SCHEDULE OF BENEFITS
HIGH PLAINS SILVER
Health Insurance Policy

Policy Number: [123456]

Policyowner: [John Doe]

Issue Age: [35]

Type of Coverage: [Individual/family]

Benefit Period: Calendar Year

Benefit Plan: HIGH PLAINS SILVER

Policy Effective Date: [January 1, 2021]

Policy Anniversary Date: [January 1 of each Year]

Initial Premium: [$]

Mode of Payment: [Monthly]

Premium Due Date: [The first day of each month]

BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
Maximum Lifetime Benefit	Unlimited	Unlimited
Deductible		
Individual Deductible (*per Covered Person per Calendar Year)*	$7,000	$12,000
Family Deductible *(per family per Calendar Year)*	$14,000	$24,000
Annual Out-of-Pocket Maximum		
Individual Annual Out-of-Pocket Maximum	$8,550	$24,450
(per Covered Person per Calendar Year)		
Family Annual Out-of-Pocket Maximum	$17,100	$48,900
(per family per Calendar Year)		
Coinsurance	40%	60%

SCHEDULE OF BENEFITS (continued)

	Your Cost In-Network	Your Cost Out-of-Network
All Covered Benefits, unless otherwise specified below in this Schedule of Benefits	40% after Deductible	60% After Deductible
Autism Spectrum Disorder		
Inpatient	40% after Deductible	60% After Deductible
Outpatient Office Visit	$40.00 Copay	60% After Deductible
Outpatient Other	40% after Deductible	60% After Deductible
Centers of Excellence (When approved by MHC)	40%	NA
Chemical Dependency		
Inpatient	40% after Deductible	60% after Deductible
Outpatient	$40.00 Copay	60% after Deductible
Other Outpatient	40% after Deductible	60% after Deductible
Chiropractic Services		
Maximum Number of Office Visits per Calendar Year – 20 visits	$75.00 Copay	60% after Deductible
Convalescent Home Services (Skilled Nursing)		
	40% after Deductible	60% After Deductible
Dental Exam	0% to $100 Reimbursement	0% to $100 Reimbursement
Durable Medical Equipment		
Rental (up to the purchase price), Purchase and Repair and Replacement	40% after Deductible	60% After Deductible
Emergency Room Services	50% after Deductible	50% after Deductible
Home Health Care Services	40% after Deductible	60% After Deductible
Hospital Services - Facility and Professional		
Inpatient Facility	40% after Deductible	60% after Deductible
Outpatient Facility	40% after Deductible	60% after Deductible

SCHEDULE OF BENEFITS (continued)

	Your Cost In-Network	Your Cost Out-of-Network
Observation Room/Bed	40% after Deductible	60% after Deductible
Laboratory Services	50% after Deductible	60% after Deductible
Mental Health Services		
Inpatient	40% after Deductible	60% after Deductible
Outpatient Office Visit	$40.00 Copay	60% after Deductible
Other Outpatient	40% after Deductible	60% after Deductible
Physician Medical Services		
Physician Office Visits (Non-Specialist)	$40.00 Copay	60% after Deductible
Physician Specialist Visits	$75.00 Copay	60% after Deductible
Prescription Drugs Benefit		
Retail Pharmacy Prescriptions (31-day supply)		
Preferred Generic Drugs (Tier 1)	20%	60% after Deductible
Non-Preferred Generic & Preferred Brand Drugs (Tier 2)	30%	60% after Deductible
Non-Preferred Brand Drugs (Tier 3)	40%	60% after Deductible
Specialty Drugs (Tier 4)	50%	60% after Deductible
If you choose a higher Tier drug when a lower Tier drug is available, you must pay an ancillary charge in addition to the deductible and/or coinsurance, as applicable.		
Mail Order Maintenance **90-day supply**		
Preferred Generic Drugs (Tier 1)	20%	60% after Deductible
Non-Preferred Generic & Preferred Brand Drugs (Tier 2)	30%	60% after Deductible
Non-Preferred Brand Drugs (Tier 3)	40%	60% after Deductible
Specialty Drugs (Tier 4) (31-Day Supply Only)	NA	NA
Preventive Health Care Services	100% Covered	60% After Deductible
Prostheses Benefit (Non-Dental)		
Rental (up to the purchase price) Purchase, Repair, Replacement of Prosthetics	40% after Deductible	60% After Deductible
Therapeutic Services (PT, OT, ST) 40 visit limit each.	$75.00 Copay	60% After Deductible
Rehab and Habilitative have separate limits. See policy for additional information.		
Transplant Services	40% after Deductible	60% After Deductible
Urgent Care Benefit – Doctor on Demand Telemedicine	$20.00 Copay	Not Available

Urgent Care Benefit - At Urgent Care Clinic	$110.00 Copay	60% after Deductible
	Your Cost In-Network	**Your Cost Out-of-Network**
Vision Exam	$60 reimbursement for one exam per year.	$60 reimbursement for one exam per year.
Vision Care Benefit – Pediatric Vision Care Services		
This Vision Care Benefit only applies to Covered Dependent Children under age 19.		
Vision Examination	None, 100% Covered	25% after Deductible
Frequency of Services: One Vision Examination per Covered Dependent Child per Calendar Year		
Vision Care Materials		
Lenses		
Single Vision	None, 100% Covered*	25% after Deductible
Bifocal	None, 100% Covered*	25% after Deductible
Trifocal	None, 100% Covered*	25% after Deductible
Lenticular	None, 100% Covered*	25% after Deductible
*Coverage includes lenses in polycarbonate, plastic or glass, scratch resistant or UV coatings also covered.		
Frequency of Services: One set of lenses per Covered Dependent Child per Calendar Year		
Frames	None, 100% Covered	25% after Deductible
Frequency of Services: One frame per Covered Dependent Child per Calendar Year. Frame selection will be from a Pediatric Exchange Collection.		
Contact Lenses	None 100% Covered	25% after Deductible
(1) Standard (one pair annually) = 1 contact lens per eye (total 2 lenses);		
(2) Monthly (six-month supply) = 6 lenses per eye (total 12 lenses);		
(3) Bi-weekly (3-month supply) = 6 lenses per eye (total 12 lenses);		
(4) Dailies (one-month supply) = 30 lenses per eye (total 60)		