

Schedule of Benefits

Taro Health • Clear Choice Bronze 9450 • Maine
54879ME00100007-00

Overview

The Schedule of Benefits (SOB) is a summary of benefit limits and Cost-Sharing amounts You must pay for certain Covered Benefits. However, it is intended to help you compare covered benefits and is a summary only. Please see Your Evidence of Coverage or reach out to customer service at 1-833-928-0569 for additional coverage details.

This is a traditional HMO network Plan and Your Provider Network is called “Taro Health Maine MP Network”. Your Network includes providers throughout the states of Maine and New Hampshire. However, there are hospitals, health care facilities, physicians or other health care providers that are not included in this Plan’s Network. All services and supplies must be provided by a Taro Network Provider, unless:

- The services are for Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center; or
- Are authorized by Taro.

Prior Authorization

Coverage for certain benefits requires Prior Authorization. If you do not receive Prior Authorization when required, payment for care may be denied. To verify Prior Authorization requirements, call Customer Service at 1-833-928-0569, or refer to the Prior Authorization List at tarohealth.com.

Plan Year 2024	
Network Deductible	\$9,450 Individual \$18,900 Family
Network Maximum Out of Pocket	\$9,450 Individual \$18,900 Family

Medical Benefits

Service	Network Cost-Share	Limits/Explanations
Primary Care Office Visit	\$50 copay before deductible	Cost-Sharing begins after the first visit
Specialist Office Visit	\$80 copay before deductible	
Preventive Care Visits Including, but not limited to, Routine Annual Physical Exam, Immunizations, Well-Baby Care, Well-Child Care, Cancer Screening	Covered in full	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will

Mammography, Prostate Cancer Screening Exam, Colorectal Cancer Screening Exam, Ovarian and Cervical Cancer Screening Exam, Gynecological exams, Pap tests, Prenatal Visits		pay.
Allergy Testing, Serum, and Injections	\$80 copay before deductible	The benefit also includes injections. Cost-Share driven by provider / setting
Routine Labs	Covered in full after deductible	
Diagnostic Imaging X-rays	Covered in full after deductible	Cost-Share driven by provider / setting
Imaging and Radiology CT Scans, MRI, PET Scans	Covered in full after deductible	Preauthorization may be required
Chiropractic Care	\$80 copay before deductible	Limited to 40 Visits per Year, combined with Manipulative Therapy. Cost-Share is driven by provider/setting
Outpatient Facility Fee Ambulatory Surgery Center	Covered in full after deductible	Preauthorization may be required
Outpatient Physician Services	Covered in full after deductible	Preauthorization may be required
Emergency Care	Covered in full after deductible	Non-Network Emergency Room and Ambulance services are covered at the Network Cost-Sharing amount if the services are for an emergency condition as defined in your Plan
Ambulance Transportation	Covered in full after deductible	
Urgent Care	\$50 copay before deductible	Non-Network Urgent Care services are covered at the Network Cost-Sharing amount. Cost-Share is driven by provider/setting
Inpatient Care (Including Facility and Physician charges)	Covered in full after deductible	Preauthorization Required
Skilled Nursing Facility	Covered in full after deductible	Limited to 150 days per Year. Preauthorization Required
Mental Health Care, Serious Mental Illness, and Chemical Dependency Office Visit	\$50 copay before deductible	Cost-Sharing begins after the first visit
Maternity Care Prenatal and Postnatal Care recommended by the USPSTF and HRSA	Covered in full	Note: Depending on the type of services (such as Specialist Office Visits, Diagnostic Imaging Services, etc.), the applicable Cost-Sharing will apply.

Outpatient Rehabilitation and Habilitation Services Physical Therapy and Occupational Therapy	\$50 copay before deductible	Hab and Rehab PT and OT is limited to 20 visits per Member per Year, combined. Hab and Rehab ST is limited to a total of 60 total combined visits per Member per Year, combined.
Outpatient Rehabilitation and Habilitation Services Speech Therapy	\$50 copay before deductible	
Home Health Care	Covered in full after deductible	Preauthorization required
Hospice Care	Covered in full after deductible	Members can receive benefits for Hospice Care services by a Home Health Agency covered up to 24 hours during each day of care. Respite Care covered for up to a 48-hour period
Durable Medical Equipment (DME) Orthotics, Prosthetics Prosthetics for Limb Replacement Prosthetic devices to replace arms and legs, in whole or in part, including hands and feet	Covered in full after deductible Covered in full after deductible	Preauthorization may be required
Diabetes Management Diabetes Self-Management Training, Diabetes Education, Diabetes Care Management	Covered in full	
Diabetes Equipment and Supplies	Included in Our formulary. See Pharmacy Benefits below for the Cost-Sharing amount	
Hearing Aids and Cochlear Implants	Covered in full after deductible	Limited to \$3,000 per hearing aid for each hearing-impaired ear every 36 months for members over age 19. \$3,000 limit does not apply to members through age 18
Pediatric Vision	Covered in full	Covered up to age 19 for 1 Exam per Year and 1 prescribed frames and lenses or contact lenses covered once every 24 months
Fertility Treatment Diagnostic Care, Preservation Services, Treatment	Covered in full after deductible	IVF, GIFT, ZIFT and FET limited to two lifetime cycles. Storage of reproductive material covered from time of cryopreservation for up to 5 years

All Other Covered Medical Benefits (Not specified herein)	Covered in full after deductible	Preauthorization may be required
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Pharmacy Benefits

	Network Cost-Share	Limits/Explanations
Retail Pharmacy (30 Day Supply)		
Tier 1 Generic Drugs	\$30 copay before deductible	90-day supply for Maintenance Drugs and Mail Order is subject to 3x retail Cost-Sharing amount. Narcotics are limited to a 30-day supply. Your cost for a covered insulin drug will not exceed \$35 per 30-day supply for \$105 per 90-day supply. Preauthorization/step therapy may be required
Tier 2 Preferred Brand Name Drugs	Covered in full after deductible	
Tier 3 Non-Preferred Drugs	Covered in full after deductible	
Tier 4 Specialty Pharmacy Drugs	Covered in full after deductible	No 90-day supply available for Maintenance Drugs or Mail Order. Preauthorization may be required

Eligible American Indians are exempt from Cost-Sharing requirements when Covered Services are rendered by an Indian Health Service, Indian Tribe, Tribal Organization or Urban Indian Organization, or through Referral under contract health services.

You may contact the Maine Bureau of Insurance to obtain information on companies, coverage, rights or complaints at 1-800-300-5000 or <https://www.maine.gov/pfr/insurance/home>. You may write the Maine Bureau of Insurance at: 34 State House Station, Augusta, Maine 04333.