Consumers Life Insurance Company
A Medical Mutual of Ohio Company

Indiana
Standard Copay Plans

Personal Health Plans from Consumers Life Insurance Company™

Base Plan	500/1500	1000/3000	1500/4500	2500/5000	5000/10000
Network Benefit Period Deductible — Single/Family	$500/$1,500	$1,000/$3,000	$1,500/$4,500	$2,500/$5,000	$5,000/$10,000
Non-Network Benefit Period Deductible – Single/Family	$1,000/$3,000	$2,000/$6,000	$3,000/$9,000	$5,000/$10,000	$10,000/$20,000
Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	$2,000/$6,000	$2,000/$6,000	$2,000/$6,000	$2,000/$6,000	$2,000/$6,000
Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	UNLIMITED	UNLIMITED	UNLIMITED	UNLIMITED	UNLIMITED
Coinsurance – Network/Non-Network	80% / 50%				
Lifetime Maximum	$2,500,000				
Office Visit (OV) Copay Options	$25, $40				

Benefits	PPO Network	Non-PPO Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	24; Removal upon End of the Month	
Physician/Office Services		
Office & Urgent Care Visits (Illness/Injury)	OV copay, then 100%	50% after deductible
Standard Immunizations	80% after deductible	50% after deductible[1]
Preventive Services		
Routine Physical Exam	OV copay, then 100%	50% after deductible[1]
Well Child Care Services to age nine. Exams and Immunizations are limited to a $500 maximum per benefit period.		
Well Child Care Exams	OV copay, then 100%	50% after deductible [1]
Well Child Immunizations and Labs	80% after deductible	50% after deductible
Routine Mammogram (one per benefit period)	80% after deductible	50% after deductible
Routine Pap Tests (one per benefit period)	80% after deductible	50% after deductible
Routine EKG, chest X-ray, comprehensive metabolic panel, urinalysis and complete blood count (one each per benefit period)	80% after deductible	50% after deductible
Outpatient Services		
Allergy Testing and Treatments	80% after deductible	50% after deductible[1]
Physical Therapy (20 visits per benefit period)	OV copay, then 80%	50% after deductible
Occupational Therapy (20 visits per benefit period)	OV copay, then 80%	50% after deductible
Speech Therapy (20 visits per benefit period)	OV copay, then 80%	50% after deductible
Chiropractic Services	OV copay, then 80%	50% after deductible
Cardiac Rehab (20 visits per benefit period)	80% after deductible	50% after deductible
Emergency Use of an Emergency Room	$150 copay, then 80% after deductible	
Non-Emergency Use of an Emergency Room	$150 copay, then 80% after deductible	$150 copay, then 50% after deductible
Surgical Services	80% after deductible	50% after deductible
Diagnostic Services	80% after deductible	50% after deductible
Inpatient Services		
Semi-Private Room and Board	80% after deductible	50% after deductible
Skilled Nursing Facility ($10,000 maximum per benefit period)	80% after deductible	50% after deductible

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Benefits	PPO Network	Non-PPO Network
Additional Services		
Ambulance ($2,500 Maximum per benefit period)	80% after deductible	
Durable Medical Equipment	80% after deductible	50% after deductible
Home Health Care (60 visits per benefit period)	80% after deductible	50% after deductible[1]
Hospice	80% after deductible	50% after deductible[1]
Organ and Tissue Transplants	80% after deductible	50% after deductible
Diabetic Education and Training	80% after deductible	50% after deductible
Mental Health & Substance Abuse		
Inpatient and Outpatient Mental Health Services	80% after deductible	50% after deductible[1]
Inpatient Substance Abuse Services (30 days per benefit period; limited to one admission per benefit period and three admissions per lifetime)	80% after deductible	50% after deductible[1]
Outpatient Substance Abuse Services (20 visits per benefit period)	50% after deductible[1]	50% after deductible[1]
Prescription Drug – Oral Contraceptives Included [2]		
Prescription Drug Benefit Period Deductible – Single/Family	$250/$500	
Prescription Drug Benefit Period Maximum	$2,000 per person	
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	
Optional Rider		
Preventive Services Rider		
All Routine Labs, EKG's, Chest X-rays, Pap Tests and Mammograms (all ages)	100% for the first $300 per benefit period, then 80% after deductible	50% after deductible

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.

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1 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.
2 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.