

# 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 CHOICE \$750/\$1500 20/50% \$3250 \$25/\$40/\$250 SPLIT COPAY - \$2,000 HEARING AID HARDWARE REDUCED OON DED - REDUCED DIAGNOSTIC DEDUCTIBLE / \$30 VISION COPAY |                                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
|                                                                                                                                                  | HERITAGE IN-NETWORK                                                                                                                                                   | OUT-OF-NETWORK                                                                                        |
| <b>MEDICAL COST SHARES</b>                                                                                                                       |                                                                                                                                                                       |                                                                                                       |
| Individual Deductible PPY (Family embedded deductible 3X Individual)                                                                             | \$750                                                                                                                                                                 | \$1,500                                                                                               |
| 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) | \$3,250 PPY / \$6,500 PPY                                                                                                                                             | \$6,500 PPY / \$13,000 PPY                                                                            |
| Non Specialist Office Visit Cost Share                                                                                                           | \$25 Copay, applies to the \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                                                                                            | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| Specialist Office Visit Cost Share                                                                                                               | \$50 Copay, applies to the \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                                                                                            | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 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                                                                                        |
| <b>PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION</b>                                                                                              |                                                                                                                                                                       |                                                                                                       |
| 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                                                                                       |
| <b>PREMERA HEALTH HUB</b>                                                                                                                        |                                                                                                                                                                       |                                                                                                       |
| Diabetes Management (Included)                                                                                                                   | Covered in Full                                                                                                                                                       | Not Applicable                                                                                        |
| Digestive Health (Included)                                                                                                                      | Covered in Full                                                                                                                                                       | Not Applicable                                                                                        |

| <b>MEDICAL PLAN</b>                                                                                                                                                          |                                                                                                                                                                                    |                                                                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| <b>YOUR CHOICE \$750/\$1500 20/50% \$3250 \$25/\$40/\$250 SPLIT COPAY - \$2,000 HEARING AID HARDWARE REDUCED OON DED - REDUCED DIAGNOSTIC DEDUCTIBLE / \$30 VISION COPAY</b> |                                                                                                                                                                                    |                                                                                                       |
|                                                                                                                                                                              | <b>HERITAGE IN-NETWORK</b>                                                                                                                                                         | <b>OUT-OF-NETWORK</b>                                                                                 |
| <b>Hypertension</b> (Included)                                                                                                                                               | Covered in Full                                                                                                                                                                    | Not Applicable                                                                                        |
| <b>Mental Health</b> (Included)                                                                                                                                              | Covered in Full                                                                                                                                                                    | Not Applicable                                                                                        |
| <b>Musculoskeletal Health</b> (Included)                                                                                                                                     | Covered in Full                                                                                                                                                                    | Not Applicable                                                                                        |
| <b>Tobacco Cessation</b> (Included)                                                                                                                                          | Covered in Full                                                                                                                                                                    | Not Applicable                                                                                        |
| <b>Weight Management</b> (Included (without clinical support))                                                                                                               | Covered in Full                                                                                                                                                                    | Not Applicable                                                                                        |
| <b>Women's Health</b> (Included (without clinical support))                                                                                                                  | Covered in Full                                                                                                                                                                    | Not Applicable                                                                                        |
| <b>CHRONIC CONDITION MANAGEMENT PROGRAMS</b>                                                                                                                                 |                                                                                                                                                                                    |                                                                                                       |
| <b>Diabetes Management Plus</b>                                                                                                                                              | Excluded                                                                                                                                                                           | Excluded                                                                                              |
| <b>Diabetes Prevention Plus</b>                                                                                                                                              | Excluded                                                                                                                                                                           | Excluded                                                                                              |
| <b>Hypertension Plus</b>                                                                                                                                                     | Excluded                                                                                                                                                                           | Excluded                                                                                              |
| <b>Weight Management</b>                                                                                                                                                     | Excluded                                                                                                                                                                           | Excluded                                                                                              |
| <b>PROFESSIONAL CARE</b>                                                                                                                                                     |                                                                                                                                                                                    |                                                                                                       |
| <b>Professional Office Visit</b>                                                                                                                                             | Non Specialist: \$25 Copay, applies to the \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum; Specialist: \$50 Copay, applies to the \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>Telemedicine with Traditional Providers - General Medical</b>                                                                                                             | \$10 Copay, applies to the \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                                                                                                         | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>VIRTUAL CARE SERVICES</b>                                                                                                                                                 |                                                                                                                                                                                    |                                                                                                       |
| <b>Telemedicine - General Medical (Virtual Care Only)</b>                                                                                                                    | \$10 Copay, applies to the \$3,250 PPY / \$6,500 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                                                                                           |
| <b>Telemedicine - Chemical Dependency (Virtual Care Only)</b>                                                                                                                | Subject to Chemical Dependency Outpatient Office Visit Cost Share                                                                                                                  | Not Covered                                                                                           |
| <b>DIAGNOSTIC SERVICES</b>                                                                                                                                                   |                                                                                                                                                                                    |                                                                                                       |
| <b>Preventive Imaging and Laboratory</b>                                                                                                                                     | Covered In Full                                                                                                                                                                    | Not Covered                                                                                           |
| <b>Diagnostic Laboratory</b>                                                                                                                                                 | \$750 Deductible, then 20% Coinsurance, applies to \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                                                                                 | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>Basic Diagnostic Imaging</b>                                                                                                                                              | \$750 Deductible, then 20% Coinsurance, applies to \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                                                                                 | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |

