

PERSONAL HEALTH PLANS



**BENEFIT SUMMARIES FOR INDIANA
FOR INDIVIDUALS AND FAMILIES UNDER 65**

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PERSONAL HEALTH PLANS FROM CONSUMERS LIFE - WITH COPAY

BENEFITS	500/1500	1000/3000	1500/4500	2500/5000	5000/15000
Benefit Period	January 1 through December 31				
Dependent Age Limit	24; Removal upon end of month				
Lifetime Maximum	\$7,500,000				
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
Office Visit (OV) Copay Option	\$25 or \$40				
	NETWORK			NON-NETWORK	
Coinsurance	80%			50%	
Coinsurance Out-of-Pocket Maximum – Single/Family	\$2,000/\$6,000			\$25,000/\$50,000	
PHYSICIAN/OFFICE SERVICES					
Office & Urgent Care Visits (Illness & Injury)	OV copay then 100%			50% after deductible	
Immunizations (tetanus toxoid, rabies vaccine and meningococcal polysaccharide vaccine)	80% after deductible			50% after deductible	
PREVENTIVE SERVICES					
Routine Physical Exam	OV copay then 100%			50% after deductible ¹	
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	
Well Child Immunizations and Labs	80% after deductible			50% after deductible	
Routine Pap Test (one per benefit period)	80% after deductible			50% after deductible	
Routine Mammogram (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), routine PSA screening (starting at age 50)	80% after deductible			50% after deductible	
OUTPATIENT SERVICES					
Allergy Testing and Treatment	80% after deductible			50% after deductible	
Diagnostic Services	80% after deductible			50% after deductible	
Surgical Services	80% after deductible			50% after deductible	
Physical, Speech and Occupational Therapy (20 visits per benefit period per therapy type)	OV copay then 80%			50% after deductible	
Chiropractic Services	OV copay then 80%			50% after deductible	
Cardiac Rehabilitation (20 visits per benefit period)	80% after deductible			50% after deductible	
Emergency Use of a Hospital Emergency Room	\$150 copay then 80% after deductible				
Non-Emergency Use of a Hospital Emergency Room	\$150 copay, then 80% after deductible		\$150 copay, then 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	
ADDITIONAL SERVICES					
Ambulance (\$2,500 maximum per benefit period)	80% after deductible				
Durable Medical Equipment	80% after deductible			50% after deductible	
Home Healthcare (60 visits per benefit period)	80% after deductible			50% after deductible	
Hospice	80% after deductible			50% after deductible	
Organ and Tissue Transplant ²	80% after deductible			50% after deductible	
MENTAL HEALTH AND SUBSTANCE ABUSE					
Inpatient and Outpatient Mental Health Services	80% after deductible			50% after deductible	
Inpatient Substance Abuse Services (30 days per benefit period; limited to one admission per benefit period and three admits per lifetime)	80% after deductible			50% after deductible	
Outpatient Substance Abuse Services (20 visits per benefit period)	50% after deductible ¹			50% after deductible	
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED³					
Prescription Drug Benefit Period Deductible – Single/Family	\$250/\$500				
Benefit Period Maximum	\$2,000 per person				
Prescription Drug Lifetime Maximum	\$2,500,000				
Retail Program Copay for 30-day supply	\$15 Generic / \$30 Formulary / 50% of cost with a minimum of \$45 and a maximum of \$90 Non-Formulary				
Home Delivery Program Copay for 90-day supply	\$37.50 Generic / \$75 Formulary / \$112.50 Non-Formulary				
OPTIONAL RIDERS					
Preventive Services Rider	100% for the first \$500 per benefit period			Then 80% after deductible	50% after deductible
Supplemental Accident Rider (Limited to the first \$500 of services received within 90 days after an accident)	100%				
Prescription Drug Rider	No deductible or maximum				
Prescription Drug Lifetime Maximum	\$2,500,000				
Retail	\$15 Generic/\$30 Formulary/50% of cost with minimum of \$45 and a maximum of \$90 Non-Formulary				
Home-Delivery	\$37.50 Generic/\$75 Formulary/\$112.50 Non-Formulary				

Please refer to the back page for important information.

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

² 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 \$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 Case 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.

