



## INDIANA STANDARD NO COPAY PLANS



BASE PLAN	500/ 1500	1000/ 3000	1500/ 4500	2500/ 5000-80	2500/ 5000-100	5000/ 10000-80	5000/ 10000-100
<b>Network Benefit Period</b>	\$500/ \$1,500	\$1,000/ \$3,000	\$1,500/ \$4,500	\$2,500/ \$5,000	\$2,500/ \$5,000	\$5,000/ \$10,000	\$5,000/ \$10,000
<b>Deductible — Single/Family</b>	\$1,500	\$3,000	\$4,500	\$5,000	\$5,000	\$10,000	\$10,000
<b>Non-Network Benefit Period</b>	\$1,000/ \$3,000	\$2,000/ \$6,000	\$3,000/ \$9,000	\$5,000/ \$10,000	\$5,000/ \$10,000	\$10,000/ \$20,000	\$10,000/ \$20,000
<b>Deductible – Single/Family</b>							
<b>Network Coinsurance Out-of-Pocket Maximum (Excludes Deductible) - Single/Family</b>	\$2,000/ \$6,000	\$2,000/ \$6,000	\$2,000/ \$6,000	\$2,000/ \$6,000	N/A	\$2,000/ \$6,000	N/A
<b>Non-Network Coinsurance Out-of-Pocket Maximum (Excludes Deductible) - Single/Family</b>	\$25,000 / \$50,000						
<b>Coinsurance – Network/Non-Network</b>	80%/50%	80%/50%	80%/50%	80%/50%	100%/50%	80%/50%	100%/50%
<b>Lifetime Maximum</b>	\$7,500,000						

BENEFITS	PPO NETWORK	NON-PPO NETWORK
<b>Benefit Period</b>	January 1 <sup>st</sup> through December 31 <sup>st</sup>	
<b>Dependent Age Limit</b>	24; Removal upon End of the Month	
<b>Physician/Office Services</b>		
Office & Urgent Care Visits (Illness/Injury)	coinsurance after deductible	coinsurance after deductible
Standard Immunizations	coinsurance after deductible	coinsurance after deductible
<b>Preventive Services</b>		
Routine Physical Exam	coinsurance after deductible	coinsurance after deductible <sup>1</sup>
Well Child Care Services to age nine. Exams and Immunizations are limited to a \$1,000 maximum per benefit period.		
Well Child Care exams	coinsurance after deductible	coinsurance after deductible <sup>1</sup>
Well Child Immunizations and Labs	coinsurance after deductible	coinsurance after deductible
Routine Mammogram (one per benefit period)	coinsurance after deductible	coinsurance after deductible
Routine Pap Tests (one per benefit period)	coinsurance after deductible	coinsurance after deductible
Routine PSA Tests (ages 50 and over)	coinsurance after deductible	coinsurance after deductible
Routine EKG, chest X-ray, comprehensive metabolic panel, urinalysis and complete blood count (one each per benefit period)	coinsurance after deductible	coinsurance after deductible
<b>Outpatient Services</b>		
Allergy Testing and Treatments	coinsurance after deductible	coinsurance after deductible <sup>1</sup>
Physical Therapy (20 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Occupational Therapy (20 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Speech Therapy (20 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Chiropractic Services	coinsurance after deductible	coinsurance after deductible
Cardiac Rehab (20 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Emergency Use of an Emergency Room	\$150 copay, then network coinsurance after deductible	
Non-Emergency Use of an Emergency Room	\$150 copay, then coinsurance after deductible	\$150 copay, then coinsurance after deductible
Surgical Services	coinsurance after deductible	coinsurance after deductible
Diagnostic Services	coinsurance after deductible	coinsurance after deductible
<b>Inpatient Services</b>		
Semi-Private Room and Board	coinsurance after deductible	coinsurance after deductible
Skilled Nursing Facility (\$10,000 maximum per benefit period)	coinsurance after deductible	coinsurance after deductible

