



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.clftpaedi.com](http://www.clftpaedi.com) or by calling 888-244-5096.

| Important Questions  | Answers  | Why this Matters:  |
|--|--|--|
| <b>What is the overall deductible?</b>                         | NETWORK: \$2,000 single / \$6,500 family maximum for in-network provider and \$6,000 single, \$15,000 family maximum for out-of-network providers<br>NO NETWORK: \$2,000 single / \$6,500 family maximum for hospitals and dialysis centers.   | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Your deductible starts over every January 1 <sup>st</sup> .  |
| <b>Are there other deductibles for specific services?</b>      | No   | Because you don't have to meet deductibles for specific services, this plan starts to cover costs sooner.  |
| <b>Is there an out-of-pocket limit on my expenses?</b>         | NETWORK: \$6,000 single / \$12,700 family maximum for in-network providers and \$20,000 per individual for out-of-network providers<br>NO NETWORK: \$6,000 single / \$12,700 family maximum for hospitals and dialysis centers.  | The out-of-pocket limit is the most you could pay during a coverage period (one calendar year) for your share of the cost of covered services. This limit helps you plan for health care expenses.   |
| <b>What is not included in the out-of-pocket limit?</b>        | Penalties, Premiums, balance-billed charges, and health care this plan doesn't cover.  | Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .   |
| <b>Is there an overall annual limit on what the plan pays?</b> | No   | The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.  |
| <b>Does this plan use a network of providers?</b>              | Yes. For a list of physician and ancillary <b>preferred providers</b> , see <a href="http://www.osmahealth.com">www.osmahealth.com</a> or call 1-888-244-5096. For hospitals or dialysis centers, there is no network. The Plan calculates benefits from the Maximum Allowable Charge. | If you use an in-network doctor or other <b>provider</b> , this plan will pay some or all of the costs of covered services. Your in-network doctor may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See page 2 for how this plan pays different <b>providers</b> . |
| <b>Do I need a referral to see a specialist?</b>               | No. You don't need a referral to see a specialist.   | You can see the <b>specialist</b> you choose without permission from this plan.  |
| <b>Are there services this plan doesn't cover?</b>             | Yes.   | Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <b>excluded services</b> .  |

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- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network physician charges \$1,500 for covered services and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use EPO or PPO **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

| Common Medical Event   | Services You May Need                                  | Your cost if you use an  |                         | Limitations & Exceptions   |
|--|--|--|-------------------------|--|
|  |  | In-network Provider  | Out-of-network Provider |  |
| <b>If you visit a health care provider’s office or clinic</b>  | Primary care visit to treat an injury or illness       | \$40 co-pay per visit  | 50% co-insurance        | ---None---   |
|  | Specialist visit                                       | \$40 co-pay per visit  | 50% co-insurance        | ---None---   |
|  | Other practitioner office visit                        | \$40 co-pay per visit<br>Spinal manipulation<br>50% co-insurance | 50% co-insurance        | 12 visits per calendar year for spinal manipulation  |
|  | Preventive care/screening/immunization                 | No Charge for Well Adult and Well Child.                         | Not Covered             | ---None---   |
| <b>If you have a test</b>  | Diagnostic test (x-ray, blood work)                    | 20% co-insurance   | 50% co-insurance        | ---None---   |
|  | Imaging (CT/PET scans, MRIs)                           | 20% co-insurance   | 50% co-insurance        | ---None---   |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.maxcarerx.com">www.maxcarerx.com</a> . | Preferred generic drugs<br>Non-preferred generic drugs | \$0 co-pay<br>\$15 co-pay  | Not Covered             | 3 months supply (90 days)<br>Preferred generic \$0 copayment.<br>Non-preferred generic \$35 copayment. |
|  | Preferred brand drugs                                  | \$40 co-pay  | Not Covered             | 3 months supply (90 days) \$100 copayment.   |
|  | Non-preferred brand drugs                              | \$60 co-pay  | Not Covered             | 3 months supply (90 days) \$150 copayment.   |

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| Common Medical Event  | Services You May Need                          | Your cost if you use an  |                         | Limitations & Exceptions  |
|---|--|--|-------------------------|---|
|   |  | In-network Provider  | Out-of-network Provider |   |
|   | Specialty drugs                                | Tier 1 \$125 co-pay per script<br>20% co-insurance<br>Tier 2 \$175 co-pay per script<br>30% co-insurance | Not Covered             | ---None---  |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center) | 20% co-insurance   |                         | The Plan calculates benefits from the Maximum Allowable Charge.   |
|   | Physician/surgeon fees                         | 20% co-insurance   | 50% co-insurance        | ---None---  |
| <b>If you need immediate medical attention</b>                                | Emergency room services                        | \$100 co-pay<br>20% co-insurance   |                         | Co-pay waived if admitted in-patient. The Plan calculates benefits from the Maximum Allowable Charge.                                 |
|   | Emergency medical transportation               | 20% co-insurance   |                         | ---None---  |
|   | Urgent care                                    | \$40 co-pay  | 50% co-insurance        | ---None---  |
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)             | 20% co-insurance   |                         | Subject to post-service notification penalty (25% up to \$1,000 max). The Plan calculates benefits from the Maximum Allowable Charge. |
|   | Physician/surgeon fee                          | 20% co-insurance   | 50% co-insurance        | ---None---  |
| <b>If you have mental health, behavioral health, or substance abuse needs</b> | Mental/Behavioral health outpatient services   | 20% co-insurance   | 50% co-insurance        | ---None---  |
|   | Mental/Behavioral health inpatient services    | 20% co-insurance   |                         | Subject to post-service notification penalty (25% up to \$1,000 max). The Plan calculates benefits from the Maximum Allowable Charge. |
|   | Substance use disorder outpatient services     | 20% co-insurance   | 50% co-insurance        | ---None---  |
|   | Substance use disorder inpatient services      | 20% co-insurance   |                         | Subject to post-service notification penalty (25% up to \$1,000 max). The Plan calculates benefits from the Maximum Allowable Charge. |

