

**SCHEDULE OF BENEFITS
HIGH PLAINS BRONZE SG
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: [Small Group]

Mode of Payment: [Monthly]

Benefit Period: Calendar Year

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

Benefit Plan: HIGH PLAINS BRONZE SG

BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
Maximum Lifetime Benefit	Unlimited	Unlimited
Deductible		
Individual Deductible (per Covered Person per Calendar Year)	\$7,200	\$21,600
Family Deductible (per family per Calendar Year)	\$14,400	\$43,200
Annual Out-of-Pocket Maximum		
Individual Annual Out-of-Pocket Maximum (per Covered Person per Calendar Year)	\$8,150	\$24,450
Family Annual Out-of-Pocket Maximum (per family per Calendar Year)	\$16,300	\$48,900
Coinsurance	60%	70%

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	60% after Deductible	70% After Deductible
Autism Spectrum Disorder		
Inpatient	60% after Deductible	70% After Deductible
Outpatient Office Visit	60% after Deductible	70% After Deductible
Other Outpatient	60% after Deductible	70% after Deductible
Centers of Excellence (When approved by MHC)	60%	NA
Chemical Dependency		
Inpatient	60% after Deductible	70% after Deductible
Outpatient Office Visit	\$60 copay /visit	70% after Deductible
Outpatient Other	60% after Deductible	70% after Deductible
Chiropractic Services		
Maximum Number of Office Visits per Calendar Year – 20 visits	60% After Deductible	70% after Deductible
Convalescent Home Services (Skilled Nursing)		
	60% after Deductible	70% 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	60% after Deductible	70% After Deductible
Emergency Room Services and Transport	70% after Deductible	70% after Deductible
Home Health Care Services	60% after Deductible	70% After Deductible
Hospital Services - Facility and Professional		
Inpatient Facility	60% after Deductible	70% after Deductible
Outpatient Facility	60% after Deductible	70% after Deductible

SCHEDULE OF BENEFITS (continued)

	Your Cost In-Network	Your Cost Out-of-Network
Observation Room/Bed	60% after Deductible	70% after Deductible
Laboratory Services	70% after Deductible	70% after Deductible
Mental Health Services		
Inpatient	60% after Deductible	70% after Deductible
Outpatient Office Visit	\$60 copay /visit	70% after Deductible
Outpatient Other	60% after Deductible	70% after Deductible
Physician Medical Services		
Physician Office Visits (Non-Specialist)	\$60.00 Copay	70% after Deductible
Physician Specialist Visits	70% after Deductible	70% after Deductible
Prescription Drugs Benefit		
Retail Pharmacy Prescriptions (31-day supply)		
Preferred Generic Drugs (Tier 1)	\$15.00 Copay after Deductible	70% after Deductible
Non-Preferred Generic & Preferred Brand Drugs (Tier 2)	\$125.00 Copay after Deductible	70% after Deductible
Non-Preferred Brand Drugs (Tier 3)	\$160.00 Copay after Deductible	70% after Deductible
Specialty Drugs (Tier 4)	\$185.00 Copay after Deductible	70% 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)	\$30.00 Copay after Deductible	70% after Deductible
Non-Preferred Generic & Preferred Brand Drugs (Tier 2)	\$250.00 Copay after Deductible	70% after Deductible
Non-Preferred Brand Drugs (Tier 3)	\$320.00 Copay after Deductible	70% after Deductible
Specialty Drugs (Tier 4) (31-Day Supply Only)	NA	NA
Preventive Health Care Services	100% Covered	70% After Deductible
Prostheses Benefit (Non-Dental)		
Rental (up to the purchase price) Purchase, Repair, Replacement of Prosthetics	60% after Deductible	70% After Deductible
Therapeutic Services (PT, OT, ST) 40 visit limit each.	70% after Deductible	70% After Deductible
Rehab and Habilitative have separate limits. See policy for additional information. Does not apply to mental health.		
Transplant Services	60% after Deductible	70% After Deductible
Urgent Care Benefit – Doctor on Demand Telemedicine	\$20.00 Copay	Not Available

SCHEDULE OF BENEFITS (continued)

	Your Cost In-Network	Your Cost Out-of-Network
Urgent Care Benefit - At Urgent Care Clinic	70%	70% after Deductible
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)		