

# Schedule of Benefits

Taro Health • Clear Choice Silver 4000 HSA • Maine  
54879ME00100011-00

## 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.

<b>Plan Year 2024</b>	
<b>Network Deductible</b>	\$4,000 Individual \$8,000 Family
<b>Network Maximum Out of Pocket</b>	\$7,000 Individual \$14,000 Family

## Medical Benefits

Service	Network Cost-Share	Limits/Explanations
<b>Primary Care Office Visit</b>	20% coinsurance after deductible	
<b>Specialist Office Visit</b>	20% coinsurance after deductible	
<b>Preventive Care Visits</b> Including, but not limited to, Routine Annual Physical Exam, Immunizations, Well-Baby Care, Well-Child Care, Cancer Screening Mammography, Prostate Cancer	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 pay.

Screening Exam, Colorectal Cancer Screening Exam, Ovarian and Cervical Cancer Screening Exam, Gynecological exams, Pap tests, Prenatal Visits		
<b>Allergy Testing, Serum, and Injections</b>	20% coinsurance after deductible	The benefit also includes injections. Cost-Share driven by provider / setting
<b>Routine Labs</b>	20% coinsurance after deductible	
<b>Diagnostic Imaging</b> X-rays	20% coinsurance after deductible	Cost-Share driven by provider / setting
<b>Imaging and Radiology</b> CT Scans, MRI, PET Scans	20% coinsurance after deductible	Preauthorization may be required
<b>Chiropractic Care</b>	20% coinsurance after deductible	Limited to 40 Visits per Year, combined with Manipulative Therapy. Cost-Share is driven by provider/setting
<b>Outpatient Facility Fee</b> Ambulatory Surgery Center	20% coinsurance after deductible	Preauthorization may be required
<b>Outpatient Physician Services</b>	20% coinsurance after deductible	Preauthorization may be required
<b>Emergency Care</b>	20% coinsurance 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
<b>Ambulance Transportation</b>	20% coinsurance after deductible	
<b>Urgent Care</b>	20% coinsurance after deductible	Non-Network Urgent Care services are covered at the Network Cost-Sharing amount. Cost-Share is driven by provider/setting
<b>Inpatient Care</b> (Including Facility and Physician charges)	20% coinsurance after deductible	Preauthorization Required
<b>Skilled Nursing Facility</b>	20% coinsurance after deductible	Limited to 150 days per Year. Preauthorization Required
<b>Mental Health Care, Serious Mental Illness, and Chemical Dependency Office Visit</b>	20% coinsurance after deductible	
<b>Maternity Care</b> 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.

<b>Outpatient Rehabilitation and Habilitation Services</b> Physical Therapy and Occupational Therapy	20% coinsurance after 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.
<b>Outpatient Rehabilitation and Habilitation Services</b> Speech Therapy	20% coinsurance after deductible	
<b>Home Health Care</b>	20% coinsurance after deductible	Preauthorization required
<b>Hospice Care</b>	20% coinsurance 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
<b>Durable Medical Equipment (DME)</b> Orthotics, Prosthetics	20% coinsurance after deductible	Preauthorization may be required
<b>Prosthetics for Limb Replacement</b> Prosthetic devices to replace arms and legs, in whole or in part, including hands and feet	20% coinsurance after deductible	
<b>Diabetes Management</b> Diabetes Self-Management Training, Diabetes Education, Diabetes Care Management	Covered in full	
<b>Diabetes Equipment and Supplies</b>	Included in Our formulary. See Pharmacy Benefits below for the Cost-Sharing amount	
<b>Hearing Aids and Cochlear Implants</b>	20% coinsurance 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
<b>Pediatric Vision</b>	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
<b>Fertility Treatment</b> Diagnostic Care, Preservation Services, Treatment	20% coinsurance 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

<b>All Other Covered Medical Benefits</b> (Not specified herein)	20% coinsurance after deductible	Preauthorization may be required
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## Pharmacy Benefits

	Network Cost-Share	Limits/Explanations
<b>Retail Pharmacy (30 Day Supply)</b>		
<b>Tier 1</b> Generic Drugs	\$25 copay after 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
<b>Tier 2</b> Preferred Brand Name Drugs	\$50 copay after deductible	
<b>Tier 3</b> Non-Preferred Drugs	\$100 copay after deductible	
<b>Tier 4</b> Specialty Pharmacy Drugs	\$250 copay after deductible	

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.