Infinity Business Solutions

Presents

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
Deductible: $0/0
Co-Insurance: $0/0
Preventive Services: 100%

Over 1.4 Million Network Providers
Max Out of pocket: $2000/13200
Out of Network Benefits
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	$0 cost - 100% covered	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**

Instructions

For applying for benefits (return this form with your application)

*Place an **X** on the plan you are applying for*

Health Benefits: Select one of the plan options below

[ ] Blue Diamond 0 Deductible [ ] White Diamond 2k Plus [ ] Blue Diamond 5k Plus

[ ] Employee [ ] Couple [ ] Employee/Children [ ] Family

Desired effective date: _____ (always on the first of the month)

Employer Name: _____

Employee Name: _____

Email: _____

*****If Spouse is coming on the plan, please provide a copy of the marriage certificate.*****
*****If children are coming on the plan, please provide a copy of the birth certificate(s).*****

Below is what needs to be reviewed by the Employee. Please fill out all applicable forms.

*___ Employee Enrollment Form.

*___ Fill out the HIPPA Release Form for each adult and child to be enrolled.
A parent/guardian must sign for children under 18 years of age.

*___ Fill out the Personal Health Questionnaire.
Include self and all family members to be enrolled and answer all questions.

We have 4 payment options.

The options here have NO BILLING FEE:

[ ] If paying by ACH/EFT, fill out the ACH form and *submit a VOIDED check* (if paying by check, do not fill out) If paying through ACH, we need the first month's payment.

[ ] You can pay through our secure portal. We will email a link every month (do not fill out ACH form)

The options below have a $25 billing fee per month:

[ ] Paying by check, you will get a paper bill each month. When paying by check, we need 2 months payment; first and last month.

[ ] Pay over the phone. This option you can do with a paper bill or the link provided. You will speak to a live person.

INFINITY
BUSINESS SOLUTIONS

235 MAIN STREET – SUITE 101
HACKENSACK, NJ 07601
TEL (631) 424-2400 | FAX (631) 424-2464

EMPLOYEE ENROLLMENT FORM

EMPLOYEE INFORMATION			
LAST	FIRST		M
ADDRESS			
CITY	STATE		ZIP
DOB	SSN		
HOME	CELL	WORK	EXT.
EMAIL			
☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED			

EMPLOYER INFORMATION		
EMPLOYER NAME		☐PART TIME ☐FULL TIME
PHONE		
JOB TITLE	HIRE DATE	

MEDICAL	
☐ BLUE DIAMOND $0	IF WAIVING, WHY? _____
☐ WHITE DIAMOND $2K+	_____
☐ BLUE DIAMOND $5K+	_____
☐ WAIVE MEDICAL	_____

LIST ALL DEPENDENTS BEING ADDED TO PLAN		
LAST, FIRST	SSN	DOB
LAST, FIRST	SSN	DOB
LAST, FIRST	SSN	DOB
LAST, FIRST	SSN	DOB
TOTAL DEPENDENTS:		

PLEASE NOTE THAT COVERAGE WILL NOT TAKE EFECT UNTIL PAYMENT HAS BEEN RECEIEVED AND PROCESSED.

FINAL APPROVAL WILL BE COMMUNICATED VIA EMAIL BEFORE YOUR EFFECTIVE DATE.

_____ _____

SIGNATURE **DATE**

Personal Health Questionnaire (PHQ)

Employer Name: _____ Date of Hire: _____

Name of Employee: _____ Job Title: _____

Address: City _____ State: _____ Zip: _____ Phone No. _____

Marital Status: ____ Single ____ Married Number of hours worked per week _____

INFORMATION ON THOSE APPLYING FOR COVERAGE (include all family members to be insured)

Name	Relationship	Sex	DOB	SSN	Zip	Height	Weight	Tobacco Use (Y or N)
	SELF							

Has the Employee or any Family Member applying for coverage:

(for yes answers, provide details below or on the back of this form and list the question number)

1. Ever had or been treated for any of the following:
   a. Chest pain; disease of the heart, arteries or blood vessels; high or low blood pressure; stroke? ___Yes ___No
   b. Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness? ___Yes ___No
   c. Asthma or other disease of lungs or respiratory organs? ___Yes ___No
   d. Kidney Stones; disease of kidney, bladder, male or female organs; infertility? ___Yes ___No
   e. Cancer and/or cancerous tumor (state type/part of body)? ___Yes ___No
   f. Diabetes; liver or thyroid disease; enlargement of the lymph nodes; blood disorders? ___Yes ___No
   g. Stomach, gallbladder intestinal or colon disorders? ___Yes ___No
   h. Rheumatoid arthritis or back disorders? ___Yes ___No
   i. Phlebitis, paralysis, or any other physical impairment or deformity? ___Yes ___No
   j. Alcoholism or drug habit, or have been a member of Alcoholics Anonymous? ___Yes ___No
   k. AIDS or an AIDS related complex; other immune system disorder? ___Yes ___No
   l. Currently pregnant, premature delivery or multiple births? ___Yes ___No
      Pending Due Date _____
   m. Any other medical condition(s) not listed above? Disability? On prescription drugs? ___Yes ___No
2. Within the past 3 years, have consulted with any doctors, therapists, counselors, or health care providers of any kind, or received any treatment other than routine checkups or minor illnesses? ___Yes ___No
3. Within the past 3 years, had any loss of weight; been in a hospital, sanitarium or institution for observation or treatment; had electrocardiograms, x-rays, blood studies, or other diagnostic tests? ___Yes ___No

