Blue Diamond

The Blue Diamond plan provides both in and out of network benefits and offers cost efficient coverage with superior provider access.

Network: Aetna Open Access POS II

No Referral Needed   Over 1.4 Million Network Providers
Deductible: $0/0   Max Out of pocket: $2000/13200
Co-Insurance: $0/0   Out of Network Benefits
Preventive Services: 100%   Maximum Benefits: Unlimited

Office Visit copay: $20/40 **No Deductible**

Rx: Covered   Lab/X-Ray: Covered   Mental Health: Covered

Coverage Tier	Price
Employee	$1,149.00
Emp + Children	$2,099.00
Emp + Spouse	$2,199.00
Family	$2,599.00

Groups of 10+ enrolled employees will be a custom quote

To search providers participating within network, please go to:

https://aetna.com

10/2024

BLUE DIAMOND

Schedule of Benefits & Plan Design

Medical Services Deductible Information

Deductible	Participating Providers (In Network)	Out of Network Providers
Individual	$0	$2000
Family	$0	$13200

Out of Pocket Maximum	Participating Providers (In Network)	Out of Network Providers
Individual	$2000	Unlimited
Family	$13,200	Unlimited

Schedule of Benefits Below

PHYSICIAN SERVICES

Plan Provisions	Prior Auth Required	Participating Providers (In Network)	Out of Network Providers
		EMPLOYEE PAYS	EMPLOYEE PAYS
Primary Care Office Visit	NO	$20 Copay	40% after deductible
Specialist office Visit	NO	$40 Copay	40% after deductible
Other Physician Services performed in the office	NO	$40 Copay	40% after deductible
Urgent Care	NO	$75 Copay	40% after deductible
Telemedicine**	NO	Through plan's telemed service only	NOT COVERED
*Preventive & Wellness Services	NO	100%	NOT COVERED

HOSPITAL/FACILITY OUTPATIENT SERVICES

Facility Fee	YES	$400 copay	40% After deductible
Physician/Surgeon	YES	No Charge	40% After deductible
ER	NO	$400 Copay	Same as in network
Emerg transportation***	NO	$400 Copay	40% after deductible

HOSPITAL/FACILITY INPATIENT SERVICES

Hospital	YES	$400 Copay	After deductible 40%
Physician/surgeon fees	YES	No Charge	After deductible 40%

Laboratory & Minor Diagnostic Services (Laboratory Services, Ultrasound, Bone Density, Echography, Etc.)	YES	$50 Copay	After deductible 40%
Radiology	YES	$50 Copay	After deductible 40%
CT/MRI/MRA/PET Scan	YES	$400 Copay	After deductible 40%

PREGNANCY BENEFITS

Maternity office visits	NO	$50 Copay per visit	After deductible 40%
Maternity/childbirth & Delivery (considered Inpatient Hospital Stay)	YES	$400 Copay	After deductible 40%

OTHER SERVICES

Allergy Services	NO	$40 Copay	40% after deductible
*Colonoscopy	YES	$400 Copay	40% after deductible
Chiropractic Care 30 visit per plan year	NO	$65 copay	40% after deductible
Durable Medical Equipment	YES	$400 Copay	40% after deductible
Home Health Care (limit 30 visits per plan year)	YES	$25 Copay	40% after deductible
Second Surgical Opinion	YES	100%	100%
Hospice	YES	$400 Copay	40% After deductible
Rehabilitation/Habilitation Services (Physical, Speech & Occupational: (Limited to 20 visits per plan year)	YES	$75 Copay	40% after deductible
Treatment for Chemical Abuse & Dependency (In-Patient)	YES	$400 Copay	40% after deductible
Treatment for Chemical Abuse & Dependency (Out-Patient)	YES	$20 Copay per visit	40% after deductible

PRESCRIPTIONS

Pharmacy Retail up to 30-day Supply (Specialty drugs and compounds are not covered)		Generic: $10 Copay Preferred: $40 Copay Non-Preferred $80 Copay Injectable coinsurance 30% 30-day supply at a time	Not covered
Pharmacy Mail Order 90-day supply		Generic: $30 Co pay Preferred: $120 Co pay Non-Preferred $240 Co pay	Not Covered
Specialty Drugs		NOT COVERED	NOT COVERED

*not covered in hospital.

Out of Network claims: are paid at 125% of Medicare, members are responsible for the copay and anything above 125% of Medicare allowable fees.

Benefits reduced by 50% if not pre-authorized

Mental Health is unlimited visits. It is treated as a primary $20 copay

A detailed SPD (summary plan description) is included with your introduction package.

**Telehealth covered through plans telemedicine services only.   Not covered through any other means
*** Ground transport only