PERSONAL HEALTH PLANS FROM CONSUMERS LIFE - WITHOUT COPAY

BENEFITS	500/1500	1000/3000	1500/4500	2500/5000	5000/15000
Benefit Period	January 1 through December 31				
Dependent Age Limit	24; Removal upon end of month				
Lifetime Maximum	\$7,500,000				
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			NON-NETWORK	
Coinsurance	80%			50%	
Coinsurance Out-of-Pocket Maximum – Single/Family	\$2,000/\$6,000			\$25,000/\$50,000	
PHYSICIAN/OFFICE SERVICES					
Office & Urgent Care Visits (Illness & Injury)	80% after deductible			50% after deductible	
Immunizations (tetanus toxoid, rabies vaccine and meningococcal polysaccharide vaccine)	80% after deductible			50% after deductible	
PREVENTIVE SERVICES					
Routine Physical Exam	80% after deductible			50% after deductible	
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	80% after deductible			50% after deductible	
Well Child Immunizations and Labs	80% after deductible			50% after deductible	
Routine Pap Test (one per benefit period)	80% after deductible			50% after deductible	
Routine Mammogram (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), routine PSA screening (starting at age 50)	80% after deductible			50% after deductible	
OUTPATIENT SERVICES					
Allergy Testing and Treatment	80% after deductible			50% after deductible	
Diagnostic Services	80% after deductible			50% after deductible	
Surgical Services	80% after deductible			50% after deductible	
Physical, Speech and Occupational Therapy (20 visits per benefit period per therapy type)	80% after deductible			50% after deductible	
Chiropractic Services	80% after deductible			50% after deductible	
Cardiac Rehabilitation (20 visits per benefit period)	80% after deductible			50% after deductible	
Emergency Use of a Hospital Emergency Room	\$150 copay then 80% after deductible				
Non-Emergency Use of a Hospital Emergency Room	\$150 copay, then 80% after deductible		\$150 copay, then 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	
ADDITIONAL SERVICES					
Ambulance (\$2,500 maximum per benefit period)	80% after deductible				
Durable Medical Equipment	80% after deductible			50% after deductible	
Home Healthcare (60 visits per benefit period)	80% after deductible			50% after deductible	
Hospice	80% after deductible			50% after deductible	
Organ and Tissue Transplant ²	80% after deductible			50% after deductible	
MENTAL HEALTH AND SUBSTANCE ABUSE					
Inpatient and Outpatient Mental Health Services	80% after deductible			50% after deductible	
Inpatient Substance Abuse Services (30 days per benefit period; limited to one admission per benefit period and three admits per lifetime)	80% after deductible			50% after deductible	
Outpatient Substance Abuse Services (20 visits per benefit period)	50% after deductible ¹			50% after deductible	
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED³					
Prescription Drug Benefit Period Deductible – Single/Family	\$250/\$500				
Benefit Period Maximum	\$2,000 per person				
Prescription Drug Lifetime Maximum	\$2,500,000				
Retail Program Copay for 30-day supply	\$15 Generic / \$30 Formulary / 50% of cost with a minimum of \$45 and a maximum of \$90 Non-Formulary				
Home Delivery Program Copay for 90-day supply	\$37.50 Generic / \$75 Formulary / \$112.50 Non-Formulary				
OPTIONAL RIDERS					
Preventive Services Rider	100% for the first \$500 per benefit period, then 80% after deductible			50% after deductible	
Supplemental Accident Rider (Limited to the first \$500 of services received with 90 days after an accident)	100%				
Prescription Drug Rider	No deductible or maximum				
Prescription Drug Lifetime Maximum	\$2,500,000				
Retail	\$15 Generic/\$30 Formulary/50% of cost with minimum of \$45 and a maximum of \$90 Non-Formulary				
Home-Delivery	\$37.50 Generic/\$75 Formulary/\$112.50 Non-Formulary				

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² 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 \$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 Case 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.