PLEASE GIVE DETAILS BELOW FOR ANY QUESTIONS CHECKED "YES" ON THE PREVIOUS PAGE. USE REVERSE SIDE AS NEEDED FOR ADDITIONAL HEALTH INFORMATION

Question #	Person	Condition Details	Onset Mo/Yr	Duration	Results/ Findings	Medication/ Dosage	Full Name/Address of Physician

AGREEMENT TO ENROLL FOR COVERAGE

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Instructions: Please read this authorization form carefully before signing. Your request to enroll for coverage cannot be processed without your signature. You have the right to receive a copy of this form following your signature.

I. Protected Health Information

Excess Loss Carrier and its affiliates are committed to the privacy of your Protected Health Information (PHI)/Personal Information and has required all business associates and vendors to agree in writing to those same protections. Despite these efforts, we are required by law to advise you that your information may, at some point fall outside of these protections, be re-disclosed and would no longer be protected.

This authorization encompasses information that is considered to be PHI and/or Personal Information, including individually identifiable health information that is created or received by your provider, health plan or insurer, data clearing house, a health authority, employer, school or university, pharmacy or pharmacy benefit managers.

PHI/Personal Information relates to the past, present, or future condition of your physical or mental health, healthcare provided to you, or payment for the healthcare provided to you. PHI/Personal Information does not include summary health information or information that has been de-identified according to the standards for de-identification provided for in the Health Insurance Portability and Accountability Act privacy rule.

By signing this form, I authorize certain entities identified below to use or disclose my protected health information. Protected health information includes but is not limited to, hospital records, physician records, lab results, mental health records, and alcohol and/or drug abuse records. Protected health information may be obtained, maintained, or transmitted in any form or medium, including written, oral, or electronic.

II. Purpose of the Authorization Form

By signing this form, I authorize the use and disclosure of protected health information for the purposes of: determining eligibility for enrollment or benefits under a health plan; determining eligibility and/or risk-rating of stop-loss insurance coverage for my employer, or to allow the plan's designee to conduct utilization review and quality improvement activities ("Purpose").

III. Entities Authorized to Use and Disclose My Protected Health Information

I hereby authorize the following entities, their reinsurers, or other organizations performing business or legal services in connection with the Purpose above and their respective legal representatives ("Entities") to receive, use, and disclose my protected health information for the Purpose listed above.

The Excess Stop-Loss Insurance Company

United States Managing General Underwriters

I authorize Entities to disclose my PHI between themselves and their affiliated companies, to reinsuring companies, to the plan administrator or plan sponsor.
I further authorize any licensed licensed physician, medical practitioner, healthcare provider, hospital, clinic, pharmacy or pharmacy benefit managers, or other medical or medically related facility, insurance or reinsurance company, or other organization that has any record or knowledge of me to give Entities any and all PHI about me concerning diagnosis, treatment and prognosis for any physical or mental condition, including but not limited to, all medical and healthcare records.
I understand I have a right to inspect and copy my own PHI/Personal Information to be used or disclosed. I understand that failure to sign this Authorization form will result in my application not being considered.
I understand that my Personal Representative or I have a right to receive a copy of this Authorization form. A simulated, faxed, or copied image of this Authorization form shall be as valid as the original.

IV. Term of Authorization

I further agree this Authorization will be valid until the Entities or their affiliates have completed their underwriting of my employer's coverage or for 12 months from the date signed, whichever is less.

V. Right to Revoke

I understand I may revoke this authorization at any time by giving advance written notice to the Entities listed above. Revocation of this authorization form will not affect actions Entities took in reliance on this form prior to receipt of the written notice of revocation.

I acknowledge and agree that if information has been intentionally omitted or misrepresented, my employer's self-funded health plan may deny or limit coverage and the Third Party Administrator service agreement may terminate for breach. I certify that the statements above are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind coverage. United Advantage Agency gathers this information for statistical and actuarial use only. This information is not to be used in connection with any decisions or actions regarding my employment. Prospective employees in Michigan should not provide information regarding height or weight. In compliance with requirements for the Genetic Insurance Nondiscrimination Act (GINA), my Employer's Benefit Plan is not requesting genetic information. My Employer's Benefit Plan Notice of Privacy Practices provides more detailed information about how United Advantage Agency and the health plan I have chosen may use and disclose my protected health information. I have a legal right to review the Notice of Privacy Practices before I sign this consent, and I am encouraged to read it in full. I have a right to request restrictions on how my protected health information is used and disclosed. My Employer's Benefit Plan is not required by law to grant my request. However, if my request is granted, My Employer's Benefit Plan is bound by their Agreement(s). I have the right to revoke this consent in writing, except to the extent my Employer's Benefit Plan has already used or disclosed my protected health information in reliance upon my consent. I will notify my Employer's Benefit Plan of any health or enrollment related changes that occur after signing this form up to the effective date of coverage on the Employer's Benefit Plan.

