PREMERA | BLUE CROSS

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 - PPO	**YOUR CHOICE $500/$1000 20/40% $3000 $25/$40/$200 SPLIT COPAY (TJR, SPINE AND CARDIAC COE) - $1,000 HEARING AID HARDWARE REDUCED OON DED - REDUCED DIAGNOSTIC DEDUCTIBLE / $25 VISION COPAY***	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARE OPTIONS		
Individual Deductible PPY (Family embedded deductible 3X Individual)	$500	$1,000
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)	$3,000 PPY / $6,000 PPY	$6,000 PPY / $12,000 PPY
Office Visit Cost Share	$25 Copay Non Specialist, applies to the $3,000 PPY / $6,000 PPY Out of Pocket Maximum; $40 Copay Specialist, applies to the $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 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	$25 Copay Non Specialist, applies to the $3,000 PPY / $6,000 PPY Out of Pocket Maximum; $40 Copay Specialist, applies to the $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 PPY Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical	$10 Copay, applies to the $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 PPY Out of Pocket Maximum

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	$10 Copay, applies to the $3,000 PPY / $6,000 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
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	Not Covered
Other Professional Diagnostic Imaging	$500 Deductible, then 20% Coinsurance, applies to $4,400 PPY / $9,500 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $8,800 PPY / $19,000 PPY Out of Pocket Maximum
Professional Diagnostic Major Imaging	$500 Deductible, then 20% Coinsurance, applies to $4,400 PPY / $9,500 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $8,800 PPY / $19,000 PPY Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology	$500 Deductible, then 20% Coinsurance, applies to $4,400 PPY / $9,500 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $8,800 PPY / $19,000 PPY Out of Pocket Maximum
Diagnostic Mammography	Covered In Full	Covered In Full
FACILITY CARE OPTIONS		
Inpatient Facility	$500 Deductible, then 20% Coinsurance, applies to $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 PPY Out of Pocket Maximum
Inpatient Professional Services	$500 Deductible, then 20% Coinsurance, applies to $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 PPY Out of Pocket Maximum
Outpatient Surgery Facility	$500 Deductible, then 20% Coinsurance, applies to $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 PPY Out of Pocket Maximum
Skilled Nursing Facility (60 days PPY; includes room and board, and facility billed professional and ancillary fees)	$500 Deductible, then 20% Coinsurance, applies to $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 PPY Out of Pocket Maximum

MEDICAL PLAN	YOUR CHOICE $500/$1000 20/40% $3000 $25/$40/$200 SPLIT COPAY (TJR, SPINE AND CARDIAC COE) - $1,000 HEARING AID HARDWARE REDUCED OON DED - REDUCED DIAGNOSTIC DEDUCTIBLE / $25 VISION COPAY*	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
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)	$500 Deductible, then 20% Coinsurance, applies to $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 PPY Out of Pocket Maximum
Hospice Care (Unlimited Hospice days & Respite care/visits hours. Coverage for 6 months of care with add 6 mos pos)	$500 Deductible, then 20% Coinsurance, applies to $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 PPY Out of Pocket Maximum
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 PPY Out of Pocket Maximum
Sterilization - Female (Unlimited)	Covered in Full	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 PPY Out of Pocket Maximum
Sterilization - Male (Unlimited)	Covered in Full	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 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)	Covered in Full	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)	Covered in Full	Covered in Full
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$200 Copay, Waive Deductible, then 20% Coinsurance, applies to $4,400 PPY / $9,500 PPY OOP Maximum	$200 Copay, Waive Deductible, then 20% Coinsurance, applies to $4,400 PPY / $9,500 PPY OOP Maximum
Emergency Room Physician	$500 Deductible, then 20% Coinsurance, applies to $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$500 Deductible, then 20% Coinsurance, applies to $3,000 PPY / $6,000 PPY Out of Pocket Maximum
Urgent Care Center	$40 Copay Specialist, applies to the $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 PPY Out of Pocket Maximum
Ambulance Transportation (Unlimited)	$500 Deductible, then 20% Coinsurance, applies to $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$500 Deductible, then 20% Coinsurance, applies to $3,000 PPY / $6,000 PPY Out of Pocket Maximum
ALTERNATIVE CARE		

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Acupuncture (12 visits PPY)	$25 Copay Non Specialist, applies to the $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 PPY Out of Pocket Maximum
Manipulations (Spinal and other) (24 visits PPY)	$25 Copay Non Specialist, applies to the $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 PPY Out of Pocket Maximum
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	$500 Deductible, then 20% Coinsurance, applies to $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 PPY Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care (Unlimited)	$25 Copay Non Specialist, applies to the $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 PPY Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	$500 Deductible, then 20% Coinsurance, applies to $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 PPY Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	$25 Copay Non Specialist, applies to the $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 PPY Out of Pocket Maximum
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PPY)	$500 Deductible, then 20% Coinsurance, applies to $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 PPY Out of Pocket Maximum
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (45 visits PPY)	$40 Copay Specialist, applies to the $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 PPY Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	$40 Copay Specialist, applies to the $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 PPY Out of Pocket Maximum
OTHER SERVICES		
Allergy/Therapeutic Injections	$25 Copay Non Specialist, applies to the $4,400 PPY / $9,500 PPY Out of Pocket	$1,500 Deductible, then 40% Coinsurance, applies to $8,800 PPY / $19,000 PPY Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	$500 Deductible, then 20% Coinsurance, applies to $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 PPY Out of Pocket Maximum
Transplants (Unlimited; $7,500 travel and lodging limits)	Covered as any other service	Not Covered
SUPPLEMENTAL BENEFITS		

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Routine Vision Exam (1 PPY)	$25 Copay	$25 Copay
Vision Hardware ($300 PPY)	Covered in Full	Covered in Full
Pediatric Vision Exam (1 PPY under age 19)	$25 Copay applies to the Out of Pocket Maximum	$25 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 (Exam: 1 PPY. Hardware: $1,000 per 24 Consecutive Months)	$25 Copay	$25 Copay
Hearing Hardware (Exam: 1 PPY. Hardware: $1,000 per 24 Consecutive Months)	Deductible Waived, Subject to constant 20% Coinsurance	Deductible Waived, Subject to constant 20% Coinsurance
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.

Highlights of your Health Care Coverage

Green Diamond Resource Company

Group Number: 1012195

Effective Date: 07/01/2022

Below is a brief overview of your Pharmacy Benefits. For more information on your benefits, please refer to your benefit booklets. To find out what tiers apply to a specific medication, refer to our Preferred Drug List in your Pharmacy Packet or at www.premera.com

PHARMACY PLAN	**ESSENTIALS: RETAIL- $10/$30/$50/30% MAIL- $25/$75/$50/30% (MAC) PV1***
PRESCRIPTION DRUGS	
Drug List	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs
Retail Cost Shares	$10/$30/$50/30%
Mail Cost Shares	$25/$75/$50/30%
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days
Individual Deductible PPY	$0
Family Deductible PPY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Cost Share, then 40% (to allowable)
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Annual Benefit Maximum	Unlimited

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