# SCHEDULE OF BENEFITS
# HIGH PLAINS GOLD
# 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 GOLD**

**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)*** | $1,000 | $2,250 |
| | | |
| **Family Deductible *(per family per Calendar Year)*** | $2,000 | $4,500 |
| | | |
| | | |
| Annual Out-of-Pocket Maximum | | |
| | | |
| **Individual Annual Out-of-Pocket Maximum** | $6,000 | $17,250 |
| | | |
| ***(per Covered Person per Calendar Year)*** | | |
| | | |
| **Family Annual Out-of-Pocket Maximum** | $12,000 | $34,500 |
| | | |
| ***(per family per Calendar Year)*** | | |
| | | |
| Coinsurance | 30% | 50% |

## 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** | 30% after Deductible | 50% After Deductible |
| **Autism Spectrum Disorder** | | |
| Inpatient | 30% after Deductible | 50% After Deductible |
| Outpatient Office Visit | $35.00 Copay | 50% After Deductible |
| Other Outpatient | 30% after Deductible | 50% After Deductible |
| | | |
| **Centers of Excellence (When approved by MHC)** | 30% | NA |
| | | |
| **Chemical Dependency** | | |
| Inpatient | 30% after Deductible | 50% after Deductible |
| Outpatient Office Visit | $35.00 Copay | 50% after Deductible |
| Other Outpatient | 30% after Deductible | 50% After Deductible |
| | | |
| **Chiropractic Services** | | |
| Maximum Number of Office Visits per Calendar Year – 20 visits | $50.00 Copay | 50% after Deductible |
| | | |
| **Convalescent Home Services (Skilled Nursing)** | | |
| | 30% after Deductible | 50% 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 | 30% after Deductible | 50% After Deductible |
| | | |
| **Emergency Room Services** | 40% after Deductible | 40% after Deductible |
| | | |
| **Home Health Care Services** | 30% after Deductible | 50% After Deductible |
| | | |
| **Hospital Services - Facility and Professional** | | |
| Inpatient Facility | 30% after Deductible | 50% after Deductible |
| Outpatient Facility | 30% after Deductible | 50% after Deductible |
| | | |

## SCHEDULE OF BENEFITS (continued)

| | Your Cost In-Network | Your Cost Out-of-Network |
|---|---|---|
| **Observation Room/Bed** | 30% after Deductible | 50% after Deductible |
| | | |
| **Laboratory Services** | 40% after Deductible | 50% after Deductible |
| **Mental Health Services** | | |
| Inpatient | 30% after Deductible | 50% after Deductible |
| Outpatient Office Visit | $35.00 Copay | 50% after Deductible |
| Other Outpatient | 30% after Deductible | 50% after Deductible |
| | | |
| **Physician Medical Services** | | |
| Physician Office Visits (Non-Specialist) | $35.00 Copay | 50% after Deductible |
| Physician Specialist Visits | $50.00 Copay | 50% after Deductible |
| | | |
| **Prescription Drugs Benefit** | | |
| Retail Pharmacy Prescriptions (31-day supply) | | |
| Preferred Generic Drugs (Tier 1) | 10% | 50% after Deductible |
| Non-Preferred Generic & Preferred Brand Drugs (Tier 2) | 25% after Deductible | 50% after Deductible |
| Non-Preferred Brand Drugs (Tier 3) | 35% | 50% after Deductible |
| Specialty Drugs (Tier 4) | 45% | 50% 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) | 10% | 50% after Deductible |
| Non-Preferred Generic & Preferred Brand Drugs (Tier 2) | 25% after Deductible | 50% after Deductible |
| Non-Preferred Brand Drugs (Tier 3) | 35% | 50% after Deductible |
| Specialty Drugs (Tier 4) (31-Day Supply Only) | NA | NA |
| | | |
| **Preventive Health Care Services** | 100% Covered | 50% After Deductible |
| | | |
| **Prostheses Benefit (Non-Dental)** | | |
| Rental (up to the purchase price) Purchase, Repair, Replacement of Prosthetics | 30% after Deductible | 50% After Deductible |
| | | |
| **Therapeutic Services (PT, OT, ST) 40 visit limit each.** | $50.00 Copay | 50% After Deductible |
| Rehab and Habilitative have separate limits. See policy for additional information. | | |
| | | |
| **Transplant Services** | 30% after Deductible | 50% After Deductible |
| | | |
| **Urgent Care Benefit – Doctor on Demand Telemedicine** | $20.00 Copay | Not Available |
| | | |

| | | |
|---|---|---|
| **Urgent Care Benefit - At Urgent Care Clinic** | $75.00 Copay | 50% 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)** | | |