Schedule of Benefits

Taro Health • Direct Primary Care Silver • $0 PCP, Mental Health, Labs, Generics • Oklahoma
58944OK0010003-01

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. You have access to both the "Taro Health Oklahoma MP Network" and the "Taro Health Oklahoma DPC Network". Your Network includes providers throughout the state of Oklahoma. 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.

Direct Primary Care

Network Primary Care visits are always covered in full by Taro Health. In addition, Taro's Network Primary Care providers are Direct Primary Care providers (DPCs), which means they take on a smaller patient panel to have more time and flexibility for their patients, like You. Taro's DPCs provide tailored care during unrushed visits, which ultimately helps build a more trusted patient-physician relationship. Once You select the DPC that best fits You and Your needs, You will see the same physician consistently, whether it is in-person, over video (Telemedicine), or other modes of communication like phone calls, email, or even text. There is no Member Cost-Share for any of these visits or communications. To take full advantage of this unique benefit, please reach out to customer service at 1-833-928-0569 and We will help you set up a relationship with one of our Direct Primary Care providers.

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	
In-Network Deductible	$7,550 Individual $15,100 Family
In-Network Maximum Out of Pocket	$9,000 Individual $18,000 Family

Medical Benefits

Service	In-Network Cost-Share	Limits/Explanations
Direct Primary Care Visit	Covered in full	All Primary Care Services (except OB/GYN and pediatrics) must be provided by a Network Direct Primary Care physician. Cost-Share applies to both in-person and virtual care visits
Primary Care Office Visit	Covered in full	
Specialist Office Visit	Up to $150 Copay not subject to deductible	
Preventive Care Visits Including, but not limited to, Routine Annual Physical Exam, Immunizations, Well-Baby Care, Well-Child Care, Cancer Screening Mammography, Prostate Cancer Screening Exam, Colorectal Cancer Screening Exam, Ovarian and Cervical Cancer Screening Exam, Prenatal Visits	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.
Allergy Testing, Serum, and Injections	Up to $150 Copay not subject to deductible	
Routine Labs	Covered in full	
Diagnostic Imaging X-rays	$200 Copay not subject to deductible	
Imaging and Radiology CT Scans, MRI, PET Scans	$450 Copay not subject to deductible	Preauthorization may be required
Chiropractic Care	$150 Copay not subject to deductible	Limited to 30 Visits per Benefit Period, combined
Outpatient Procedure (Including Facility charges)	Covered in full subject to deductible	Preauthorization may be required
Outpatient Physician Services	Covered in full subject to deductible	Preauthorization may be required
Emergency Care	Covered in full subject to deductible	Non-Network Emergency Room and Ambulance services are covered at the In-Network cost-sharing amount if the services are for an emergency condition as defined in your Plan
Ambulance Transportation	Covered in full subject to deductible	
Urgent Care	$100 Copay not subject to deductible	When temporarily out of the Service Area, Non-Network Urgent Care services are covered and the In-Network cost-sharing amount
Inpatient Care (Including Facility	Covered in full subject to deductible	This Inpatient Care benefit also

and Physician charges)		includes mental health and substance use disorder benefits. Preauthorization Required
Skilled Nursing Facility	Covered in full subject to deductible	Limited to 30 days per Plan Year. Preauthorization Required
Outpatient Mental Health Care, Serious Mental Illness, and Chemical Dependency	Covered in full	
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 Services Physical Therapy, Occupational Therapy, Speech Therapy	$150 Copay not subject to deductible	Limited to 30 Visits per Benefit Period, combined. Visit limits do not apply to the treatment of Autism Spectrum Disorder
Habilitation Services Physical Therapy, Occupational Therapy, Speech Therapy	$150 Copay not subject to deductible	
Home Health Care	Covered in full subject to deductible	Limited to 30 visits per Plan Year. Preauthorization required
Hospice Care	Covered in full subject to deductible	
Durable Medical Equipment (DME) Orthotics, Prosthetics	Covered in full subject to deductible	Preauthorization may be required
Diabetes Management Diabetes Self-Management Training, Diabetes Education, Diabetes Care Management	Covered in full	
Diabetes Equipment and Supplies	Covered in full subject to deductible	
Hearing Aids and Cochlear Implants	Covered in full subject to deductible	1 hearing aid per ear every 48 months up to the last day of the month when child turns age 19
Pediatric Vision	Covered in full	Covered up to age 19 for 1 check up and 1 prescribed lenses and frames per Benefit Period
All Other Covered Medical Benefits (Not specified herein)	Covered in full subject to deductible	Preauthorization may be required

Pharmacy Benefits

	In-Network Cost-Share	Limits/Explanations
Retail Pharmacy (30 Day Supply)		
Tier 1 Generic Drugs	Covered in full	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.
Tier 2 Preferred Brand Name Drugs	$160 Copay not subject to deductible	
Tier 3 Non-Preferred Drugs	Covered in full subject to deductible	
Tier 4 Specialty Pharmacy Drugs and Oral Anticancer Medications	Covered in full subject to 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 Oklahoma Insurance Department to obtain information on companies, coverage, rights or complaints at 405-521-2828 or https://www.oid.ok.gov/. You may write the Oklahoma Insurance Department at: 400 NE 50th Street Oklahoma City, OK 73105.