

## 2025 Schedule of Benefits

Plan Name: Low Premium Silver 1 Adult Vision & Fitness  
40356MI002000604



### 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: \$6,000 Family: \$12,000
Coinsurance	30%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$7,250 Family: \$14,500



\* 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)
<b>Preventive Services</b> As defined by federal & state law	No charge	Refer to your Evidence of Coverage
<b>Office Visits</b> 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	\$70 copay	None
<b>Urgent Care</b>	\$50 copay	None

Learn more about HAP CareSource and all our plan options at [HAPCareSource.com](https://HAPCareSource.com).

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Diagnostic Services</b>		
Lab	\$40 copay	None
X-Ray/Radiology	\$200 copay after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	\$250 copay after deductible	None
<b>Mammograms (Outpatient)</b>		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	\$200 copay after deductible	None
<b>Inpatient Services</b>		
Facility Fee	\$450 copay after deductible per stay	None
Physician/Surgeon Fees	No charge after deductible	1 visit per physician per day
Skilled Nursing Facility	\$450 copay after deductible per stay	45 Day limit per Benefit Year
<b>Outpatient Services</b>		
Facility Fee	30% coinsurance after deductible	None
Physician/Surgeon Fees	30% coinsurance after deductible	None
<b>Maternity Services</b>		
Prenatal Visit, Office Visits, and Postpartum Care	\$70 copay	None
Inpatient Services	\$450 copay after deductible	None
Outpatient Services	30% coinsurance after deductible	None
<b>Ambulance Services</b>	30% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Emergency Health Care Services</b>	\$450 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.
<b>Habilitative Services</b>		
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)
<b>Rehabilitative Services</b> 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 30% coinsurance after deductible 30% coinsurance after deductible 30% coinsurance after deductible \$30 copay 30% 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
<b>Chiropractor Services</b>	\$70 copay	Limits for Physical Therapy and Manipulation apply
<b>Autism Spectrum Disorder Services</b> 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)
<b>Behavioral Health Services</b> Office Visits Outpatient Services Intensive Outpatient Program (IOP) Services Partial Hospitalization Program (PHP) Services Residential Services Opioid Treatment Program Inpatient Services	\$30 copay 30% coinsurance after deductible 30% coinsurance after deductible \$450 copay after deductible per stay 30% coinsurance after deductible \$450 copay after deductible per stay	None None
<b>Transplant Services</b>	Covered the same as office visits, inpatient services, and outpatient services	Refer to your Evidence of Coverage
<b>Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder</b>	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)
<b>Home Health</b> Home Infusion Therapy	30% coinsurance after deductible	None
All Other Services	30% coinsurance after deductible	None
<b>Hospice Care</b>	30% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Medical Supplies, Durable Medical Equipment, and Appliances</b> Appliances Durable Medical Equipment Medical Supplies Orthotic Device Prosthetics	30% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Prescription Drugs</b> 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 \$75 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.
<b>Vision (pediatric)</b> 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.
<b>Vision (adults)</b> Eye Exam Low Vision Testing and Aids Eyewear	\$35 copay 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
<b>Other Dental Services</b> Accidental Dental Dental Anesthesia	30% coinsurance after deductible 30% coinsurance after deductible	Limited to ER or Urgent Care setting. Injury as a result of chewing or biting is not considered an accidental injury. Refer to your Evidence of Coverage
<b>Fitness Program</b>	No charge	Refer to your Evidence of Coverage

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**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](http://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](http://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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