

# Highlights of your Health Care Coverage

Green Diamond Resource Company

Group Number: 1012195

Effective Date: 07/01/2023

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.

<b>MEDICAL PLAN - HEALTH SAVINGS PLAN</b>		<b>YOUR FUTURE - \$3200/\$6400 20/40% \$4500/\$9000 (TJR, SPINE AND CARDIAC COE) - PV CORE PLUS*</b>	
	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>MEDICAL COST SHARE OPTIONS</b>			
<b>Individual Deductible PPY</b> (Family embedded deductible 2X Individual)	\$3,200 PPY	\$6,400 PPY	
<b>Coinsurance (Member's percentage of costs after deductible based on allowable charges)</b>	20%	40%	
<b>Individual Out of Pocket Maximum PPY, includes deductible, coinsurance, copay and pharmacy if applicable</b> (Family embedded OOP max 2X Individual)	\$4,500 PPY / \$9,000 PPY	\$9,000 PPY / \$18,000 PPY	
<b>Office Visit Cost Share</b>	\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION</b>			
<b>Preventive Office Visit</b> (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered	
<b>Immunizations</b> (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered	
<b>Health Education (HE)</b> (Unlimited)	Covered in Full	Not Covered	
<b>Nicotine Dependency Programs (ND)</b> (Unlimited)	Covered in Full	Not Covered	
<b>Diabetes Health Education (DE)</b> (Unlimited)	Covered in Full	Covered in Full	
<b>PROFESSIONAL CARE</b>			
<b>Professional Office Visit</b>	\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>Telemedicine with Traditional Providers - General Medical</b>	\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>VIRTUAL CARE SERVICES</b>			
<b>Telemedicine - General Medical (Virtual Care Only)</b>	\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	Not Covered	
<b>Telemedicine - Mental Health (Virtual Care Only)</b>	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered	

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	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Telemedicine - Mental Health for Children (Virtual Care Only)</b>	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered	
<b>Telemedicine - Chemical Dependency (Virtual Care Only)</b>	Subject to Chemical Dependency Outpatient Office Visit	Not Covered	
<b>Telemedicine - Outpatient Rehab (Virtual Care Only)</b> (Shared with Rehab Outpatient Care)	Subject to Rehab Outpatient Care In-Network Cost Share	Not Covered	
<b>DIAGNOSTIC SERVICE OPTIONS</b>			
<b>Preventive Professional Imaging and Laboratory Services - Including Mammogram and PAP/PSA</b>	Covered in Full	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>Other Professional Diagnostic Imaging</b>	\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>Professional Diagnostic Major Imaging</b>	\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>Other Professional Diagnostic Laboratory/Pathology</b>	\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>Diagnostic Mammography</b>	\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>FACILITY CARE OPTIONS</b>			
<b>Inpatient Facility</b>	\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>Inpatient Professional Services</b>	\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>Outpatient Surgery Facility</b>	\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>Skilled Nursing Facility</b> (60 days PPY; includes room and board, and facility billed professional and ancillary fees)	\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>HOSPICE &amp; HOME HEALTH CARE</b>			
<b>Hospice Inpatient Facility</b> (Unlimited Hospice days & Respite care/visits hours. Coverage for 6 months of care with add 6 mos pos)	\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	

<b>MEDICAL PLAN</b>		<b>YOUR FUTURE - \$3200/\$6400 20/40% \$4500/\$9000 (TJR, SPINE AND CARDIAC COE) - PV CORE PLUS*</b>	
	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Hospice Care</b> (Unlimited Hospice days & Respite care/visits hours. Coverage for 6 months of care with add 6 mos pos)	\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>MATERNITY &amp; REPRODUCTIVE CARE</b>			
<b>Contraceptive Management Services</b> (Unlimited)	Covered in Full	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>Sterilization - Female</b> (Unlimited)	Covered in Full	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>Sterilization - Male</b> (Unlimited)	Subject to the IRS Minimum Deductibles, then 0% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>PREMERA DESIGNATED CENTERS OF EXCELLENCE</b>			
<b>Centers of Excellence for Knee &amp; Hip Total Joint Replacement (Not Including Partial &amp; Revisions)</b> (Included)	\$3,200 PPY Deductible, 0% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	Not Applicable	
<b>Centers of Excellence for Knee &amp; Hip Total Joint Replacement (Including Partial &amp; Revisions)</b> (Excluded)	Excluded	Excluded	
<b>Centers of Excellence for Radiology</b> (Member Outreach Excluded)	Covered as any other service	Covered as any other service	
<b>Centers of Excellence for Spine Surgery</b> (Included)	\$3,200 PPY Deductible, 0% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	Not Applicable	
<b>Centers of Excellence for Cardiac Care</b> (Included)	\$3,200 PPY Deductible, 0% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	Not Applicable	
<b>MEDICAL TRANSPORTATION BENEFITS</b>			
<b>Centers of Excellence Travel and Care Coordination</b> (Limited to IRS Guidelines)	\$3,200 PPY Deductible, 0% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$3,200 PPY Deductible, 0% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	
<b>Transplant Travel &amp; Lodging</b> (\$7,500 per transplant)	\$3,200 PPY Deductible, 0% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$3,200 PPY Deductible, 0% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	
<b>EMERGENCY CARE AND TRANSPORTATION OPTION</b>			
<b>Emergency Care</b>	\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	

