# Schedule of Benefits

Taro Health • Clear Choice Bronze 9450 • Maine
54879ME00100007-01

## 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** | |
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| **Network Deductible** | $9,450 Individual<br>$18,900 Family |
| **Network Maximum Out of Pocket** | $9,450 Individual<br>$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**<br>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 |

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| 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**<br>X-rays | Covered in full after deductible | Cost-Share driven by provider / setting |
| **Imaging and Radiology**<br>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**<br>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**<br>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. |

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| **Outpatient Rehabilitation and Habilitation Services**<br>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**<br>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)**<br>Orthotics, Prosthetics<br><br>**Prosthetics for Limb Replacement**<br>Prosthetic devices to replace arms and legs, in whole or in part, including hands and feet | Covered in full after deductible<br><br>Covered in full after deductible | Preauthorization may be required |
| **Diabetes Management**<br>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**<br>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 |

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

## Pharmacy Benefits

| | Network Cost-Share | Limits/Explanations |
|---|---|---|
| **Retail Pharmacy (30 Day Supply)** | | |
| **Tier 1**<br>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**<br>Preferred Brand Name Drugs | Covered in full after deductible | |
| **Tier 3**<br>Non-Preferred Drugs | Covered in full after deductible | |
| **Tier 4**<br>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.