$5K+ DEDUCTIBLE PLAN

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 Referrals Needed
Deductible: $5000/10000
Maximum Benefits: Unlimited

Over 1.4 Million Network Providers
Preventive Services: 100%
Out of Network Benefits

Office Visit Copay: $30/50 **No Deductible**

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

Coverage Tier	Price
Employee	$739.00
Emp + Children	$1,599.00
Emp + Spouse	$1,649.00
Family	$2,045.00

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 5K PLUS

Schedule of Benefits & Plan Design

Medical Services Deductible Information

Deductible	Participating Providers (In Network)	Out of Network Providers
Individual	$5000	$10000
Family	$10000	$20000

Out of Pocket Maximum	Participating Providers (In Network)	Out of Network Providers
Individual	$9200	Unlimited
Family	$18400	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	$30 Copay – No Deductible	50% then Deductible
Specialist office Visit	NO	$50 Copay – No Deductible	50% then Deductible
Other Physician Services performed in the office	NO	$50 Copay – No Deductible	50% then Deductible
Urgent Care	NO	$95 Copay – No Deductible	50% then Deductible
Telemedicine***	NO	Plans telemed services only	NOT COVERED
*Preventive & Wellness Services	NO	$0 cost - 100% covered	not covered

HOSPITAL/FACILITY OUTPATIENT SERVICES

Facility Fee	YES	30% then Deductible	50% then Deductible
Physician/Surgeon	YES	30% then Deductible	50% then Deductible
Emergency Room	NO	30% then Deductible	Same as in network
**Emerg transportation	NO	30% then Deductible	50% then Deductible

HOSPITAL/FACILITY INPATIENT SERVICES

Hospital	YES	30% then Deductible	50% then Deductible
Physician/surgeon fees	YES	30% then Deductible	50% then Deductible

**Laboratory & Minor Diagnostic Services (Laboratory Services, Ultrasound, Bone Density, Echography, Etc.)	YES	$30 Co pay per test – No Deductible If done in hospital, then falls under hospital benefits	50% then Deductible
Radiology free standing	YES	30% then Deductible	50% then Deductible
CT/MRI/MRA/PET Scan	YES	30% then Deductible	50% then Deductible

PREGNANCY BENEFITS

Maternity visit	NO	100% less $50 Copay per visit	50% then Deductible
Maternity/childbirth & Delivery (considered Inpatient Hospital Stay)	YES	30% then Deductible	50% then Deductible

OTHER SERVICES

Allergy Services	NO	$50 Copay no deductible	50% then deductible
*Colonoscopy	YES	Deductible then 30%	50% then deductible
Chiropractic Care (10 visits per plan year)	NO	$85 Copay then deductible	Not Covered
Durable Medical Equipment	YES	30% then Deductible	50% then Deductible
Home Health Care (limit 20 visits per plan year)	YES	30% then Deductible	Not Covered
Second Surgical Opinion	YES	100%	Not covered
Hospice	YES	30% then Deductible	50% then Deductible
Rehabilitation/Habilitation Services (Physical, Speech & Occupational: Limited to 10 visits per plan year	NO	30% then Deductible	50% then Deductible
Treatment for Chemical Abuse & Dependency (In-Patient)	YES	Falls under Inpatient hospital benefits	50% then Deductible
Treatment for Chemical Abuse & Dependency (Out-Patient)	YES	No Deductible $30 copay per visit	50% then Deductible

PRESCRIPTIONS

Pharmacy Retail up to 30-day Supply (Specialty drugs and compounds are not covered)		Generic: $10 Copay Preferred not covered Non-Preferred not covered Injectable not covered	Not Covered
Pharmacy Mail Order 90-day supply		Generic: $30 Copay Preferred: not covered Non-Preferred not covered	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.

<u>**Mental Health is unlimited visits. It is treated as a primary $30 copay**</u>

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

Benefits reduced by 50% if not pre-authorized.

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

****Ground transport only**