2025 Surest Standard Plan Designs - Maryland
Case Effective August 1, 2025 through June 30, 2026

For Employers and Brokers only.

Category	Plan Design Element	Plan F8500	
		In-Network	Out-of-Network
Overall Provisions	**Deductible**	None	Not Covered
	Coinsurance (Plan Paid)	100%	Not Covered
	OOP Limit Individual	$8,500	Not Covered
	OOP Limit Family	$17,000	Not Covered
Medical Coverage	**Preventive Care Office Visit**	$0	Not Covered
	Office Visit	$50 to $160	Not Covered
	Virtual Urgent Care	$0	Not Covered
	Urgent Care	$110	Not Covered
	Emergency Room	$1,000	$1,000
	Ambulance	$700	$700
	Maternity		
	Prenatal and Postnatal Care	$0	Not Covered
	Delivery	$2,400 to $4,500	Not Covered
	Procedures (Office, Outpatient and Inpatient)	$80 to $5,500	Not Covered
	Procedures (Inpatient and some Outpatient)	$400 to $5,500	Not Covered
	Other outpatient hospital services	$350 to $1,250	Not Covered
	Other inpatient hospital stay (inc. admission from ER)	$4,500	Not Covered
	Bariatric Surgery*	Covered	Not Covered
	Rehabilitative Therapies	$25 to $200	Not Covered
	Acupuncture	$70	Not Covered
	Chiropractic	$35	Not Covered
	Occupational Therapy	$25 to $140	Not Covered
	Physical Therapy	$25 to $110	Not Covered
	Speech Therapy	$25 to $140	Not Covered
	Mental Health & Substance Use Disorder		
	Office Visit/ABA	$50	Not Covered
	Intensive Outpatient Treatment Program	$100	Not Covered
	Partial Hospitalization Program	$200	Not Covered
	In an outpatient setting	$200	Not Covered
	In an inpatient setting	$4,500	Not Covered
	Routine Diagnostic Test (Ex: X-ray, Lab, Ultrasound)	$0	Not Covered
	Advanced Tests[1]	$40 to $1,600	Not Covered
	Complex Imaging (Ex: MRI, CT, etc.)	$200 to $1,300	Not Covered
	Chemotherapy	$65 to $800	Not Covered
	Medical Infusions	$75 to $4,600	Not Covered
	Therapeutic Treatments - All Other [2]	$20 to $4,800	Not Covered
	Durable Medical Equipment (including hearing aids)	$0 to $1,000	Not Covered
	Home Health Care	$90	Not Covered
	Hospice		
	Home Hospice Visit	$90	Not Covered
	Inpatient Hospice Care	$4,500	Not Covered
	Skilled Nursing Facility	$3,500	Not Covered
	Fertility Treatment*	$100 to $1,500	Not Covered
Other Benefit Notes	**Therapy Visit Limits**:**		
	Acupuncture	60 visit limit per person per plan year	Not Covered
	Chiropractic	No visit limits	Not Covered
	Physical Therapy	No visit limits	Not Covered
	Occupational Therapy	No visit limits	Not Covered
	Cognitive Therapy	No visit limits	Not Covered
	Speech Therapy	No visit limits	Not Covered
	Home Health Care	120 visit limit per person per plan year	Not Covered
	Skilled Nursing Facility	120 day limit per person per plan year	Not Covered

*Bariatric Surgery and Fertility Treatment services are covered.

[1] Advanced Test 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.

Insurance coverage provided by UnitedHealthcare Insurance Company. Administrative services provided by United HealthCare Services, Inc. or its affiliates.

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, those that are excluded or limited, and other terms and conditions of coverage. Contact your Surest representative for plan design information.

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Category	Plan Design Element	Plan F8500	
		In-Network	Out-of-Network
ALT 1 Pharmacy Coverage - OptumRx	**Retail and Mail Order Pharmacy - 30 day supply**		
	Tier 1	$10.00	Not Covered
	Tier 2	$35.00	Not Covered
	Tier 3	$70.00	Not Covered
	Retail and Mail Order Pharmacy - 90 day supply		
	Tier 1	$25.00	Not Covered
	Tier 2	$87.50	Not Covered
	Tier 3	$175.00	Not Covered
	Specialty Retail Pharmacy		
	Tier 1	$10.00	Not Covered
	Tier 2	$100.00	Not Covered
	Tier 3	$150.00	Not Covered
ALT 2 Pharmacy Coverage - OptumRx	**Retail and Mail Order Pharmacy - 30 day supply**		
	Tier 1	$10.00	Not Covered
	Tier 2	$60.00	Not Covered
	Tier 3	$90.00	Not Covered
	Retail and Mail Order Pharmacy - 90 day supply		
	Tier 1	$25.00	Not Covered
	Tier 2	$150.00	Not Covered
	Tier 3	$225.00	Not Covered
	Specialty Retail Pharmacy		
	Tier 1	$10.00	Not Covered
	Tier 2	$150.00	Not Covered
	Tier 3	$150.00	Not Covered
ALT 3 Pharmacy Coverage - OptumRx	**Retail and Mail Order Pharmacy - 30 day supply**		
	Tier 1	$20.00	Not Covered
	Tier 2	$90.00	Not Covered
	Tier 3	$150.00	Not Covered
	Retail and Mail Order Pharmacy - 90 day supply		
	Tier 1	$50.00	Not Covered
	Tier 2	$225.00	Not Covered
	Tier 3	$375.00	Not Covered
	Specialty Retail Pharmacy		
	Tier 1	$20.00	Not Covered
	Tier 2	$150.00	Not Covered
	Tier 3	$150.00	Not Covered

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