PERSONAL HEALTH PLANS FROM CONSUMERS LIFE - WITHOUT COPAY

BENEFITS	2500/5000	5000/10000
Benefit Period	January 1 through December 31	
Dependent Age Limit	24; Removal upon end of month	
Lifetime Maximum	\$7,500,000	
Benefit Period Deductible – Single/Family	\$2,500/\$5,000	\$5,000/\$10,000
Non Network Benefit Period Deductible – Single/Family	\$5,000/\$10,000	\$10,000/\$20,000
	NETWORK	NON-NETWORK
Coinsurance	100%	50%
Coinsurance Out-of-Pocket Maximum – Single/Family	N/A	\$25,000/\$50,000
PHYSICIAN/OFFICE SERVICES		
Office & Urgent Care Visit (Illness/Injury)	100% after deductible	50% after deductible
Immunizations (tetanus toxoid, rabies vaccine and meningococcal polysaccharide vaccine)	100% after deductible	50% after deductible
PREVENTIVE SERVICES		
Routine Physical Exam	100% after deductible	50% after deductible
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	100% after deductible	50% after deductible
Well Child Immunizations and Labs	100% after deductible	50% after deductible
Routine Pap Test (one per benefit period)	100% after deductible	50% after deductible
Routine Mammogram (one per benefit period)	100% after deductible	50% after deductible
Routine EKG, Chest X-ray, Comprehensive Metabolic panel, Urinalysis and Complete Blood Count (one each per benefit period), routine PSA screening (starting at age 50)	100% after deductible	50% after deductible
	100% after deductible	50% after deductible
OUTPATIENT SERVICES		
Allergy Testing and Treatment	100% after deductible	50% after deductible
Diagnostic Services	100% after deductible	50% after deductible
Surgical Services	100% after deductible	50% after deductible
Physical, Speech and Occupational therapy (20 visits per benefit period per therapy type)	100% after deductible	50% after deductible
Chiropractic Services	100% after deductible	50% after deductible
Cardiac Rehab (20 visits per benefit period)	100% after deductible	50% after deductible
Emergency Use of a Hospital Emergency Room	\$150 copay, then 100% after deductible	
Non-Emergency Use of a Hospital Emergency Room	\$150 copay, then 100% after deductible	\$150 copay, then 50% after deductible
INPATIENT SERVICES		
Semi-private Room and Board	100% after deductible	50% after deductible
Skilled Nursing Facility (\$10,000 maximum per benefit period)	100% after deductible	50% after deductible
ADDITIONAL SERVICES		
Ambulance (\$2500 maximum per benefit period)	100% after deductible	
Durable Medical Equipment	100% after deductible	50% after deductible
Home Healthcare (60 visits per benefit period)	100% after deductible	50% after deductible
Hospice	100% after deductible	50% after deductible
Organ and Tissue Transplant ²	100% after deductible	50% after deductible
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient and Outpatient Mental Health Services	100% after deductible	50% after deductible
Inpatient Substance Abuse Services (30 days per benefit period; limited to one admission per benefit period and three admits per lifetime)	100% after deductible	50% after deductible
Outpatient Substance Abuse Services (20 visits per benefit period)	50% after deductible ¹	50% after deductible
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED ³		
Prescription Drug Benefit Period Deductible – Single/Family	\$250/\$500	
Benefit Period Maximum	\$2,000 per person	
Prescription Drug Lifetime Maximum	\$2,500,000	
Retail Program Copay for 30-day supply	\$15 Generic / \$30 Formulary /50% of cost with minimum of \$45 and maximum of \$90 Non-Formulary	
Home Delivery Program Copay for 90-day supply	\$37.50 Generic / \$75 Formulary / \$112.50 Non-Formulary	
OPTIONAL RIDERS		
Preventive Services Rider	100% for the first \$500 per benefit period, then 80% after deductible	50% after deductible
Supplemental Accident Rider (Limited to the first \$500 of services received with 90 days after an accident)	100%	
Prescription Drug Rider	No deductible or maximum	
Prescription Drug Lifetime Maximum	\$2,500,000	
Retail	\$15 Generic/\$30 Formulary/50% of cost with minimum of \$45 and a maximum of \$90 Non-Formulary	
Home-Delivery	\$37.50 Generic/\$75 Formulary/\$112.50 Non-Formulary	

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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.

PERSONAL HEALTH VALUE PLANS

BENEFITS	500/1500	1000/3000	1500/4500	2500/7500	5000/15000
Benefit Period	January 1 through December 31				
Dependent Age Limit	24; Removal upon end of month				
Lifetime Maximum	\$2,000,000				
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
Coinsurance Out-of-Pocket Maximum – Single/Family	\$4,000/\$12,000				
Non-Network Coinsurance Out-of-Pocket Maximum – Single/Family	\$25,000/\$50,000				
Office Visit Copay	\$35				
	NETWORK		NON-NETWORK		
Coinsurance	70%		50%		
PHYSICIAN/OFFICE SERVICES					
Office and Urgent Care Visits	\$35 copay then 100%		50% after deductible		
Immunizations	70% after deductible		50% after deductible ¹		
PREVENTIVE SERVICES					
Routine Physical Exam	Not Covered				
Well Child Care Services to age nine. Well Child Care Immunizations are limited to a \$1,000 per child to age 1; thereafter, \$150 per child from birth to age 9					
Well Child Care Exam	\$35 copay then 100%				
Well Child Immunizations & Labs	70% after deductible		50% after deductible		
Routine Pap Test (one per benefit period)	70% after deductible		50% after deductible		
Routine Mammogram (one per benefit period)	70% after deductible		50% after deductible		
Routine PSA screenings (beginning at age 50)	70% after deductible		50% after deductible		
OUTPATIENT SERVICES					
Allergy Testing and Treatments	Not Covered				
Diagnostic Services	\$250 copay per day, then 70% after deductible		50% after deductible		
Surgery	\$250 copay per day, then 70% after deductible		50% after deductible		
Physical Therapy (10 visits per benefit period)	70% after deductible		50% after deductible		
Occupational Therapy (10 visits per benefit period)	70% after deductible		50% after deductible		
Speech Therapy	Not Covered				
Chiropractic Services	70% after deductible		50% after deductible		
Emergency Use of a Hospital Emergency Room	\$250 copay then 70% after deductible				
Non-Emergency Use of a Hospital Emergency Room	Not Covered				
INPATIENT FACILITY					
Semi-Private Room and Board	\$250 copay per admission then 70% after deductible		50% after deductible		
Skilled Nursing Facility (\$10,000 maximum per benefit period)	\$250 copay per admission then 70% after deductible		50% after deductible		
ADDITIONAL SERVICES					
Ambulance Services (\$2,500 maximum per benefit period)	70% after deductible				
Durable Medical Equipment	50% after deductible				
Home Healthcare (60 visits per benefit period)	70% after deductible		50% after deductible ¹		
Hospice	70% after deductible		50% after deductible ¹		
Organ and Tissue Transplants	\$250 copay per admission, then 70% after deductible		50% after deductible		
MENTAL HEALTH AND SUBSTANCE ABUSE					
Inpatient Mental/Substance Abuse Services	Not Covered				
Outpatient Mental/Substance Abuse Services	Not Covered				
PRESCRIPTION DRUG					
Benefit Period Deductible	\$100 per person				
Retail – 30 Day Supply	\$10 Copay – Generic drugs only				
Home Delivery	Not Covered				
OPTIONAL RIDER					
PRESCRIPTION DRUG RIDER – ORAL CONTRACEPTIVES INCLUDED²					
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				

Please refer to the back page for important information.

