

**SCHEDULE OF BENEFITS  
HIGH PLAINS SILVER 73  
Health Insurance Policy**

**Policy Number:** [123456]

**Policy Effective Date:** [January 1, 2021]

**Policyowner:** [John Doe]

**Policy Anniversary Date:** [January 1 of each Year]

**Issue Age:** [35]

**Initial Premium:** [\$]

**Type of Coverage:** [Individual/Family]

**Mode of Payment:** [Monthly]

**Benefit Period:** Calendar Year

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

**Benefit Plan:** HIGH PLAINS SILVER 73

BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
Maximum Lifetime Benefit	Unlimited	Unlimited
Deductible		
<b>Individual Deductible (per Covered Person per Calendar Year)</b>	\$6,500	\$9,900
<b>Family Deductible (per family per Calendar Year)</b>	\$13,000	\$19,800
Annual Out-of-Pocket Maximum		
<b>Individual Annual Out-of-Pocket Maximum (per Covered Person per Calendar Year)</b>	\$6,800	\$20,400
<b>Family Annual Out-of-Pocket Maximum (per family per Calendar Year)</b>	\$13,600	\$40,800
Coinsurance	40%	60%

## SCHEDULE OF BENEFITS (continued)

	Your Cost In-Network	Your Cost Out-of-Network
<b>All Covered Benefits, unless otherwise specified below in this Schedule of Benefits</b>	40% after Deductible	60% After Deductible
<b>Autism Spectrum Disorder</b>		
Inpatient	40% after Deductible	60% After Deductible
Outpatient Office Visit	\$40.00 Copay	60% After Deductible
Other Outpatient	40% after Deductible	60% After Deductible
<b>Centers of Excellence (When approved by MHC)</b>	40%	NA
<b>Chemical Dependency</b>		
Inpatient	40% after Deductible	60% after Deductible
Outpatient Office Visit	\$40.00 Copay	60% after Deductible
Other Outpatient	40% after Deductible	60% After Deductible
<b>Chiropractic Services</b>		
Maximum Number of Office Visits per Calendar Year – 20 visits	\$75.00 Copay	60% after Deductible
<b>Convalescent Home Services (Skilled Nursing)</b>		
	40% after Deductible	60% After Deductible
<b>Dental Exam</b>	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
<b>Emergency Room Services</b>	50% after Deductible	50% after Deductible
<b>Home Health Care Services</b>	40% after Deductible	60% After Deductible
<b>Hospital Services - Facility and Professional</b>		
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
<b>Observation Room/Bed</b>	40% after Deductible	60% after Deductible
<b>Laboratory Services</b>	50% after Deductible	60% after Deductible
<b>Mental Health Services</b>		
Inpatient	40% after Deductible	60% after Deductible
Outpatient Office Visit	\$40.00 Copay	60% after Deductible
Other Outpatient	40% after Deductible	60% after Deductible
<b>Physician Medical Services</b>		
Physician Office Visits (Non-Specialist)	\$40.00 Copay	60% after Deductible
Physician Specialist Visits	\$75.00 Copay	60% after Deductible
<b>Prescription Drugs Benefit</b>		
Retail Pharmacy Prescriptions (31-day supply)		
Preferred Generic Drugs (Tier 1)	15%	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
<b>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.</b>		
<b>Mail Order Maintenance 90-day supply</b>		
Preferred Generic Drugs (Tier 1)	10%	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
<b>Preventive Health Care Services</b>	100% Covered	60% After Deductible
<b>Prostheses Benefit (Non-Dental)</b>		
Rental (up to the purchase price) Purchase, Repair, Replacement of Prosthetics	40% after Deductible	60% After Deductible
<b>Therapeutic Services (PT, OT, ST) 40 visit limit each.</b>	\$75.00 Copay	60% After Deductible
Rehab and Habilitative have separate limits. See policy for additional information.		
<b>Transplant Services</b>	40% after Deductible	60% After Deductible
<b>Urgent Care Benefit – Doctor on Demand Telemedicine</b>	\$20.00 Copay	Not Available
<b>Urgent Care Benefit - At Urgent Care Clinic</b>	\$110.00 Copay	60% after Deductible

## SCHEDULE OF BENEFITS (continued)

	<b>Your Cost In-Network</b>	<b>Your Cost Out-of-Network</b>
<b>Vision Exam</b>	\$60 reimbursement for one exam per year.	\$60 reimbursement for one exam per year.
<b>Vision Care Benefit – Pediatric Vision Care Services</b>		
This Vision Care Benefit only applies to Covered Dependent Children under age 19.		
<b>Vision Examination</b>	None, 100% Covered	25% after Deductible
Frequency of Services: One Vision Examination per Covered Dependent Child per Calendar Year		
<b>Vision Care Materials</b>		
<b>Lenses</b>		
<b>Single Vision</b>	None, 100% Covered*	25% after Deductible
<b>Bifocal</b>	None, 100% Covered*	25% after Deductible
<b>Trifocal</b>	None, 100% Covered*	25% after Deductible
<b>Lenticular</b>	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		
<b>Frames</b>	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.		
<b>Contact Lenses</b>	None 100% Covered	25% after Deductible
<b>(1) Standard (one pair annually) = 1 contact lens per eye (total 2 lenses);</b>		
<b>(2) Monthly (six-month supply) = 6 lenses per eye (total 12 lenses);</b>		
<b>(3) Bi-weekly (3-month supply) = 6 lenses per eye (total 12 lenses);</b>		
<b>(4) Dailies (one-month supply) = 30 lenses per eye (total 60)</b>		