<b>MEDICAL PLAN</b>			<b>YOUR FUTURE - \$3200/\$6400 20/40% \$4500/\$9000 (TJR, SPINE AND CARDIAC COE) - PV CORE PLUS*</b>			
			<b>HERITAGE IN-NETWORK</b>		<b>OUT-OF-NETWORK</b>	
<b>Emergency Room Physician</b>			\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum		\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	
<b>Urgent Care Center</b>			\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum		\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>Ambulance Transportation (Unlimited)</b>			\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum		\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	
<b>ALTERNATIVE CARE</b>						
<b>Acupuncture (12 visits PPY)</b>			\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum		\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>Manipulations (Spinal and other) (24 visits PPY)</b>			\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum		\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>CHEMICAL DEPENDENCY &amp; MENTAL HEALTH</b>						
<b>Chemical Dependency Inpatient Facility Care (Unlimited)</b>			\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum		\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>Chemical Dependency Outpatient Professional Care (Unlimited)</b>			\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum		\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>Mental Health Inpatient Facility Care (Unlimited)</b>			\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum		\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>Mental Health Outpatient Professional Care (Unlimited)</b>			\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum		\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>PHARMACY</b>						
<b>Drug List</b>			E1 Essentials Formulary No Tiers		E1 Essentials Formulary No Tiers	
<b>Prescription Drugs - Retail (Retail: 90 Days; Mail: 90 Days; Specialty: 30 Days)</b>			\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum		Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share	
<b>Prescription Drugs - Mail (Retail: 90 Days; Mail: 90 Days; Specialty: 30 Days)</b>			\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum		Not Covered	
<b>REHABILITATION &amp; NEURO</b>						

<b>MEDICAL PLAN</b>			<b>YOUR FUTURE - \$3200/\$6400 20/40% \$4500/\$9000 (TJR, SPINE AND CARDIAC COE) - PV CORE PLUS*</b>		
			<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Rehab Inpatient Facility</b> (30 days PPY)			\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain</b> (45 visits PPY)			\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer</b>			\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>OTHER SERVICES</b>					
<b>Allergy/Therapeutic Injections</b>			\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>Medical Supplies, Equipment, Prosthetics</b> (Unlimited)			\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$6,400 PPY Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
<b>Transplants</b> (Unlimited)			Covered as any other service	Not Covered	
<b>SUPPLEMENTAL BENEFITS</b>					
<b>Routine Vision Exam</b> (1 PPY)			\$30 Copay	\$30 Copay	
<b>Vision Hardware</b> (\$300 PPY)			Covered in Full	Covered in Full	
<b>Pediatric Vision Exam</b> (1 PPY under age 19)			\$30 Copay, applies to the Out of Pocket Maximum	\$30 Copay, applies to the Out of Pocket Maximum	
<b>Pediatric Vision Hardware</b> (<19 1 pair glasses PPY frames & lenses. 12 MO supp contacts PPY, in lieu of glasses frames & lenses)			Covered in Full	Covered in Full	
<b>Routine Hearing Exam</b> (1 PPY)			Exam & Test: Deductible; then 20% coinsurance	Exam & Test: Deductible; then 20% coinsurance	
<b>Hearing Hardware</b> (\$1,000 per 24 Consecutive Months)			\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	
<b>ANNUAL PLAN MAXIMUM</b>					
<b>Annual Plan Maximum</b>			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 of the plan. This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.*