¹ Coinsurance does not apply to out-of-pocket maximums. These services will not be covered at 100% once out-of-pocket maximum is 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 and the brand-name drug.

PERSONAL HEALTH PLANS SHORT-TERM BENEFITS

BENEFITS	NETWORK	NON-NETWORK
Benefit Period	January 1 through December 31	
Dependent Age Limit	24; Removal upon end of month	
Lifetime Maximum	\$1,500,000	
Benefit Period Deductible – Single/Family	\$500/\$1,000	
Coinsurance	80%	50%
Coinsurance Out-of-Pocket Maximum – Single/Family	\$2,000/\$4,000	\$4,000/\$8,000
PHYSICIAN/OFFICE SERVICES		
Office and Urgent Care Visits (Illness/Injury)	\$15 copay, then 100%	\$15 copay, then 50%
Immunizations (tetanus toxoid, rabies vaccine and meningococcal polysaccharide vaccine)	80% after deductible	50% after deductible
PREVENTIVE SERVICES		
Well Child Care Services to age nine – \$500 maximum per benefit period		
Well Child Exams	50% after deductible	50% after deductible
Well Child Immunizations and Labs	80% after deductible	50% after deductible
Routine Pap Test (One per benefit period)	50% after deductible	50% after deductible
Routine Mammogram (One per benefit period)	50% after deductible	50% after deductible
OUTPATIENT SERVICES		
Diagnostic Services	80% after deductible	50% after deductible
Surgical Services	80% after deductible	50% after deductible
Physical, Occupational and Speech Therapy (10 visits per benefit period per therapy type)	80% after deductible	50% after deductible
Chiropractic Services	80% after deductible	50% after deductible
Outpatient Cardiac Rehab (10 visits per benefit period)	80% after deductible	50% after deductible
Emergency Use of a Hospital Emergency Room	\$100 copay, then 80%	
Non-Emergency Use of a Hospital Emergency Room	\$100 copay, then 80%	\$100 copay, then 50%
INPATIENT FACILITY		
Semi-private Room and Board	80% after deductible	50% after deductible
Skilled Nursing (30 days per benefit period)	80% after deductible	50% after deductible
ADDITIONAL SERVICES		
Ambulance (\$2,500 maximum per benefit period)	\$100 copay, then 80%	\$100 copay, then 50%
Durable Medical Equipment	80% after deductible	50% after deductible
Home Healthcare (60 visits per benefit period)	80% after deductible	50% after deductible
Hospice	80% after deductible	50% after deductible
Organ and Tissue Transplants	80% after deductible	50% after deductible
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient and Outpatient Mental Health Substance	80% after deductible	50% after deductible
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
Outpatient Substance Abuse Services (20 visits per benefit period)	50% after deductible	
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED		
Prescription Drug Benefit Period Deductible ¹	\$250 Single/\$500 Family	
Benefit Period Maximum ²	\$2,000	
Retail — 30 day Supply	80% after deductible	50% after deductible
Home Delivery — 90 day Supply	80% after deductible	Not Covered

Please refer to the back page for important information.

¹ The Prescription Drug Benefit Period Deductible includes deductibles paid for both retail and home delivery drugs.

² The benefit period maximum is combined for both retail and home delivery drugs.

PERSONAL HEALTH PLANS HSA COMPATIBLE PLANS

BENEFITS	1200/2400	2000/4000
Benefit Period	January 1 through December 31	
Dependent Age Limit	24; Removal upon End of Month	
Lifetime Maximum	\$7,500,000	
Network Benefit Period Deductible — Single/Family	\$1,200/\$2,400 ¹	\$2,000/\$4,000 ¹
Non-Network Benefit Period Deductible — Single/Family	\$2,400/\$4,800 ¹	\$4,000/\$8,000 ¹
	IN-NETWORK	OUT-OF-NETWORK
Coinsurance — Single/Family	80%	50%
Coinsurance Out-of-Pocket Maximum – Single/Family	\$2,000/\$4,000 ²	\$4,000/\$8,000 ²
PHYSICIAN/OFFICE SERVICES		
Office & Urgent Care Visits (Illness/Injury)	80% after deductible	50% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine)	80% after deductible	50% after deductible
PREVENTIVE SERVICES		
Routine Physical Exam (\$500 maximum per benefit period)	80% after deductible	50% after deductible
Well Child Care Services to age nine. Well Child Care Exams, Immunizations and Labs are limited to a \$500 maximum per benefit period.	80% after deductible	50% after deductible
Routine Pap Test (One per benefit period)	80% after deductible	50% after deductible
Routine Mammogram (One per benefit period)	80% after deductible	50% after deductible
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period.)	80% after deductible	50% after deductible
OUTPATIENT SERVICES		
Allergy Testing and Treatments	80% after deductible	50% after deductible
Diagnostic Services	80% after deductible	50% after deductible
Surgical Services	80% after deductible	50% after deductible
Physical, Occupational and Speech Therapy (20 visits per benefit period per therapy type)	80% after deductible	50% after deductible
Chiropractic Services	80% after deductible	50% after deductible
Cardiac Rehabilitation (20 visits per benefit period)	80% after deductible	50% after deductible
Emergency Use of a Hospital Emergency Room	80% after deductible	
Non-Emergency Use of a Hospital Emergency Room	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
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
Hospice	80% after deductible	50% after deductible
Organ and Tissue Transplants	80% after deductible	50% after deductible
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient and Outpatient Mental Health Services	80% after deductible	50% after deductible
Inpatient Substance Abuse Services (30 days per benefit period; limited to one admission per benefit period and three admits per lifetime)	80% after deductible	50% after deductible ³
Outpatient Substance Abuse Services (20 visits per benefit period)	50% after deductible	50% after deductible ³
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED		
Retail — 90 day Supply	80% after deductible	
Home Delivery — 90 day Supply	80% after deductible	

