

Highlights of your Health Care Coverage

Green Diamond Shared Services LLC

Group Number: 1012195

Effective Date: 07/01/2026

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 AGG/EMB \$3400/\$5600 20/40% \$4500/\$9000 - \$2000 HEARING HARDWARE - PV CORE PLUS	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
MEDICAL COST SHARES			
Individual Deductible PPY (Embedded Fam; Ind \$3,400 replaces \$2,800 IND Agg Fam Ded \$5,600)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY	\$5,600 PPY Individual / \$11,200 Family	
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	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 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	
PREMERA HEALTH HUB			
Diabetes Management (Included)	Covered in Full	Not Applicable	
Digestive Health (Included)	Covered in Full	Not Applicable	
Hypertension (Included)	Covered in Full	Not Applicable	
Mental Health (Included)	Covered in Full	Not Applicable	
Musculoskeletal Health (Included)	Covered in Full	Not Applicable	
Tobacco Cessation (Included)	Covered in Full	Not Applicable	

MEDICAL PLAN			YOUR FUTURE - \$2800 AGG/EMB \$3400/\$5600 20/40% \$4500/\$9000 - \$2000 HEARING HARDWARE - PV CORE PLUS		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK			
Weight Management (Included (without clinical support))	Covered in Full	Not Applicable			
Women's Health (Included (without clinical support))	Covered in Full	Not Applicable			
CHRONIC CONDITION MANAGEMENT PROGRAMS					
Diabetes Management Plus	Excluded	Excluded			
Diabetes Prevention Plus	Excluded	Excluded			
Hypertension Plus	Excluded	Excluded			
Weight Management	Excluded	Excluded			
PROFESSIONAL CARE					
Professional Office Visit	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum			
Telemedicine with Traditional Providers - General Medical	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family 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)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY 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 - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit Cost Share	Not Covered			
DIAGNOSTIC SERVICES					
Preventive Imaging and Laboratory	Covered in Full	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum			
Diagnostic Laboratory	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum			
Basic Diagnostic Imaging	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family 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	
Major Diagnostic Imaging	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
Preventive Mammography	Covered in Full	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
Diagnostic Mammography	Covered in Full	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
Supplemental Breast Exam	Covered in Full	Covered as any other service	
FACILITY CARE			
Inpatient Facility	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
Inpatient Professional Services	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
Hospital Outpatient Surgery Facility	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
Ambulatory Surgery Center	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family 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)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family 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)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family 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)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
MATERNITY & REPRODUCTIVE CARE			
Birth Center	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
Contraceptive Management Services (Unlimited)	Covered in Full	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
Sterilization - Female (Unlimited)	Covered in Full	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
Sterilization - Male (Unlimited)	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
PREMERA DESIGNATED CENTERS OF EXCELLENCE			
Centers of Excellence for Knee & Hip Total Joint Replacement (Including Partial & Revisions) (Included)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, 0% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	Not Applicable	
Centers of Excellence for Spine Surgery (Included)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, 0% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	Not Applicable	
Centers of Excellence for Cardiac Care (Included)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, 0% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	Not Applicable	
MEDICAL TRANSPORTATION BENEFITS			
Centers of Excellence Travel and Care Coordination (Limited to IRS Guidelines)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, 0% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, 0% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	

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	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Transplant Travel & Lodging (\$7,500 per transplant)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, 0% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, 0% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	
EMERGENCY CARE AND TRANSPORTATION			
Emergency Care	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	
Emergency Room Physician	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	
Urgent Care Center	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
Ambulance Transportation (Unlimited)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	
ALTERNATIVE CARE			
Acupuncture (12 visits PPY)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
Manipulations (Spinal and other) (24 visits PPY)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family 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)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
Chemical Dependency Outpatient Professional Care (Unlimited)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family 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	
Mental Health Inpatient Facility Care (Unlimited)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
Mental Health Outpatient Professional Care (Unlimited)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
PHARMACY			
Formulary Drug List	E1 Essentials Formulary; No Tiers	E1 Essentials Formulary; No Tiers	
Prescription Drugs - Retail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 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	
Prescription Drugs - Mail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	Not Covered	
REHABILITATION & NEURODEVELOPMENTAL THERAPY			
Inpatient Rehab (30 days PPY)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
Outpatient Rehab, Including Physical and Occupational Therapy (45 visits PPY)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
Outpatient Rehab for Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer (Unlimited)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
Outpatient Massage Therapy (Applies to the outpatient rehab limit)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
Outpatient Speech Therapy (Applies to the outpatient rehab limit)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	

MEDICAL PLAN		YOUR FUTURE - \$2800 AGG/EMB \$3400/\$5600 20/40% \$4500/\$9000 - \$2000 HEARING HARDWARE - PV CORE PLUS	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Inpatient Neurodevelopmental Therapy	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
Outpatient Neurodevelopmental Therapy (45 visits PPY)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
OTHER SERVICES			
Allergy/Therapeutic Injections	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
Medical Supplies, Equipment, Prosthetics (Unlimited)	Individual Only: \$2,800 (agg) PPY Individual + Family: \$3,400 / \$5,600 PPY Deductible, then 20% Coinsurance, applies to \$4,500 PPY / \$9,000 PPY Out of Pocket Maximum	\$5,600 PPY Individual / \$11,200 Family Deductible, then 40% Coinsurance, applies to \$9,000 PPY / \$18,000 PPY Out of Pocket Maximum	
Transplants (Unlimited)	Covered as any other service	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 Device per ear every 36 months)	\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500/ \$9,000 Out of Pocket Maximum	\$3,200 PPY Deductible, then 20% Coinsurance, applies to \$4,500/ \$9,000 Out of Pocket Maximum	
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.