



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.tarohealth.com](http://www.tarohealth.com) or call us at 1-833-928-0569. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$5,900 Individual or \$11,800 family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Primary Care, Specialist visit, Urgent Care, Mental health visit, Hab/Rehab, Chiro, Tier 1 and Tier 2 Drugs	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this plan covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$9,100 Individual or \$18,200 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.tarohealth.com">www.tarohealth.com</a> or call 1-833-928-0569 for a list of network providers.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use a <a href="#">non-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use a <a href="#">non-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$40 copay; <a href="#">Deductible</a> does not apply	Not covered	None
	<a href="#">Specialist</a> visit	\$80 copay; <a href="#">Deductible</a> does not apply	Not covered	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge; <a href="#">Deductible</a> does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	40% coinsurance after <a href="#">deductible</a>	Not covered	<a href="#">Cost-sharing</a> driven by provider/setting
	Imaging (CT/PET scans, MRIs)	40% coinsurance after <a href="#">deductible</a>	Not covered	<a href="#">Preauthorization</a> is required
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.tarohealth.com/">www.tarohealth.com/</a>	Generic drugs	\$20 copay; <a href="#">Deductible</a> does not apply	Not covered	Up to 30-day supply Retail and up to 90-day supply Retail & Mail Order, except narcotics and Specialty Drugs. Insulin will not exceed \$30 for a 30-day supply and \$90 for a 90-day supply. <a href="#">Preauthorization</a> /step therapy may be required
	Preferred brand drugs	\$40 copay; <a href="#">Deductible</a> does not apply	Not covered	
	Non-preferred brand drugs	\$80 copay after <a href="#">deductible</a>	Not covered	
	<a href="#">Specialty drugs</a>	\$350 copay after <a href="#">deductible</a>	Not covered	Limited to a 30-day supply. <a href="#">Preauthorization</a> /step therapy may be required. If you don't get <a href="#">preauthorization</a> payment may be denied
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance after <a href="#">deductible</a>	Not covered	<a href="#">Preauthorization</a> may be required
	Physician/surgeon fees	40% coinsurance after <a href="#">deductible</a>	Not covered	<a href="#">Preauthorization</a> may be required
If you need immediate medical attention	<a href="#">Emergency room care</a>	40% coinsurance after <a href="#">deductible</a>	40% coinsurance after <a href="#">deductible</a>	<a href="#">Non-Network</a> Emergency Room services are covered if the services are for an emergency condition

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.tarohealth.com](http://www.tarohealth.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<a href="#">Emergency medical transportation</a>	40% coinsurance after <u>deductible</u>	40% coinsurance after <u>deductible</u>	Emergency Transportation services by a <u>Non-Network provider</u> are covered if the services are for an emergency condition
	<a href="#">Urgent care</a>	\$60 copay/visit; <u>Deductible</u> does not apply	\$60 copay/visit; <u>Deductible</u> does not apply	When temporarily out of the Service Area, <u>Non-Network Urgent Care</u> services are covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance after <u>deductible</u>	Not covered	<u>Preauthorization</u> is required
	Physician/surgeon fees	40% coinsurance after <u>deductible</u>	Not covered	<u>Preauthorization</u> is required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 copay; <u>Deductible</u> does not apply	Not covered	<u>Preauthorization</u> may be required for outpatient non-office services
	Inpatient services	40% coinsurance after <u>deductible</u>	Not covered	<u>Preauthorization</u> is required
If you are pregnant	Office visits	\$80 copay; <u>Deductible</u> does not apply	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound)
	Childbirth/delivery professional services	40% coinsurance after <u>deductible</u>	Not covered	
	Childbirth/delivery facility services	40% coinsurance after <u>deductible</u>	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	40% coinsurance after <u>deductible</u>	Not covered	30 Visits per Benefit Period. Limit does not apply to Private Duty Nursing; Private Duty Nursing is limited to 85 visits per Benefit Period. <u>Preauthorization</u> is required
	<a href="#">Rehabilitation services</a>	\$40 copay; <u>Deductible</u> does not apply	Not covered	Limited to 30 Visits per Benefit Period, combined. Visit limits do not apply to the treatment of Autism Spectrum Disorder
	<a href="#">Habilitation services</a>	\$40 copay; <u>Deductible</u> does not apply	Not covered	
	<a href="#">Skilled nursing care</a>	40% coinsurance after <u>deductible</u>	Not covered	30 Days per Benefit Period. <u>Preauthorization</u> is required
	<a href="#">Durable medical equipment</a>	40% coinsurance after <u>deductible</u>	Not covered	<u>Preauthorization</u> may be required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<a href="#">Hospice services</a>	40% coinsurance after deductible	Not covered	<a href="#">Preauthorization</a> is required
If your child needs dental or eye care	Children's eye exam	No charge; <a href="#">Deductible</a> does not apply	Not covered	Limited to one exam per Benefit Period
	Children's glasses	No charge; <a href="#">Deductible</a> does not apply	Not covered	Limited to one prescribed lenses and frames per Benefit Period.
	Children's dental check-up	Not Covered	Not covered	None

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)			
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric Surgery</li> <li>Cosmetic Surgery</li> </ul>	<ul style="list-style-type: none"> <li>Dental Care (Adult)</li> <li>Infertility Treatment</li> <li>Long-Term Care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Routine Eye Care (Adult)</li> <li>Routine Foot Care</li> <li>Weight Loss Programs</li> </ul>	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)			
<ul style="list-style-type: none"> <li>Abortion (to save the life of the pregnant woman)</li> <li>Chiropractic Care (subject to hab/rehab limits)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing Aids (1 hearing aid per ear every 48 months up to last day of month child turns 19)</li> </ul>	<ul style="list-style-type: none"> <li>Private Duty Nursing (85 visits per year)</li> </ul>	

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Oklahoma Insurance Department, 400 NE 50th Street, Oklahoma City, OK 73105 at 800-522-0071 or <https://www.oid.ok.gov>, or contact Taro at the number on the back of your ID card. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318- 2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: <https://www.oid.ok.gov>.

**Does this plan provide Minimum Essential Coverage?** Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards?** Not Applicable.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

#### Language Access Services:

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.tarohealth.com](http://www.tarohealth.com).

Spanish (Español): Para obtener asistencia en Español, llame al 1-833-928-0569.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$5,900
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	40%

#### This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$5,900
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$8,670</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$5,900
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	40%

#### This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$1,000
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,920</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$5,900
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	40%

#### This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,100
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,500</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.tarohealth.com](http://www.tarohealth.com).