¹ Maximum family deductible. Family deductible must be met before benefits are provided on a family contract. The single deductible applies to single contracts.

² Maximum family coinsurance out-of-pocket. Family coinsurance out-of-pocket must be met before all benefits are paid at 100% on a family contract. The single coinsurance out-of-pocket applies to single contracts.

³ 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.

PERSONAL HEALTH PLANS HSA COMPATIBLE PLANS

BENEFITS	2500/5000	3000/6000	4000/8000	5000/10000
Benefit Period	January 1 through December 31			
Dependent Age Limit	24; Removal upon End of Month			
Lifetime Maximum	\$7,500,000			
Network Benefit Period Deductible — Single/Family ¹	\$2,500/\$5,000	\$3,000/\$6,000	\$4,000/\$8,000	\$5,000/\$10,000
Non-Network Benefit Period Deductible — Single/Family ¹	\$5,000/\$10,000	\$6,000/\$12,000	\$8,000/\$16,000	\$10,000/\$20,000
	IN-NETWORK	OUT-OF-NETWORK		
Coinsurance — Single/Family	100%	50%		
Coinsurance Out-of-Pocket Maximum – Single/Family	N/A	\$4,000/\$8,000		
PHYSICIAN/OFFICE SERVICES				
Office & Urgent Care Visits (Illness/Injury)	100% after deductible		50% after deductible	
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine)	100% after deductible		50% after deductible	
PREVENTIVE SERVICES				
Routine Physical Exam (\$500 maximum per benefit period)	100% after deductible		50% after deductible	
Well Child Care Services to age nine. Well Child Care Exams, Immunizations and Labs are limited to a \$500 maximum per benefit period.	100% after deductible		50% after deductible	
Routine Pap Test (One per benefit period)	100% after deductible		50% after deductible	
Routine Mammogram (One per benefit period)	100% after deductible		50% after deductible	
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period.)	100% after deductible		50% after deductible	
OUTPATIENT SERVICES				
Allergy Testing and Treatments	100% after deductible		50% after deductible	
Diagnostic Services	100% after deductible		50% after deductible	
Surgical Services	100% after deductible		50% after deductible	
Physical, Occupational and Speech Therapy (20 visits per benefit period per therapy type)	100% after deductible		50% after deductible	
Chiropractic Services	100% after deductible		50% after deductible	
Cardiac Rehabilitation (20 visits per benefit period)	100% after deductible		50% after deductible	
Emergency Use of a Hospital Emergency Room	100% after deductible			
Non-Emergency Use of a Hospital Emergency Room	100% after deductible		50% after deductible	
INPATIENT SERVICES				
Semi-Private Room and Board	100% after deductible		50% after deductible	
Skilled Nursing Facility (\$10,000 maximum per benefit period)	100% after deductible		50% after deductible	
ADDITIONAL SERVICES				
Ambulance (\$2,500 maximum per benefit period)	100% after deductible			
Durable Medical Equipment	100% after deductible		50% after deductible	
Home Health Care (60 visits per benefit period)	100% after deductible		50% after deductible	
Hospice	100% after deductible		50% after deductible	
Organ and Tissue Transplants	100% after deductible		50% after deductible	
MENTAL HEALTH AND SUBSTANCE ABUSE				
Inpatient and Outpatient Mental Health Services	100% after deductible		50% after deductible ²	
Inpatient Substance Abuse Services (30 days per benefit period; limited to one admission per benefit period and three admits per lifetime)	100% after deductible		50% after deductible ²	
Outpatient Substance Abuse Services (20 visits per benefit period)	50% after deductible		50% after deductible ²	
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED				
Retail — 90 day Supply	100% after deductible			
Home Delivery — 90 day Supply	100% after deductible			