**YOUR CHOICE \$750/\$1500 20/50% \$3250 \$25/\$40/\$250 SPLIT COPAY -  
\$2,000 HEARING AID HARDWARE REDUCED OON DED - REDUCED  
DIAGNOSTIC DEDUCTIBLE / \$30 VISION COPAY**

| <b>MEDICAL PLAN</b>                                                                                                                      |                                                                                                        |                                                                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
|                                                                                                                                          | <b>HERITAGE IN-NETWORK</b>                                                                             | <b>OUT-OF-NETWORK</b>                                                                                 |
| <b>Major Diagnostic Imaging</b>                                                                                                          | \$750 Deductible, then 20% Coinsurance, applies to \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum     | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>Preventive Mammography</b>                                                                                                            | Covered in Full                                                                                        | Covered in Full                                                                                       |
| <b>Diagnostic Mammography</b>                                                                                                            | Covered in Full                                                                                        | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>Supplemental Breast Exam</b>                                                                                                          | Covered in Full                                                                                        | Covered as any other service                                                                          |
| <b>FACILITY CARE</b>                                                                                                                     |                                                                                                        |                                                                                                       |
| <b>Inpatient Facility</b>                                                                                                                | \$750 Deductible, then 20% Coinsurance, applies to \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum     | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>Inpatient Professional Services</b>                                                                                                   | \$750 Deductible, then 20% Coinsurance, applies to \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum     | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>Hospital Outpatient Surgery Facility</b>                                                                                              | \$750 Deductible, then 20% Coinsurance, applies to \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum     | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>Ambulatory Surgery Center</b>                                                                                                         | \$750 Deductible, then 10% Coinsurance, applies to the \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>Skilled Nursing Facility</b> (60 days PPY; includes room and board, and facility billed professional and ancillary fees)              | \$750 Deductible, then 20% Coinsurance, applies to \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum     | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 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) | \$750 Deductible, then 20% Coinsurance, applies to \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum     | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>Hospice Care</b> (Unlimited Hospice days & Respite care/visits hours. Coverage for 6 months of care with add 6 mos pos)               | \$750 Deductible, then 20% Coinsurance, applies to \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum     | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>MATERNITY &amp; REPRODUCTIVE CARE</b>                                                                                                 |                                                                                                        |                                                                                                       |
| <b>Birth Center</b>                                                                                                                      | \$750 Deductible, then 10% Coinsurance, applies to \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum     | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>Contraceptive Management Services</b> (Unlimited)                                                                                     | Covered in Full                                                                                        | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |

