Highlights of your Health Care Coverage

Green Diamond Resource Company

Group Number: 1012195

Effective Date: 07/01/2022

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN	**YOUR FUTURE - $2800/$5600 20/40% $4500/$9000 (TJR, SPINE AND CARDIAC COE) - (MAC) PV1***	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARE OPTIONS		
Individual Deductible PPY (Family embedded deductible 2X Individual)	$2,800	$5,600
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	40%
Individual Out of Pocket Maximum PPY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$4,500 PPY / $9,000 PPY	$9,000 PPY / $18,000 PPY
Office Visit Cost Share	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered
Health Education (HE) (Unlimited)	Covered in Full	Not Covered
Nicotine Dependency Programs (ND) (Unlimited)	Covered in Full	Not Covered
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Covered in Full
PROFESSIONAL CARE		
Professional Office Visit	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	Not Covered
Telemedicine - Outpatient Rehab (Virtual Care Only)	Subject to Rehab Outpatient Care In-Network Cost Share	Not Covered
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
Other Professional Diagnostic Imaging	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
Professional Diagnostic Major Imaging	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
Diagnostic Mammography	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
FACILITY CARE OPTIONS		
Inpatient Facility	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
Inpatient Professional Services	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
Outpatient Surgery Facility	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
Skilled Nursing Facility (60 days PPY; includes room and board, and facility billed professional and ancillary fees)	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (Unlimited Hospice days & Respite care/visits hours. Coverage for 6 months of care with add 6 mos pos)	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Hospice Care (Unlimited Hospice days & Respite care/visits hours. Coverage for 6 months of care with add 6 mos pos)	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
Sterilization - Female (Unlimited)	Covered in Full	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
Sterilization - Male (Unlimited)	Subject to the IRS Minimum Deductibles, then 0% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
PREMERA DESIGNATED CENTERS OF EXCELLENCE		
Centers of Excellence Packaged Services (Eligible Services Include: Total Joint Replacement (Knee & Hip), Cardiac Care, Spine Surgery)	$2,800 Deductible, 0% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	Covered as any other service
Centers of Excellence for Radiology (Member Outreach Excluded)	Covered as any other service	Covered as any other service
MEDICAL TRANSPORTATION BENEFITS		
Centers of Excellence Travel and Care Coordination (Limited to IRS Guidelines)	$2,800 Deductible, 0% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$2,800 Deductible, 0% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum
Emergency Room Physician	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum
Urgent Care Center	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
Ambulance Transportation (Unlimited)	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum
ALTERNATIVE CARE		

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Acupuncture (12 visits PPY)	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
Manipulations (Spinal and other) (24 visits PPY)	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care (Unlimited)	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PPY)	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (45 visits PPY)	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
OTHER SERVICES		
Allergy/Therapeutic Injections	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$5,600 Deductible, then 40% Coinsurance, applies to $9,000 PPY / $18,000 PPY Out of Pocket Maximum
Transplants (Unlimited; $7,500 travel and lodging limits)	Covered as any other service	Not Covered
PHARMACY		

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Prescription Drugs - Retail (Specific preventive drugs and legend Retail: 90 day supply/Mail: 90 day supply/Specialty: 30 day supply)	$2,800 Deductible, then 20% Coinsurance, applies to the $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$2,800 Deductible, then 20% Coinsurance, applies to the $4,500 PPY / $9,000 PPY Out of Pocket Maximum
Prescription Drugs - Mail (Specific preventive drugs and legend Retail: 90 day supply/Mail: 90 day supply/Specialty: 30 day supply)	$2,800 Deductible, then 20% Coinsurance, applies to the $4,500 PPY / $9,000 PPY Out of Pocket Maximum	Not Covered
Drug List	E1 Essentials Formulary No Tiers	E1 Essentials Formulary No Tiers
Specialty Pharmacy (Mandatory - Exclusive)	$2,800 Deductible, then 20% Coinsurance, applies to the $4,500 PPY / $9,000 PPY Out of Pocket Maximum	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (1 PPY)	$30 Copay	$30 Copay
Vision Hardware ($300 PPY)	Covered in Full	Covered in Full
Pediatric Vision Exam (1 PPY under age 19)	$30 Copay, applies to the Out of Pocket Maximum	$30 Copay, applies to the Out of Pocket Maximum
Pediatric Vision Hardware (<19 1 pair glasses PPY frames & lenses. 12 MO supp contacts PPY, in lieu of glasses frames & lenses)	Covered in Full	Covered in Full
Routine Hearing Exam (1 PPY)	Exam & Test: Deductible; then 20% coinsurance	Exam & Test: Deductible; then 20% coinsurance
Hearing Hardware ($1,000 per 24 Consecutive Months)	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum	$2,800 Deductible, then 20% Coinsurance, applies to $4,500 PPY / $9,000 PPY Out of Pocket Maximum
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

*This plan is self-funded by Green Diamond Resource Company, which means that this group is financially responsible for the payment of plan benefits. The group has contracted with Premera Blue Cross, an independent Licensee of the Blue Cross Blue Shield Association, to perform administrative duties, including the processing of claims, under the plan. Premera Blue Cross does not insure the benefits of this plan.

Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

PPY = Per Plan Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.