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

PERSONAL HEALTH PLANS HSA COMPATIBLE WELLNESS PLANS

BENEFITS	1200/2400	2000/4000
Benefit Period	January 1 through December 31	
Dependent Age Limit	24; Removal upon End of Month	
Lifetime Maximum	\$7,500,000	
Network Benefit Period Deductible — Single/Family	\$1,200/\$2,400 ¹	\$2,000/\$4,000 ¹
Non-Network Benefit Period Deductible — Single/Family	\$2,400/\$4,800 ¹	\$4,000/\$8,000 ¹
	IN-NETWORK	OUT-OF-NETWORK
Coinsurance — Single/Family	80%	50%
Coinsurance Out-of-Pocket Maximum – Single/Family	\$2,000/\$4,000 ²	\$4,000/\$8,000 ²
PHYSICIAN/OFFICE SERVICES		
Office & Urgent Care Visits (Illness/Injury)	80% after deductible	50% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine)	80% after deductible	50% after deductible
PREVENTIVE SERVICES		
Routine Physical Exam	100%	50% after deductible
Well Child Care Services to age nine. Well Child Care Exams, Immunizations and Labs are limited to a \$500 maximum per benefit period.	100%	50% after deductible
Routine Pap Test (One per benefit period)	100%	50% after deductible
Routine Mammogram (One per benefit period)	100%	50% after deductible
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period.)	100%	50% after deductible
Routine PSA, Cholesterol, Colon Cancer Screening tests, Bone Density Tests and Endoscopic Services	100%	50% after deductible
OUTPATIENT SERVICES		
Allergy Testing and Treatments	80% after deductible	50% after deductible
Diagnostic Services	80% after deductible	50% after deductible
Surgical Services	80% after deductible	50% after deductible
Physical, Occupational and Speech Therapy (20 visits per benefit period per therapy type)	80% after deductible	50% after deductible
Chiropractic Services	80% after deductible	50% after deductible
Cardiac Rehabilitation (20 visits per benefit period)	80% after deductible	50% after deductible
Emergency Use of a Hospital Emergency Room	80% after deductible	
Non-Emergency Use of a Hospital Emergency Room	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
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
Hospice	80% after deductible	50% after deductible
Organ and Tissue Transplants	80% after deductible	50% after deductible
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient and Outpatient Mental Health Services	80% after deductible	50% after deductible
Inpatient Substance Abuse Services (30 days per benefit period; limited to one admission per benefit period and three admits per lifetime)	80% after deductible	50% after deductible ³
Outpatient Substance Abuse Services (20 visits per benefit period)	50% after deductible	50% after deductible ³
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED		
Retail — 90 day Supply	80% after deductible	
Home Delivery — 90 day Supply	80% after deductible	

¹ Maximum family deductible. Family deductible must be met before benefits are provided on a family contract. The single deductible applies to single contracts.

² Maximum family coinsurance out-of-pocket. Family coinsurance out-of-pocket must be met before all benefits are paid at 100% on a family contract. The single coinsurance out-of-pocket applies to single contracts.

³ 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.

PERSONAL HEALTH PLANS HSA COMPATIBLE WELLNESS PLANS

BENEFITS	2500/5000	3000/6000	4000/8000	5000/10000
Benefit Period	January 1 through December 31			
Dependent Age Limit	24; Removal upon End of Month			
Lifetime Maximum	\$7,500,000			
Network Benefit Period Deductible — Single/Family ¹	\$2,500/\$5,000	\$3,000/\$6,000	\$4,000/\$8,000	\$5,000/\$10,000
Non-Network Benefit Period Deductible — Single/Family ¹	\$5,000/\$10,000	\$6,000/\$12,000	\$8,000/\$16,000	\$10,000/\$20,000
	IN-NETWORK		OUT-OF-NETWORK	
Coinsurance — Single/Family	100%		50%	
Coinsurance Out-of-Pocket Maximum – Single/Family	N/A		\$4,000/\$8,000	
PHYSICIAN/OFFICE SERVICES				
Office & Urgent Care Visits (Illness/Injury)	100% after deductible		50% after deductible	
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine)	100% after deductible		50% after deductible	
PREVENTIVE SERVICES				
Routine Physical Exam (\$500 maximum per benefit period)	100%		50% after deductible	
Well Child Care Services to age nine. Well Child Care Exams, Immunizations and Labs are limited to a \$500 maximum per benefit period.	100%		50% after deductible	
Routine Pap Test (One per benefit period)	100%		50% after deductible	
Routine Mammogram (One per benefit period)	100%		50% after deductible	
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period.)	100%		50% after deductible	
Routine PSA, Cholesterol, Colon Cancer Screening tests, Bone Density Tests and Endoscopic Services	100%		50% after deductible	
OUTPATIENT SERVICES				
Allergy Testing and Treatments	100% after deductible		50% after deductible	
Diagnostic Services	100% after deductible		50% after deductible	
Surgical Services	100% after deductible		50% after deductible	
Physical, Occupational and Speech Therapy (20 visits per benefit period per therapy type)	100% after deductible		50% after deductible	
Chiropractic Services	100% after deductible		50% after deductible	
Cardiac Rehabilitation (20 visits per benefit period)	100% after deductible		50% after deductible	
Emergency Use of a Hospital Emergency Room	100% after deductible			
Non-Emergency Use of a Hospital Emergency Room	100% after deductible		50% after deductible	
INPATIENT SERVICES				
Semi-Private Room and Board	100% after deductible		50% after deductible	
Skilled Nursing Facility (\$10,000 maximum per benefit period)	100% after deductible		50% after deductible	
ADDITIONAL SERVICES				
Ambulance (\$2,500 maximum per benefit period)	100% after deductible			
Durable Medical Equipment	100% after deductible		50% after deductible	
Home Health Care (60 visits per benefit period)	100% after deductible		50% after deductible	
Hospice	100% after deductible		50% after deductible	
Organ and Tissue Transplants ¹	100% after deductible		50% after deductible	
MENTAL HEALTH AND SUBSTANCE ABUSE				
Inpatient and Outpatient Mental Health Services	100% after deductible		50% after deductible ²	
Inpatient Substance Abuse Services (30 days per benefit period; limited to one admission per benefit period and three admits per lifetime)	100% after deductible		50% after deductible ²	
Outpatient Substance Abuse Services (20 visits per benefit period)	50% after deductible		50% after deductible ²	
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED				
Retail — 90 day Supply	100% after deductible			
Home Delivery — 90 day Supply	100% after deductible			