| <b>MEDICAL PLAN</b>                                                                                                    |  |                                                                                                       | <b>YOUR CHOICE \$750/\$1500 20/50% \$3250 \$25/\$40/\$250 SPLIT COPAY - \$2,000 HEARING AID HARDWARE REDUCED OON DED - REDUCED DIAGNOSTIC DEDUCTIBLE / \$30 VISION COPAY</b> |  |  |
|------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
|                                                                                                                        |  | <b>HERITAGE IN-NETWORK</b>                                                                            | <b>OUT-OF-NETWORK</b>                                                                                                                                                        |  |  |
| <b>Sterilization - Female (Unlimited)</b>                                                                              |  | Covered in Full                                                                                       | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum                                                                        |  |  |
| <b>Sterilization - Male (Unlimited)</b>                                                                                |  | Covered in Full                                                                                       | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum                                                                        |  |  |
| <b>PREMERA DESIGNATED CENTERS OF EXCELLENCE</b>                                                                        |  |                                                                                                       |                                                                                                                                                                              |  |  |
| <b>Centers of Excellence for Knee &amp; Hip Total Joint Replacement (Including Partial &amp; Revisions) (Included)</b> |  | Covered in Full                                                                                       | Not Applicable                                                                                                                                                               |  |  |
| <b>Centers of Excellence for Spine Surgery (Included)</b>                                                              |  | Covered in Full                                                                                       | Not Applicable                                                                                                                                                               |  |  |
| <b>Centers of Excellence for Cardiac Care (Included)</b>                                                               |  | Covered in Full                                                                                       | Not Applicable                                                                                                                                                               |  |  |
| <b>MEDICAL TRANSPORTATION BENEFITS</b>                                                                                 |  |                                                                                                       |                                                                                                                                                                              |  |  |
| <b>Centers of Excellence Travel and Care Coordination (Limited to IRS Guidelines)</b>                                  |  | Covered in Full                                                                                       | Covered in Full                                                                                                                                                              |  |  |
| <b>Transplant Travel &amp; Lodging (\$7,500 per transplant)</b>                                                        |  | \$750 Deductible, 0% Coinsurance, applies to \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum          | \$750 Deductible, 0% Coinsurance, applies to \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                                                                                 |  |  |
| <b>EMERGENCY CARE AND TRANSPORTATION</b>                                                                               |  |                                                                                                       |                                                                                                                                                                              |  |  |
| <b>Emergency Care (If applicable, waive copay if admitted to inpatient facility)</b>                                   |  | \$250 Copay, Waive Deductible, then 20% Coinsurance, applies to \$3,000 PPY / \$6,000 PPY OOP Maximum | \$250 Copay, Waive Deductible, then 20% Coinsurance, applies to \$3,000PPY / \$6,000 PPY OOP Maximum                                                                         |  |  |
| <b>Emergency Room Physician</b>                                                                                        |  | \$750 Deductible, then 20% Coinsurance, applies to \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum    | \$750 Deductible, then 20% Coinsurance, applies to \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                                                                           |  |  |
| <b>Urgent Care Center</b>                                                                                              |  | \$50 Copay, applies to the \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                            | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum                                                                        |  |  |
| <b>Ambulance Transportation (Unlimited)</b>                                                                            |  | \$750 Deductible, then 20% Coinsurance, applies to \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum    | \$750 Deductible, then 20% Coinsurance, applies to \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                                                                           |  |  |
| <b>ALTERNATIVE CARE</b>                                                                                                |  |                                                                                                       |                                                                                                                                                                              |  |  |
| <b>Acupuncture (12 visits PPY)</b>                                                                                     |  | \$25 Copay, applies to the \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                            | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum                                                                        |  |  |
| <b>Manipulations (Spinal and other) (24 visits PPY)</b>                                                                |  | \$25 Copay, applies to the \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                            | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum                                                                        |  |  |

