Out-of-Network
Pharmacy Coverage (OptumRX)***	**Pharmacy Alt Plan 1**		
	Retail and Mail Order Pharmacy - 30 day supply		
	Tier 1	$10	Not Covered
	Tier 2	$35	Not Covered
	Tier 3	$70	Not Covered
	Specialty Retail Pharmacy		
	Tier 1	$10	Not Covered
	Tier 2	$100	Not Covered
	Tier 3	$200	Not Covered

*Fertility Treatment and Bariatric Surgery are 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** Order90 day ratio is2.5

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, A2, CO, DC, DE, GA, IA, ID, IN, KS, LA, Ml, 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,