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

PERSONAL HEALTH PLANS VISION EYEMED ACCESS NETWORK

BENEFITS	NETWORK	NON-NETWORK ¹
Dependent Age Limit	24; Removal upon end of month	
PROFESSIONAL SERVICES (ONE EVERY 12 MONTHS)		
Spectacle exam	\$15 copayment	\$15 maximum
Contact lens exam	\$15 copayment + any amount over spectacle exam	\$15 maximum
MATERIALS		
Frame (One every 12 months)	\$0 copayment (Up to \$100; 20% off amount over \$100)	\$30 maximum
Lenses (Uncoated plastic. One pair every 12 months)		
Single Vision	\$15 copayment	\$10 maximum
Bifocal	\$15 copayment	\$20 maximum
Trifocal	\$15 copayment	\$30 maximum
Lenticular	\$15 copayment	\$40 maximum
Contact lenses (Instead of lenses and frames. One pair every 12 months)		
Cosmetic	\$15 copayment (Up to \$100)	\$40 maximum
Medically necessary	\$15 copayment (Up to \$200)	\$75 maximum
Disposable	\$15 copayment (Up to \$100)	\$40 maximum

LISTED BELOW ARE ADDITIONAL WAYS TO SAVE ON LENS OPTIONS AND CONTACT LENSES.

If an EyeMed Vision Care professional is used, members are entitled to a discount in addition to the lens copayments listed above. The discount applies to items whether or not they are covered as part of a vision plan. The available discounted lens options are listed below:

Lens Options	Discounted Price (in addition to the \$15 lens copayment)
Anti-reflective coating	\$45
Glass	20% off retail
Photochromic	20% off retail
Polycarbonate	\$40
Progressive (no-line bifocal)	\$65
Scratch-resistant coating	\$15
Solid or Gradient tint	\$15
Ultraviolet coating	\$15

Contact Lenses: Two convenient ways to obtain contact lenses

1. Visit a participating EyeMed Vision Care location and save 15% on non-disposable contact lenses.
2. Use the mail-order Vision One Contact Lens Replacement Program and apply discounts when ordering contacts by mail.

The discount schedule for lens options and contact lenses listed above is subject to change by EyeMed Vision Care.

This document is only a partial listing of benefits. This is not a contract of insurance. No person other than an officer of Consumers Life may agree, verbally or in writing, to change the benefits listed here. The certificate provides a complete listing of covered services.

¹ The non-network maximum is the amount a member receives for covered vision services received from a non-network healthcare professional.

SUPERDENTAL® BENEFITS

BENEFITS	IN NETWORK	OUT OF NETWORK
Benefit Period	January 1 through December 31	
Dependent Age Limit	24; Removal upon end of month	
Annual Maximum (per member)	\$1,000 per benefit period	
Benefit Period Deductible	\$50 per individual	\$100 per individual
PREVENTIVE SERVICES		
Oral Exams – 2 per benefit period	100%	80%
Bite Wing X-rays – 2 per benefit period	100%	80%
Prophylaxis (cleaning) – 2 per benefit period	100%	80%
Fluoride Treatment – 1 treatment per benefit period, limited to age 19	100%	80%
Space Maintainers – limited to age 19	100%	80%
Emergency Palliative Treatment – includes emergency oral exam	100%	80%
ESSENTIAL SERVICES		
Fillings	80% after deductible	60% after deductible

BENEFIT EXCLUSIONS AND LIMITATIONS

Personal Health Plans does not provide benefits for services, supplies or charges for the following:

- Diagnostic X-Rays
- Minor Restorative Services
- Endodontics/Pulp Services
- Apicoectomy
- Periodontal Services
- Repairs, Relines & Adjustments of Prosthetics
- Simple Extractions
- Impactions
- Alveoplasty
- Minor Oral Surgery Services
- General Anesthesia
- Gold Foil Restoration
- Inlays, Onlays
- Crowns
- Bridgework (Pontics & Abutments)
- Partial and Complete Dentures
- Orthodontic Diagnostic Services
- Minor Treatment for Tooth Guidance
- Minor Treatment for Harmful Habits
- Interceptive Orthodontic Treatment
- Comprehensive Orthodontic Treatment

NOTE:

- Benefit will be determined based on Consumers Life's medical and administrative policies and procedures. The plan design remains the same for all providers, whether DenteMax or non-DenteMax. This document is only a partial listing of dental benefits. This is not a contract of insurance. Your certificate of insurance provides a complete listing of covered services.