| <b>MEDICAL PLAN</b>                                                                                        |  |  | <b>YOUR CHOICE \$750/\$1500 20/50% \$3250 \$25/\$40/\$250 SPLIT COPAY - \$2,000 HEARING AID HARDWARE REDUCED OON DED - REDUCED DIAGNOSTIC DEDUCTIBLE / \$30 VISION COPAY</b> |  |                                                                                                       |
|------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|
|                                                                                                            |  |  | <b>HERITAGE IN-NETWORK</b>                                                                                                                                                   |  | <b>OUT-OF-NETWORK</b>                                                                                 |
| <b>CHEMICAL DEPENDENCY &amp; MENTAL HEALTH</b>                                                             |  |  |                                                                                                                                                                              |  |                                                                                                       |
| <b>Chemical Dependency Inpatient Facility Care (Unlimited)</b>                                             |  |  | \$750 Deductible, then 20% Coinsurance, applies to \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                                                                           |  | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>Chemical Dependency Outpatient Professional Care (Unlimited)</b>                                        |  |  | \$25 Copay, applies to the \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                                                                                                   |  | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>Mental Health Inpatient Facility Care (Unlimited)</b>                                                   |  |  | \$750 Deductible, then 20% Coinsurance, applies to \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                                                                           |  | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>Mental Health Outpatient Professional Care (Unlimited)</b>                                              |  |  | \$25 Copay, applies to the \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                                                                                                   |  | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>REHABILITATION &amp; NEURODEVELOPMENTAL THERAPY</b>                                                     |  |  |                                                                                                                                                                              |  |                                                                                                       |
| <b>Inpatient Rehab (30 days PPY)</b>                                                                       |  |  | \$750 Deductible, then 20% Coinsurance, applies to \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                                                                           |  | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>Outpatient Rehab, Including Physical and Occupational Therapy (45 visits PPY)</b>                       |  |  | \$50 Copay, applies to the \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                                                                                                   |  | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>Outpatient Rehab for Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer (Unlimited)</b> |  |  | \$50 Copay, applies to the \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                                                                                                   |  | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>Outpatient Massage Therapy (Applies to the outpatient rehab limit)</b>                                  |  |  | \$50 Copay, applies to the \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                                                                                                   |  | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>Outpatient Speech Therapy (Applies to the outpatient rehab limit)</b>                                   |  |  | \$50 Copay, applies to the \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                                                                                                   |  | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>Inpatient Neurodevelopmental Therapy</b>                                                                |  |  | \$750 Deductible, then 20% Coinsurance, applies to \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                                                                           |  | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>Outpatient Neurodevelopmental Therapy (45 visits PPY)</b>                                               |  |  | \$50 Copay, applies to the \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum                                                                                                   |  | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |
| <b>OTHER SERVICES</b>                                                                                      |  |  |                                                                                                                                                                              |  |                                                                                                       |