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|  |                                     |                  |                  |   |
|--|-------------------------------------|------------------|------------------|---|
| If you are pregnant  | Prenatal and postnatal care         | 20% co-insurance | 50% co-insurance | ---None---  |
|  | Delivery and all inpatient services | 20% co-insurance |                  | Subject to post-service notification penalty (25% up to \$1,000 max). The Plan calculates benefits from the Maximum Allowable Charge. |
| If you need help recovering or have other special health needs | Home health care                    | 20% co-insurance | 50% co-insurance | Subject to post-service notification penalty (25% up to \$1,000 max)  |
|  | Rehabilitation services             | 20% co-insurance | 50% co-insurance | See Facility fee (e.g. hospital room) for inpatient rehabilitation services   |
|  | Habilitation services               | 20% co-insurance | 50% co-insurance | See Facility fee (e.g. hospital room) for inpatient habilitation services   |
|  | Skilled nursing care                | 20% co-insurance | 50% co-insurance | 60 visits per calendar year. Subject to post-service notification penalty (25% up to \$1,000 max)                                     |
|  | Durable medical equipment           | 50% co-insurance | 50% co-insurance | Subject to post-service notification penalty (25% up to \$1,000 max)  |
|  | Hospice service                     | 20% co-insurance | 50% co-insurance | ---None---  |
| If your child needs dental or eye care                         | Eye exam                            | Not Covered      | Not Covered      | ---None---  |
|  | Glasses                             | Not Covered      | Not Covered      | ---None---  |
|  | Dental check-up                     | Not Covered      | Not Covered      | ---None---  |

**Excluded Services & Other Covered Services:**

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Complications of a Non-covered Treatment
- Foreign Travel
- Exercise programs
- Cosmetic Services and Treatment
- Family, group, marital and religious counseling
- TMJ Syndrome
- Dental Care
- Infertility
- Surgical Sterilization Reversal

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Emergency Ambulance Service
- Prosthetics and Orthotics
- Pregnancy of Dependent Child

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**Your Rights to Continue Coverage:**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-244-5096. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

**Your Grievance and Appeals Rights:**

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to file a **grievance**. A grievance is a complaint you have about your health insurer or plan. You have the right to file a written complaint to express your dissatisfaction or denial of coverage for claims under this health insurance.

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal**. An appeal is a request for your health insurer or plan to review a decision or a grievance again. For more information on the appeals process, call your state office of health insurance customer assistance at: 1-800-522-0071 or visit [www.ok.gov/oid](http://www.ok.gov/oid).

For questions about your rights or assistance, you can contact:

Frates Benefit Administrators  
13439 Broadway Extension Suite 110  
Oklahoma City, OK 73114  
1-800-850-7166

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
 (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$3,660
- Patient pays \$ 3,880

**Sample care costs:**

|                            |                |
|----------------------------|----------------|
| Hospital charges (mother)  | \$2,700        |
| Routine obstetric care     | \$2,100        |
| Hospital charges (baby)    | \$900          |
| Anesthesia                 | \$900          |
| Laboratory tests           | \$500          |
| Prescriptions              | \$200          |
| Radiology                  | \$200          |
| Vaccines, other preventive | \$40           |
| <b>Total</b>               | <b>\$7,540</b> |

**Patient pays:**

|                      |                |
|----------------------|----------------|
| Deductibles          | \$2,900        |
| Co-pays              | \$100          |
| Co-insurance         | \$880          |
| Limits or exclusions | \$0            |
| <b>Total</b>         | <b>\$3,880</b> |

**Managing type 2 diabetes**  
 (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$4,100
- Plan pays \$1,590
- Patient pays \$ 2,510

**Sample care costs:**

|                                |                |
|--------------------------------|----------------|
| Prescriptions                  | \$1,500        |
| Medical Equipment and Supplies | \$1,300        |
| Office Visits and Procedures   | \$730          |
| Education                      | \$290          |
| Laboratory tests               | \$140          |
| Vaccines, other preventive     | \$140          |
| <b>Total</b>                   | <b>\$4,100</b> |

**Patient pays:**

|                      |                |
|----------------------|----------------|
| Deductibles          | \$1,730        |
| Co-pays              | \$780          |
| Co-insurance         | \$0            |
| Limits or exclusions | \$0            |
| <b>Total</b>         | <b>\$2,510</b> |

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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