

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: \$0 Family: \$0
Coinsurance	0%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$0 Family: \$0



\* 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	No charge	None
Specialist	No charge	None
<b>Urgent Care</b>	No charge	None

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Diagnostic Services</b>		
Lab	No charge	None
X-Ray/Radiology	No charge	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	No charge	None
<b>Mammograms (Outpatient)</b>		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	No charge	None
<b>Inpatient Services</b>		
Facility Fee	No charge	None
Physician/Surgeon Fees	No charge	1 visit per physician per day
Skilled Nursing Facility	No charge	45 Day limit per Benefit Year
<b>Outpatient Services</b>		
Facility Fee	No charge	None
Physician/Surgeon Fees	No charge	None
<b>Maternity Services</b>		
Prenatal Visit, Office Visits, and Postpartum Care	No charge	None
Inpatient Services	No charge	None
Outpatient Services	No charge	None
<b>Ambulance Services</b>	No charge	Refer to your Evidence of Coverage
<b>Emergency Health Care Services</b>	No charge	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	No charge	30 visits Combined per Benefit Year
Occupational Therapy	No charge	30 visits Combined per Benefit Year
Speech Therapy	No charge	30 visits per Benefit Year

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

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Rehabilitative Services</b>		
Physical Therapy	No charge	30 visits Combined per Benefit Year
Occupational Therapy	No charge	30 visits Combined per Benefit Year
Speech Therapy	No charge	30 visits per Benefit Year
Pulmonary Rehabilitation	No charge	30 visits per Benefit Year
Cardiac Rehabilitation Services	No charge	30 visits per Benefit Year
Manipulation Therapy	No charge	30 visits per Benefit Year
Post-Cochlear Implant Aural Therapy	No charge	30 visits per Benefit Year
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	No charge	Refer to your Evidence of Coverage
<b>Chiropractor Services</b>	No charge	Limits for Physical Therapy and Manipulation apply
<b>Autism Spectrum Disorder Services</b>		
Physical Therapy	No charge	None
Occupational Therapy	No charge	None
Speech Therapy	No charge	None
Adaptive Behavior Treatment	No charge	Includes Applied Behavior Analysis (ABA)
<b>Behavioral Health Services</b>		
Office Visits	No charge	
Outpatient Services		
Intensive Outpatient Program (IOP) Services	No charge	
Partial Hospitalization Program (PHP) Services	No charge	None
Residential Services	No charge	
Opioid Treatment Program	No charge	
Inpatient Services	No charge	
<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
<b>Home Health</b>		
Home Infusion Therapy	No charge	None
All Other Services	No charge	None
<b>Hospice Care</b>	No charge	Refer to your Evidence of Coverage

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Medical Supplies, Durable Medical Equipment, and Appliances</b> Appliances Durable Medical Equipment Medical Supplies Orthotic Device Prosthetics	No charge	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 No charge No charge No charge No charge	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</b> (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.
<b>Other Dental Services</b> Accidental Dental  Dental Anesthesia	No charge   No charge	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

**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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