| <b>MEDICAL PLAN</b>                                                                                                                               |                                                                                                    |                                                                                                       | <b>YOUR CHOICE \$750/\$1500 20/50% \$3250 \$25/\$40/\$250 SPLIT COPAY - \$2,000 HEARING AID HARDWARE REDUCED OON DED - REDUCED DIAGNOSTIC DEDUCTIBLE / \$30 VISION COPAY</b> |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
|                                                                                                                                                   | <b>HERITAGE IN-NETWORK</b>                                                                         | <b>OUT-OF-NETWORK</b>                                                                                 |                                                                                                                                                                              |  |  |
| <b>Allergy/Therapeutic Injections</b>                                                                                                             | \$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 |                                                                                                                                                                              |  |  |
| <b>Medical Supplies, Equipment, Prosthetics (Unlimited)</b>                                                                                       | \$750 Deductible, then 20% Coinsurance, applies to \$3,250 PPY / \$6,500 PPY Out of Pocket Maximum | \$1,500 Deductible, then 40% Coinsurance, applies to \$6,500 PPY / \$13,000 PPY Out of Pocket Maximum |                                                                                                                                                                              |  |  |
| <b>Transplants (Unlimited)</b>                                                                                                                    | Covered as any other service                                                                       | Not Covered                                                                                           |                                                                                                                                                                              |  |  |
| <b>SUPPLEMENTAL BENEFITS</b>                                                                                                                      |                                                                                                    |                                                                                                       |                                                                                                                                                                              |  |  |
| <b>Routine Vision Exam (1 PPY)</b>                                                                                                                | \$30 Copay                                                                                         | \$30 Copay                                                                                            |                                                                                                                                                                              |  |  |
| <b>Vision Hardware (\$300 PPY)</b>                                                                                                                | Covered in Full                                                                                    | Covered in Full                                                                                       |                                                                                                                                                                              |  |  |
| <b>Pediatric Vision Exam (1 PPY under age 19)</b>                                                                                                 | \$30 Copay applies to the Out of Pocket Maximum                                                    | \$30 Copay applies to the Out of Pocket Maximum                                                       |                                                                                                                                                                              |  |  |
| <b>Pediatric Vision Hardware (&lt;19 1 pair glasses PPY frames &amp; lenses. 12 MO supp contacts PPY, in lieu of glasses frames &amp; lenses)</b> | Covered in Full                                                                                    | Covered in Full                                                                                       |                                                                                                                                                                              |  |  |
| <b>Routine Hearing Exam (1 PPY)</b>                                                                                                               | \$25 Copay                                                                                         | \$25 Copay                                                                                            |                                                                                                                                                                              |  |  |
| <b>Hearing Hardware (1 Device per ear every 36 months)</b>                                                                                        | Deductible Waived, Subject to constant 20% Coinsurance                                             | Deductible Waived, Subject to constant 20% Coinsurance                                                |                                                                                                                                                                              |  |  |
| <b>ANNUAL PLAN MAXIMUM</b>                                                                                                                        |                                                                                                    |                                                                                                       |                                                                                                                                                                              |  |  |
| <b>Annual Plan Maximum</b>                                                                                                                        | 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 Shared Services LLC

Group Number: 1012195

Effective Date: 07/01/2026

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

| <b>PHARMACY PLAN</b>                                        |                                                                                                                                                   | <b>ESSENTIALS: RETAIL- \$10/\$30/\$50/30% MAIL- \$25/\$75/\$50/30% PV CORE PLUS*</b> |
|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| <b>PRESCRIPTION DRUGS</b>                                   |                                                                                                                                                   |                                                                                      |
| <b>Formulary Drug List</b>                                  | E4 Essentials Formulary<br>Tier 1 = Preferred Generic<br>Tier 2 = Preferred Brand<br>Tier 3 = Preferred Specialty<br>Tier 4 = Non-preferred Drugs |                                                                                      |
| <b>Annual Benefit Maximum</b>                               | Unlimited                                                                                                                                         |                                                                                      |
| <b>Individual Deductible PPY</b>                            | \$0                                                                                                                                               |                                                                                      |
| <b>Family Deductible PPY</b>                                | No Family Deductible                                                                                                                              |                                                                                      |
| <b>Out of Network (Non-participating retail pharmacies)</b> | Cost Share, then 40% (to allowable)                                                                                                               |                                                                                      |
| <b>Out of Pocket Maximum</b>                                | Applies to the medical out of pocket maximum                                                                                                      |                                                                                      |
| <b>Retail Cost Shares</b>                                   | Tier 1 = \$10<br>Tier 2 = \$30<br>Tier 3 = \$50<br>Tier 4 = 30%                                                                                   |                                                                                      |
| <b>Mail Cost Shares</b>                                     | Tier 1 = \$25<br>Tier 2 = \$75<br>Tier 3 = \$50<br>Tier 4 = 30%                                                                                   |                                                                                      |
| <b>Day Supply</b>                                           | Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days                                                                                                |                                                                                      |

\*This plan is self-funded by Green Diamond Shared Services LLC, 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.*