BENEFITS	PPO NETWORK	NON-PPO NETWORK
<b>Additional Services</b>		
Ambulance (\$2,500 Maximum per benefit period)	network coinsurance after deductible	
Durable Medical Equipment	coinsurance after deductible	coinsurance after deductible
Home Health Care (60 visits per benefit period)	coinsurance after deductible	coinsurance after deductible <sup>1</sup>
Hospice	coinsurance after deductible	coinsurance after deductible <sup>1</sup>
Organ and Tissue Transplants	coinsurance after deductible	coinsurance after deductible
Diabetic Education and Training	coinsurance after deductible	coinsurance after deductible
<b>Mental Health &amp; Substance Abuse</b>		
Inpatient and Outpatient Mental Health Services	coinsurance after deductible	coinsurance after deductible
Inpatient Substance Abuse Services (30 days per benefit period; limited to one admission per benefit period and three admissions per lifetime)	coinsurance after deductible	coinsurance after deductible <sup>1</sup>
Outpatient Substance Abuse Services (20 visits per benefit period)	50% after deductible <sup>1</sup>	coinsurance after deductible <sup>1</sup>
<b>Prescription Drug – Oral Contraceptives Included<sup>2</sup></b>		
Prescription Drug Benefit Period Deductible – Single/Family	\$250/\$500	
Prescription Drug Benefit Period Maximum	\$2,000 per person	
Prescription Drug Lifetime Maximum	\$2,500,000	
Retail – 30 Day Supply	\$15 Generic / \$30 Formulary / 50% with a minimum of \$45 and maximum of \$90 Non-Formulary	
Home Delivery – 90 Day Supply	\$37.50 Generic / \$75 Formulary / \$112.50 Non-Formulary	
<b>Optional Riders</b>		
<b>Preventive Services Rider</b>		
All Routine Labs, EKG's, Chest X-rays, Pap Tests and Mammograms (all ages)	100% for the first \$500 per benefit period, then 100% after deductible	50% after deductible
<b>Supplemental Accident Rider</b>		
Supplemental Accident Care (Limited to the first \$500 of services received within 90 days after an accident)	100%	
<b>Prescription Drug – Oral Contraceptives Included<sup>2</sup></b>		
Prescription Drug Lifetime Maximum	\$2,500,000	
Retail – 30 Day Supply	\$15 Generic / \$30 Formulary / 50% with a minimum of \$45 and maximum of \$90 Non-Formulary	
Home Delivery – 90 Day Supply	\$37.50 Generic / \$75 Formulary / \$112.50 Non-Formulary	

*This document is not a contract of insurance. It is a partial listing of healthcare benefits. Refer to your certificate for a complete listing of healthcare benefits. Benefits are determined based on Consumers Life Insurance Company's medical and administrative policies and procedures. No person other than an officer of Consumers Life Insurance Company may agree, orally or in writing, to change the benefits listed here. The contract or certificate will contain the complete listing of covered services. In certain instances, Consumers Life Insurance Company payment may not equal the percentage listed in these charts. However, the covered person's coinsurance will always be based on the lesser of the provider's billed charges or Consumers Life Insurance Company's negotiated rate with the provider.*

Deductible and coinsurance expenses incurred for services by a PPO Network provider will only apply to the PPO Network deductible and coinsurance out-of-pocket. Deductible and coinsurance expenses incurred for services by a Non PPO Network provider will only apply to the Non PPO Network deductible and coinsurance out-of-pocket.

The coinsurance for non-contracting institutional providers will be the same coinsurance percentage as the Non PPO Network provider. However, you may be subject to balance billing by the non-contracting provider.

The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Consumers Life Case Manager (except for corneal transplants). Failure to contact Care Management prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

<sup>1</sup> Coinsurance does not apply to coinsurance out-of-pocket maximums. These services will not be covered at 100% once Coinsurance out-of-pocket maximums are met.

<sup>2</sup> Drug benefit contains the following:

- Rx Selections® Drug List: A list of drugs on the Rx Selections® formulary will be used.
- Generic Incentive: If the member or physician requests a brand-name drug, and a generic equivalent exists, the member pays the generic copayment PLUS the difference between the cost of the generic drug and the brand-name drug.