

PERSONAL HEALTH PLANS FROM CONSUMERS LIFE – VALUE PLANS

BASE PLAN	500/1500	1000/3000	1500/4500	2500/7500	5000/15000
Benefit Period	January 1 through December 31				
Dependent Age Limit	27; Removal upon end of month				
Lifetime Maximum	\$5,000,000				
Benefit Period Deductible (Single/Family)	\$500/\$1,500	\$1,000/\$3,000	\$1,500/\$4,500	\$2,500/\$7,500	\$5,000/\$15,000
Non-Network Benefit Period Deductible (Single/Family)	\$1,500/\$4,500	\$2,000/\$6,000	\$2,500/\$7,500	\$3,500/\$10,500	\$6,000/\$18,000
Network Coinsurance Out-of-Pocket Maximum (Single/Family)	\$4,000/\$12,000	\$4,000/\$12,000	\$4,000/\$12,000	\$4,000/\$12,000	\$4,000/\$12,000
Non-Network Coinsurance Out-of-Pocket Maximum (Single/Family)	\$25,000/\$50,000	\$25,000/\$50,000	\$25,000/\$50,000	\$25,000/\$50,000	\$25,000/\$50,000
Coinsurance – Network/Non-Network	70% / 50%				
Office Visit (OV) Copay	\$35				
PHYSICIAN/OFFICE SERVICES	NETWORK		NON-NETWORK		
Office & Urgent Care Visits (Illness & Injury)	OV copay then 100%		50% after deductible		
Immunizations	coinsurance after deductible		50% after deductible ¹		
PREVENTIVE SERVICES	NETWORK		NON-NETWORK		
Routine Physical Exam	Not Covered		Not Covered		
Well Child Care Services to age nine. Well Child Care Exams and Well Child Immunizations are limited to a \$1,000 maximum per benefit period.					
Well Child Exam	OV copay then 100%		50% after deductible ¹		
Well Child Immunizations (Up to age 6)	100%		100%		
Well Child Labs	coinsurance after deductible		50% after deductible		
Routine Pap Test (one per benefit period)	coinsurance after deductible		50% after deductible		
Routine Mammogram (one per benefit period)	coinsurance after deductible		50% after deductible		
Routine EKG, Chest X-ray, Comprehensive Metabolic panel, Urinalysis and Complete Blood Count (one each per benefit period)	Not covered		Not covered		
OUTPATIENT SERVICES	NETWORK		NON-NETWORK		
Diagnostic Services	\$250 copay per day, then coinsurance after deductible		50% after deductible		
Surgical Services	\$250 copay per day, then coinsurance after deductible		50% after deductible		
Physical and Occupational Therapy (10 visits per benefit period per therapy type)	coinsurance after deductible		50% after deductible		
Chiropractic Services (6 visits per benefit period)	coinsurance after deductible		50% after deductible		
Emergency Use of a Hospital Emergency Room	\$250 copay then network coinsurance after deductible				
Non-Emergency Use of a Hospital Emergency Room	Not Covered				
INPATIENT SERVICES	NETWORK		NON-NETWORK		
Semi-private Room and Board	\$250 copay per admission, then coinsurance after deductible		50% after deductible		
Skilled Nursing Facility (\$10,000 maximum per benefit period)	\$250 copay per admission, then coinsurance after deductible		50% after deductible		
ADDITIONAL SERVICES	NETWORK		NON-NETWORK		
Ambulance (\$2,500 maximum per benefit period)	network coinsurance after deductible				
Durable Medical Equipment	50% after deductible		50% after deductible		
Home Healthcare (60 visits per benefit period)	coinsurance after deductible		50% after deductible ¹		
Hospice	coinsurance after deductible		50% after deductible ¹		
Organ and Tissue Transplant ²	\$250 copay per admission, then coinsurance after deductible		50% after deductible		
MENTAL HEALTH AND SUBSTANCE ABUSE	NETWORK		NON-NETWORK		
Inpatient Mental Health and Substance Abuse Services (\$7,000 maximum per benefit period)	50% after deductible		50% after deductible ¹		
Outpatient Mental Health and Substance Abuse Services (\$2,000 maximum per benefit period)	50% after deductible		50% after deductible ¹		
Transitional Treatment (\$3,000 maximum per benefit period)	50% after deductible ¹		50% after deductible ¹		
PRESCRIPTION DRUG – ORAL CONTRACEPTIVES INCLUDED³	NETWORK		NON-NETWORK		
Prescription Drug Benefit Period Deductible – Single/Family	\$100 per person				
Retail	\$10 copay – Generic drug only				
Home Delivery	Not covered				
OPTIONAL RIDERS (AT AN ADDITIONAL PREMIUM)	NETWORK		NON-NETWORK		
Prescription Drug Rider ³	\$250/\$750 (Waived for Generic)				
Prescription Drug Benefit Period Maximum	\$2,000				
Retail	\$15 Generic/\$30 Formulary/50% of cost with minimum of \$45 and a maximum of \$90				
Home-Delivery	\$37.50 Generic/\$75 Formulary/\$112.50 Non-Formulary				

Please refer to the next page for important information

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 this chart. 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 expenses incurred for services by a PPO network doctor or hospital will only apply to the PPO network deductible. Deductible expenses incurred for services by a non-PPO network doctor or hospital will only apply to the non-network deductible. Coinsurance expenses incurred for services by a PPO network doctor or hospital will only apply to the PPO network coinsurance out-of-pocket. Coinsurance expenses incurred for services by a non-PPO network doctor or hospital will only apply to the Non-PPO network coinsurance out-of-pocket.

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

² The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by 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 \$5,000 penalty. There will be a \$10,000 non-network penalty for failure to use a network hospital or a network Organ Transplant healthcare professional. The penalty may be waived by the Care Manager if the proper pre-determination procedures are followed.

³ 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 and the brand-name drug.

**NOTICE: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING
(NON-PPO NETWORK) PROVIDERS ARE USED.**

You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered service, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy.

**YOU RISK PAYING MORE THAN THE COINSURANCE, DEDUCTIBLE AND COPAYMENT
AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.**

Nonparticipating providers may bill enrollees for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payment for covered services with no additional billing to the enrollee other than copayment, coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free number on your identification card, 1-800-242-1936 or visiting the company's website, www.ConsumersLife.com.