WHITE DIAMOND

$2K+ DEDUCTIBLE PLAN

The White 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
Deductible: $2000/5000
Maximum Benefits: Unlimited

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

Office Visit Copay: $25/40 **No Deductible**

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

Coverage Tier	Price
Employee	$949.00
Emp + Children	$1,849.00
Emp + Spouse	$1,949.00
Family	$2,349.00

Groups of 10+ enrolled employees will be a custom quote

To search providers participating within network, please go to:

https://aetna.com

10/2024

WHITE DIAMOND

Schedule of Benefits & Plan Design

Medical Services Deductible Information

Deductible	Participating Providers (In Network)	Out of Network Providers
Individual	$2000	$5000
Family	$5000	$12500

Out of Pocket Maximum	Participating Providers (In Network)	Out of Network Providers
Individual	$9000	Unlimited
Family	$18000	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	$25 Copay no deductible	40% then deductible
Specialist office Visit	NO	$40 Copay no deductible	40% then deductible
Other Physician Services performed in the office	NO	$40 Copay then deductible	40% then deductible
Urgent Care	NO	Copay $95 no deductible	40% 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	$1000 then deductible	50% then deductible
Physician/Surgeon	YES	$1000 then deductible	50% then deductible
Emergency Room	NO	$850 then deductible	Same as in network
*****Emergency Transportation	NO	$850 then deductible	50% then deductible

HOSPITAL/FACILITY INPATIENT SERVICES

Hospital	YES	$1000 then deductible	50% then deductible
Physician/surgeon fees	YES	$1000 then deductible	50% then deductible

***Laboratory & Minor Diagnostic Services (Laboratory Services, Ultrasound, Bone Density, Echography, Etc.)	YES	$55 Co pay per test (if done in a hospital falls under hospital benefits)	40% then deductible
Radiology	YES	$100 then deductible	40% then deductible
***CT/MRI/MRA/PET Scan	YES	$600 then deductible	Not covered

PREGNANCY BENEFITS

Maternity office visits	YES	$40 Copay per visit	40% then deductible
Maternity/childbirth & Delivery (considered Inpatient Hospital Stay)	YES	$1000 then deductible	50% then deductible

OTHER SERVICES

Allergy Services	NO	$40 Copay then Deductible	40% then deductible
*Colonoscopy	YES	$1000 then deductible	50% then deductible
Chiropractic Care (30 visits per plan year)	NO	$85 Copay then deductible	Not Covered
Durable Medical Equipment	YES	30% then deductible	Not covered
Home Health Care (limit 20 visits per plan year)	YES	$40 Copay then deductible per visit	Not covered
Second Surgical Opinion	YES	100%	Not covered
Hospice	YES	30% then deductible	Not covered
Rehabilitation/Habilitation Services (Physical, Speech & Occupational: (Limited to 20 visits per plan year)	NO	$85 then deductible per visit	40% 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 $25 per visit	40% then deductible

PRESCRIPTIONS

Pharmacy Retail up to 30-day Supply (Specialty drugs and compounds are not covered)		Generic: formulary $1 no deductible Gen non Formulary $10 no deductible Preferred: $60 Co pay $200 deductible Non-Preferred $100 $200 deductible **Injectable 30% coinsurance &$500 deductible	Not covered
Pharmacy Mail Order 90-day supply		Generic: formulary $1 no deductible Generic non formulary $30 no deductible Preferred: $180 deductible $200 Non-Preferred $300 deductible $200	Not Covered
Specialty Drugs		Not Covered	Not Covered

***Not covered in hospital.**

**** 30-day supply at a time.**

*******Ground transport only.**

***** If done in hospital falls under hospital benefits and limitations.**

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 $25 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.