PREMERA BLUE CROSS

Highlights of your Health Care Coverage

Green Diamond Resource Company
Group Number: 1012195

Effective Date: 07/01/2025

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 CHOICE $500/$1000 20/40% $3000 $25/$40/$200 SPLIT COPAY - $2,000 HEARING AID HARDWARE REDUCED OON DED - REDUCED DIAGNOSTIC DEDUCTIBLE / $25 VISION COPAY**	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARES		
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
Non Specialist Office Visit Cost Share	$25 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
Specialist Office Visit Cost Share	$40 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
Kinwell Connect Cost Share Waiver (Excluded)	All services rendered and billed by any Kinwell clinic are subject to standard cost shares	Not Applicable
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
CHRONIC CONDITION MANAGEMENT PROGRAMS		
Diabetes Management Plus	Excluded	Excluded
Diabetes Prevention Plus	Excluded	Excluded

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Hypertension Plus	Excluded	Excluded
Weight Management	Excluded	Excluded
PROFESSIONAL CARE		
Professional Office Visit	Non Specialist: $25 Copay, applies to the $3,000 PPY / $6,000 PPY Out of Pocket Maximum; Specialist: $40 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
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
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) (Shared with Rehab Outpatient Care)	Subject to Rehab Outpatient Care In-Network Cost Share	Not Covered
DIAGNOSTIC SERVICES		
Preventive Imaging and Laboratory	Covered In Full	Not Covered
Diagnostic Laboratory	$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
Basic Diagnostic Imaging	$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
Major Diagnostic Imaging	$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
Preventive Mammography	Covered in Full	Covered in Full
Diagnostic Mammography	$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 - $2,000 HEARING AID HARDWARE REDUCED OON DED - REDUCED DIAGNOSTIC DEDUCTIBLE / $25 VISION COPAY	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Supplemental Breast Exam	Covered as any other service	Covered as any other service
FACILITY CARE		
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
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 for Knee & Hip Total Joint Replacement (Including Partial & Revisions) (Included)	Covered in Full	Not Applicable
Centers of Excellence for Spine Surgery (Included)	Covered in Full	Not Applicable
Centers of Excellence for Cardiac Care (Included)	Covered in Full	Not Applicable

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL TRANSPORTATION BENEFITS		
Centers of Excellence Travel and Care Coordination (Limited to IRS Guidelines)	Covered in Full	Covered in Full
Transplant Travel & Lodging ($7,500 per transplant)	$500 Deductible, 0% Coinsurance, applies to $3,000 PPY / $6,000 PPY Out of Pocket Maximum	$500 Deductible, 0% Coinsurance, applies to $3,000 PPY / $6,000 PPY Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$200 Copay, Waive Deductible, then 20% Coinsurance, applies to $3,000 PPY / $6,000 PPY OOP Maximum	$200 Copay, Waive Deductible, then 20% Coinsurance, applies to $3,000PPY / $6,000 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, 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		
Acupuncture (12 visits PPY)	$25 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
Manipulations (Spinal and other) (24 visits PPY)	$25 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
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, 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

MEDICAL PLAN	YOUR CHOICE $500/$1000 20/40% $3000 $25/$40/$200 SPLIT COPAY - $2,000 HEARING AID HARDWARE REDUCED OON DED - REDUCED DIAGNOSTIC DEDUCTIBLE / $25 VISION COPAY	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Mental Health Outpatient Professional Care (Unlimited)	$25 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
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PPY combined limit for inpatient 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
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (45 visits PPY combined limit for outpatient services)	$40 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
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	$40 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
OTHER SERVICES		
Allergy/Therapeutic Injections	$25 Copay Non Specialist, applies to the $3,000 PPY / $6,000 PPY Out of Pocket	$1,000 Deductible, then 40% Coinsurance, applies to $6,000 PPY / $12,000 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)	Covered as any other service	Not Covered
SUPPLEMENTAL BENEFITS		
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: $2,000 per 24 Consecutive Months)	$25 Copay	$25 Copay
Hearing Hardware (Exam: 1 PPY. Hardware: $2,000 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

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.

Highlights of your Health Care Coverage

Green Diamond Resource Company
Group Number: 1012195

Effective Date: 07/01/2025

Below is a brief overview of your pharmacy benefit. For more information, please refer to your benefit booklet or sign into www.premera.com to find drug costs and coverages specific to your plan.

PHARMACY PLAN	**ESSENTIALS: RETAIL- $10/$30/$50/30% MAIL- $25/$75/$50/30% PV CORE PLUS***
PRESCRIPTION DRUGS	
Formulary Drug List	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs
Annual Benefit Maximum	Unlimited
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
Retail Cost Shares	Tier 1 = $10 Tier 2 = $30 Tier 3 = $50 Tier 4 = 30%
Mail Cost Shares	Tier 1 = $25 Tier 2 = $75 Tier 3 = $50 Tier 4 = 30%
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days

*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.

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.
Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 800-722-1471 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.

037378 (07-01-2021)