

Base Plan	1000	2000	3500	5000	10000
Network Benefit Period Deductible — Single/Family	\$1,000/\$3,000	\$2,000/\$6,000	\$3,500/\$10,500	\$5,000/\$15,000	\$10,000/\$30,000
Non-Network Benefit Period Deductible – Single/Family	\$2,000/\$6,000	\$4,000/\$12,000	\$7,000/\$21,000	\$10,000/\$30,000	\$20,000/\$60,000
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	\$5,000/\$15,000
Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	UNLIMITED	UNLIMITED	UNLIMITED	UNLIMITED	UNLIMITED
Prescription Drug Plan Deductible – Single/Family	\$200/\$600	\$200/\$600	\$350/\$1,050	\$500/\$1,500	\$1,000/\$3,000
Office Visit (OV) Copay	\$40				
Coinsurance – Network/Non-Network	70% / 60%				
Overall Annual Benefit Period Maximum	\$7,500,000				

Benefits	PPO Network	Non-PPO Network
Benefit Period	January 1 st through December 31 st	
Dependent Age Limit	26; Removal upon End of the Month	
Physician/Office Services		
Office & Urgent Care Visits (Illness/Injury)	\$40 copay, then 100%	60% after deductible
Diagnostic Services in a Physician's Office	100%	70% after deductible
Standard Immunizations	70% after deductible	60% after deductible
Preventive Services		
Routine Physical Exam (\$250 maximum per benefit period)	70% after deductible	60% after deductible
Well Child Care Services (to age six)	70%	60%
Well Child Care Exams, Immunizations & Labs		
Well Child Care Services (ages six to nine)		
Exams and Well Child Immunizations are limited to a \$500 maximum per benefit period.		
Well Child Care Exams, Immunizations & Labs	70% after deductible	60% after deductible
Routine Flu Vaccine	70% after deductible	60% after deductible
Routine Mammogram (one per benefit period)	100%	70%
Routine Pap Tests	100%	70%
Routine PSA and Chlamydia Screening	100%	100%
Routine Cholesterol, Colon Cancer Screening Tests, Endoscopic Services, Ovarian Cancer Screening and Bone Density Testing	70% after deductible	60% after deductible
Routine EKG, chest X-ray, comprehensive metabolic panel, urinalysis and complete blood count (one each per benefit period)	70% after deductible	60% after deductible
Outpatient Services		
Allergy Testing and Treatments	70% after deductible	60% after deductible
Physical Therapy, Occupational Therapy and Chiropractic Services (30 visits combined per benefit period)	70% after deductible	60% after deductible
Speech Therapy (30 visits per benefit period)	70% after deductible	60% after deductible
Cardiac Rehabilitation (20 visits per benefit period)	70% after deductible	60% after deductible
Emergency Use of an Emergency Room	\$150 copay, then 70%	
Non-Emergency Use of an Emergency Room	\$150 copay, then 70%	\$150 copay, then 60%
Surgical Services	70% after deductible	60% after deductible
Diagnostic Services (other than a physician's office)	70% after deductible	60% after deductible

Benefits	PPO Network	Non-PPO Network
Inpatient Services		
Semi-Private Room and Board	70% after deductible	60% after deductible
Skilled Nursing Facility (30 days per benefit period)	70% after deductible	60% after deductible
Additional Services		
Ambulance (\$2,500 Maximum per benefit period)	70% after deductible	
Durable Medical Equipment	70% after deductible	60% after deductible
Home Health Care (100 visits per benefit period)	70% after deductible	70% after deductible
Hospice (\$10,000 lifetime maximum)	70%	60%
Organ and Tissue Transplants	70% after deductible	60% after deductible
Diabetic Education and Training	70% after deductible	60% after deductible
Substance Abuse		
Inpatient and Outpatient Substance Abuse	NOT COVERED	
Prescription Drug – Oral Contraceptives Included ¹		
Prescription Drug Benefit Period Deductible – Single/Family	See Prescription Drug Plan Deductibles listed above	
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		
Mental Health Rider		
Inpatient Mental Health Services (30 days per benefit period; limited to one admission per benefit period and three admissions per lifetime)	70% after deductible	70% after deductible
Outpatient Mental Health Services (48 visits per benefit period)	70% after deductible	70% 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.

¹ Drug benefit contains the following:

- Rx Selections[®] Drug List: A list of drugs on the Rx Selections[®] formulary will be used.