Employee Medical Amendment

I understand that the stop loss insurance company has the right to revise rates (retroactively or prospectively), rescind or terminate my Employer's Stop-Loss insurance Contract if I completed these forms with false, incomplete or misleading information. The Plan or my Employer will rescind or terminate my or my dependent(s)'s coverage for fraud or intentional misrepresentation of material fact if I completed these forms with false, incomplete or misleading information. I understand that I have the opportunity to edit any of my information at this time by disclosing such information in the Employee Eligibility Statement.

I have read and agree to the attached Authorization.

Employee Signature _____ Date: _____

Print Name: _____

Group Name: _____

Infinity Business Solutions, LLC

AUTHORIZATION TO OBTAIN AND DISCLOSE PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF DETERMINING ELIGIBILITY FOR HEALTH COVERAGE

Name of Employee:_____Date of Birth: _____

Address:_____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to Infinity Business Solutions, LLC (IBS). This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (*HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. By my signature below, I acknowledge that any agreements I have made to restrict my protected health information does not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. This protected health information is to be disclosed under this Authorization so that IBS may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with IBS. This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing a written request for revocation to : IBS at 36 Oswego Street, Ste 201, Baldwinsville, NY 13027 Attention: Underwriting Department. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or the extent that IBS has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, IBS may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that any authorized representative or I have received a copy of this authorization. COMPLETE IN DUPLICATE AND RETAIN A COPY FOR YOUR RECORD

_____

Signature of Individual Whose Information is to be Disclosed or Authorized Representative

_____

Print Name of Individual or Authorized Representative Date Signed

ACH/EFT Authorization Form

INFINITY BUSINESS SOLUTIONS

Name:_____Middle:_____Last Name:_____

Address_____STE/Apt:_____

City/Sate/Zip:_____

Home Phone: (_____)_____-_____Work Phone: (_____)_____-_____

Date of Birth: _____Last 4 of Social Security # or Federal Tax ID #: _____

Driver's License #: _____Driver's License State: _____

Payment Plan Schedule: Must check options that apply (may choose both options)

[ ] One Time Payment Payment Amount : $_____ Payment Date:_____

[ ] Recurring Debit: [ ] Day [ ] Week [ ] Month Start Date:_____

Recurring Debit Amount: $_____ Day of Month of Recurring Debit_____

_____

Must choose one (1) of the options below.

[ ] End Date of Recurring Debit:_____

[ ] End with written notice (can be by email).

CUSTOMER BANK ACCOUNT INFORMATION:

Bank Name:_____Bank Phone:_____

Routing Number: _____Account Number:_____

ATTACH VOIDED CHECK Attach Voided Check Here

Type of Account : [ ] Business Checking [ ] Personal Checking

PAYMENT AUTHORIZATION:

I authorize my bank to debit my account as identified above to the terms stated here. This Authorization shall remain in effect until the services provider and bank receive written notification from me of intent to terminate at such time and in such manner as to afford the service provider and bank reasonable opportunity to act (minimum 30 days).

I understand that if the total amount owed to the service provider is increased, I authorize this plan to continue as long as the payment amount remains unchanged until the amount owed the service provider is paid off, or unless the plan is terminated earlier by me as above. I understand any added amounts can be applied for with a new ACH/EFT Debit authorization form.

All other changes such as payment amount, frequency, bank account number changes will require a new ACH/EFT debit payment authorization form to be filled out and submitted to the merchant 15 days prior to any changes being implemented. I understand that this payment plan may be canceled by the services provider or merchant due to NSF (Non-sufficient funds). I will be liable to pay an NSF fee of $50 (or the amount allowable by law) which may be automatically debited for each NSF.

I represent and warrant that I am authorized to execute this payment for the purpose of implementing this payment plan. I indemnify and hold the services provider, the bank and the merchant harmless from damage, loss, or claim resulting from all authorized actions hereunder:

Customer Signature:_____ Date:_____

Second Signature (If required by bank):_____Date:_____

Memo

Thank you for your interest in our services.

If you are signing up for health coverage and have a dependant/dependants, each person will need to sign a HIPPA release form. If a dependent is a minor, an adult/guardian may sign a separate form on their behalf. If a dependent such as a spouse is not a minor, they will need to sign a separate HIPPA form themselves. Please include their email(s) below.

Email: _____

Email: _____

Email: _____

Email: _____

If you would prefer not to use our digital signature services you are welcome to fax any documents, you may do so via our fax number: 631-424-2464 and put Attention: New Application Processing Unit

We are here to help you and if you have any questions, please feel free to call your representative or myself.

Please upload the necessary documents below.

Voided Check

Marriage Certificate (if applicable)

Birth Certificate (if applicable)