2025 Schedule of Benefits

Plan Name: Low Premium Silver 2 Adult Vision & Fitness 40356MI002000605



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: \$1,000 Family: \$2,000
Coinsurance	20%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$3,050 Family: \$6,100



- * 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	\$10 copay	None
Specialist	\$40 copay	None
Urgent Care	\$25 copay	None

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
Lab	\$15 copay	None
X-Ray/Radiology	\$150 copay after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	\$200 copay after deductible	None
Mammograms (Outpatient) Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	\$150 copay after deductible	None
Inpatient Services Facility Fee	\$350 copay after deductible per stay	None
Physician/Surgeon Fees	No charge after deductible	1 visit per physician per day
Skilled Nursing Facility	\$300 copay after deductible per stay	45 Day limit per Benefit Year
Outpatient Services Facility Fee Physician/Surgeon Fees	20% coinsurance after deductible 20% coinsurance after	None None
, ,	deductible	
Maternity Services Prenatal Visit, Office Visits, and Postpartum Care	\$40 copay	None
Inpatient Services	\$350 copay after deductible	None
Outpatient Services	20% coinsurance after deductible	None
Ambulance Services	20% coinsurance after deductible	Refer to your Evidence of Coverage
Emergency Health Care Services	\$350 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	\$10 copay	30 visits Combined per Benefit Year
Occupational Therapy	\$10 copay	30 visits Combined per Benefit Year
Speech Therapy	\$10 copay	30 visits per Benefit Year

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		, iii
Physical Therapy	\$10 copay	30 visits Combined per Benefit Year
Occupational Therapy	\$10 copay	30 visits Combined per Benefit Year
Speech Therapy	\$10 copay	30 visits per Benefit Year
Pulmonary Rehabilitation	20% coinsurance after deductible	30 visits per Benefit Year
Cardiac Rehabilitation Services	20% coinsurance after deductible	30 visits per Benefit Year
Manipulation Therapy	20% coinsurance after deductible	30 visits per Benefit Year
Post-Cochlear Implant Aural Therapy	\$10 copay	30 visits per Benefit Year
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	20% coinsurance after deductible	Refer to your Evidence of Coverage
Chiropractor Services	\$40 copay	Limits for Physical Therapy and Manipulation apply
Autism Spectrum Disorder Services Physical Therapy	\$10 copay	None
Occupational Therapy	\$10 copay	None
Speech Therapy	\$10 copay	None
Adaptive Behavior Treatment	\$10 copay	Includes Applied Behavior Analysis (ABA)
Behavioral Health Services Office Visits	\$10 copay	
Outpatient Services		
Intensive Outpatient Program (IOP) Services	20% coinsurance after deductible	
Partial Hospitalization Program (PHP) Services	20% coinsurance after deductible	None
Residential Services	\$300 copay after deductible per stay	
Opioid Treatment Program	20% coinsurance after deductible	
Inpatient Services	\$350 copay after deductible per stay	
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

Home Infusion Therapy 20% coinsurance after deductible None All Other Services 20% coinsurance after deductible None Hospice Care 20% coinsurance after deductible Refer to your Evidence of Coverage deductible Medical Supplies, Durable Medical Equipment, and Appliances Appliances Durable Medical Equipment Refer to your Evidence of Coverage deductible Medical Supplies Orthotic Device Prosthetics 20% coinsurance after deductible Refer to your Evidence of Coverage deductible Prescription Drugs Tier 0 (Preventive) No charge Up to \$2 copay Tier 1 (Low Cost) Up to \$40 copay Hetail for Genetic Drugs in Tiers 0-3 Mail Order for drugs in Tiers 0-3 Mail Order for drugs in Tiers 0-3 All others limited to a 30-day supply when filled at the properties of the supply in Tiers 0-3 All others limited to a 30-day supply when filled at the properties of the supply in Tiers 0-3 All others limited to a 30-day supply when filled at the properties of Copay and Feet all are supply in Tiers 0-3 All others limited to a 30-day supply when filled at the properties of the properties of the properties of Copay and Feet all are supply and for Generic Drugs in Tiers 0-3 All others limited to a 30-day supply when filled at the properties of Generic Drugs in Tiers 0-3 All others limited to a 30-day supply when filled at the properties of Generic Drugs in Tiers 0-3 All others limited to a 30-day supply when filled at the properties of Generic Drugs in Tiers 0-3 All others limited to a 30-day supply when filled at the properties of Generic Drugs in Tiers 0-3 All others limited to	Covered Service	You Pay	Limit
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Fitness Program No charge Refer to your Evidence of Coverage	Dental Anesthesia		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.

Dependent Information

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