

2025 Schedule of Benefits

Plan Name: Diabetes Silver Adult Vision & Fitness
40356MI002000401



Plan Information

Primary Member	[John Doe]
Member ID	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2025]
Last Coverage Change Date	[01/01/2024]

[Dependent information can be found at the end of this document.]

Highlights

Annual Deductible*	Individual: \$4,000 Family: \$8,000
Coinsurance	50%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$8,800 Family: \$17,600



* Deductible: The individual Deductible applies to each covered family member. No one person can contribute more than the individual Deductible amount. Once two or more covered family members' Deductibles combine to equal the family Deductible amount, the Deductible will be satisfied for the family for that Calendar Year.

** Out-of-Pocket Maximum: The individual Out-of-Pocket Limit applies to each covered family member. Once two or more covered family members' Out-of-Pocket Limits combine to equal the family Out-of-Pocket Limit amount, the Out-of-Pocket Limit will be satisfied for the family for that Calendar Year.

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Preventive Services As defined by federal & state law	No charge	Refer to your Evidence of Coverage
Office Visits Zero Cost Telehealth Partner	No charge	Refer to your Evidence of Coverage
Primary Includes Primary Care Provider, Behavioral Health/Substance Use Disorder, and Retail Clinics	\$30 copay	None
Specialist	\$50 copay	None
Urgent Care	\$70 copay	None

Learn more about HAP CareSource and all our plan options at HAPCareSource.com.

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
Lab	\$75 copay	None
X-Ray/Radiology	\$250 copay after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	\$300 copay after deductible	None
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	\$250 copay after deductible	None
Inpatient Services		
Facility Fee	\$600 copay after deductible per stay	None
Physician/Surgeon Fees	No charge after deductible	1 visit per physician per day
Skilled Nursing Facility	50% coinsurance after deductible	45 Day limit per Benefit Year
Outpatient Services		
Facility Fee	50% coinsurance after deductible	None
Physician/Surgeon Fees	50% coinsurance after deductible	None
Maternity Services		
Prenatal Visit, Office Visits, and Postpartum Care	\$50 copay	None
Inpatient Services	\$600 copay after deductible	None
Outpatient Services	50% coinsurance after deductible	None
Ambulance Services	50% coinsurance after deductible	Refer to your Evidence of Coverage
Emergency Health Care Services	\$600 copay after deductible	If admitted to the hospital directly from the Emergency Department, these services will be covered the same as inpatient services and the applicable copayment and coinsurance will apply.
Habilitative Services		
Physical Therapy	\$30 copay	30 visits Combined per Benefit Year
Occupational Therapy	\$30 copay	30 visits Combined per Benefit Year
Speech Therapy	\$30 copay	30 visits per Benefit Year

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services Physical Therapy Occupational Therapy Speech Therapy Pulmonary Rehabilitation Cardiac Rehabilitation Services Manipulation Therapy Post-Cochlear Implant Aural Therapy Other Rehabilitative Services Includes Chemotherapy, Dialysis, and Radiation	\$30 copay \$30 copay \$30 copay 50% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible \$30 copay 50% coinsurance after deductible	30 visits Combined per Benefit Year 30 visits Combined per Benefit Year 30 visits per Benefit Year 30 visits per Benefit Year 30 visits per Benefit Year 30 visits per Benefit Year 30 visits per Benefit Year Refer to your Evidence of Coverage
Chiropractor Services	\$50 copay	Limits for Physical Therapy and Manipulation apply
Autism Spectrum Disorder Services Physical Therapy Occupational Therapy Speech Therapy Adaptive Behavior Treatment	\$30 copay \$30 copay \$30 copay \$30 copay	None None None Includes Applied Behavior Analysis (ABA)
Behavioral Health Services Office Visits Outpatient Services Intensive Outpatient Program (IOP) Services Partial Hospitalization Program (PHP) Services Residential Services Opioid Treatment Program Inpatient Services	\$30 copay 50% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible \$600 copay after deductible per stay	None
Transplant Services	Covered the same as office visits, inpatient services, and outpatient services	Refer to your Evidence of Coverage
Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	Covered the same as office visits, inpatient services, and outpatient services	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Home Health Home Infusion Therapy All Other Services	50% coinsurance after deductible 50% coinsurance after deductible	None None
Hospice Care	50% coinsurance after deductible	Refer to your Evidence of Coverage
Medical Supplies, Durable Medical Equipment, and Appliances Appliances Durable Medical Equipment Medical Supplies Orthotic Device Prosthetics	50% coinsurance after deductible	Refer to your Evidence of Coverage
Diabetes Plan Services Select Diabetic Drugs Select Diabetic Supplies Specialized Medical Services	No charge	Refer to HAPCareSource.com/MIMPElite2025 for Select Drugs, Supplies, and Specialized Medical Services
Prescription Drugs Tier 0 (Preventive) Tier 1 (Low Cost) Tier 2 (Preferred) Tier 3 (Non-Preferred) Tier 4 (Specialty)	No charge Up to \$3 copay Up to \$70 copay 40% coinsurance after deductible 50% coinsurance after deductible	Up to a 90-day supply when filled at: Retail for Generic Drugs in Tiers 0-3 Mail Order for drugs in Tiers 0-3 All others limited to a 30-day supply Any copays shown are for a 30-day supply. 90-day supplies for Retail are 3 times the copay and for Mail Order are 2.5 times the copay.
Vision (pediatric) Children's Eye Exam Low Vision Testing and Aids Children's Eyewear	No charge No charge No charge	1 routine eye exam per Benefit Year Limited to one evaluation and aid per Benefit Year. Limited to one pair of glasses or contact lenses per Benefit Year. If medically necessary, a replacement pair of glasses is allowed. Refer to your Evidence of Coverage for additional eyewear options that may have an additional charge.
Vision (adults) Eye Exam Low Vision Testing and Aids Eyewear	No charge No charge No charge	1 routine eye exam per Benefit Year Limited to one evaluation and aid per Benefit Year. 1 pair of glasses/contacts per Benefit Year up to a \$250 allowance

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Other Dental Services		
Accidental Dental	50% coinsurance after deductible	Limited to ER or Urgent Care setting. Injury as a result of chewing or biting is not considered an accidental injury.
Dental Anesthesia	50% coinsurance after deductible	Refer to your Evidence of Coverage
Fitness Program	No charge	Refer to your Evidence of Coverage

Prior Authorization: Some services and items require prior authorization, which is the process used by the Plan to determine if it meets medical necessity and coverage requirements prior to the service being provided. The provider, or the member when using an out-of-network provider, is responsible for obtaining prior authorization for the services and items described on the prior authorization list. Please refer to the prior authorization list attached to your Evidence of Coverage for additional detail or you can obtain the list at www.caresource.com/mp-MI-pa.

This Schedule of Benefits is a summary of your financial responsibility when you receive health care services from a physician, pharmacy, facility, or other provider. All Covered Services are subject to the conditions, exclusions, limitations, terms, and rules of the Evidence of Coverage including any rider/enhancements or amendments. Except as otherwise provided in the Evidence of Coverage, Covered Services must be provided to you by a network provider and medically necessary. The Plan does not cover all health care service expenses. In the event of any discrepancy between this Schedule of Benefits and your Evidence of Coverage, the Evidence of Coverage shall control. For more detailed information about your Covered Services, please refer to the Evidence of Coverage at HAPCareSource.com.

For Covered Services listed in the Evidence of Coverage that are not specifically listed on this Schedule of Benefits, the cost sharing is equal to the coinsurance after the deductible.

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Dependent Information

Dependent Name	[John Doe]
Relationship to You	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2025]

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