BENEFIT EXCLUSIONS AND LIMITATIONS

In addition to the exclusions and limitations explained in the Health Care Benefits section, coverage is not provided for services and supplies:

1. Not prescribed by or performed by or under the direction of a Physician or Other Professional Provider.
2. Not performed within the scope of the Provider's license.
3. Received from other than a Provider.
4. For Experimental or Investigational equipment, drugs, devices, services, supplies, tests, medical treatments or procedures.
5. To the extent that governmental units or their agencies provide benefits, except Health Departments, as determined by Consumers Life.
6. For a Condition that occurs as a result of any act of war, declared or undeclared.
7. For which you have no legal obligation to pay in the absence of this or like coverage.
8. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
9. Received from a member of your Immediate Family.
10. Incurred after you stop being a Covered Person except as specified in the Benefits After Termination of Coverage section.
11. For the following:
 - physical examinations or services required by an insurance company to obtain insurance;
 - physical examinations or services required by a governmental agency such as the FAA and DOT;
 - physical examinations or services required by an employer in order to begin or to continue working;
 - premarital examinations;
 - screening examinations, except as specified; or
 - X-ray examinations made without film.
12. For a Condition occurring in the course of employment or for occupational injuries sustained by sole proprietors, if whole or partial benefits or compensation could be available under the laws of any governmental unit. This applies whether or not you claim such compensation or recover losses from a third party.
13. For which payment was made or would have been made under Medicare Parts A or B if benefits were claimed. This applies when you are eligible for Medicare even if you did not apply for or claim Medicare benefits.
14. Received in a military facility for a military service related Condition.
15. For Surgery and other services primarily to improve appearance or to treat a mental or emotional Condition through a change in body form (including cosmetic Surgery following weight loss or weight loss Surgery), except as specified in the Surgical Services section.
16. For Surgery to correct a deformity for psychological reasons where there is no function impairment except as specified in the Surgical Services section.
17. For the removal of tattoos.
18. For dietary and/or nutritional guidance or training, except as specified in the Diabetes Treatment section of your Policy.
19. For educational, vocational or training purposes, except as specified.
20. For treatment of Conditions related to learning disabilities, hyperkinetic syndromes, behavioral problems or mental retardation, except for pervasive development disorders which are neurological conditions including Asperger's syndrome and autism.
21. For topical anesthetics.
22. For minor nonoperative endoscopic procedures which include, but are not limited to, anoscopy. (Does not apply to HSA Wellness plans)
23. For arch supports and other foot care or foot support devices only to improve comfort or appearance which include, but are not limited to, care for flatfeet, subluxations, corns, bunions (except capsular and bone Surgery), calluses and toenails.
24. For weight loss drugs.
25. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss.
26. For weight loss Surgery including complications related to this Surgery.
27. For water aerobics.
28. For residential care rendered by a Residential Treatment Facility.
29. For marital counseling.
30. For the medical treatment of sexual problems not caused by a biological Condition.
31. For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
32. For reverse sterilization.
33. For artificial insemination or in vitro fertilization.
34. For services for normal pregnancy and elective abortions.
35. For treatments associated with teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) Surgery, except as specified.
36. For oral implants considered part of a dental process or dental treatment including preparation of the mouth for any type of dental prosthetic except when due to trauma, accident or as deemed Medically Necessary by Consumers Life.
37. For treatment with intraoral prosthetic devices or by any other method, to alter vertical dimension.

38. For treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis.
39. For personal hygiene and convenience items.
40. For eyeglasses, contact lenses or examinations for prescribing or fitting them, except those for aphakic patients, keratoconus, and soft lenses or sclera shells for use as corneal bandages when needed as a result of Surgery.
41. For any surgical procedure for the correction of a visual refractive problem including, but not limited to, radial keratotomy and LASIK (laser in situ keratomileusis).
42. For all services related to hearing loss including hearing aids or examinations for prescribing or fitting them.
43. For immunizations, other than those specified as covered in the Routine and Wellness Services section of the Policy.
44. For massotherapy or massage therapy.
45. For hypnosis and acupuncture.
46. For After Hours Care.
47. For telephone consultations, online consultations, missed appointments, completion of claim forms or copies of medical records.
48. For fraudulent or misrepresented claims.
49. For blood which is available without charge. For Outpatient blood storage services.
50. For Prescription Drugs, except as specified.
51. For over the counter drugs, vitamins or herbal remedies.
52. For Private Duty Nursing Services.
53. For specialized camps.
54. For Routine Services, except as specified.
55. For non-covered services or services specifically excluded in the text of this Policy.
56. For any medication prescribed to induce ovulation or spermatogenesis. (Applies only to HSA Wellness plans.)
57. For the second or subsequent organ transplant(s) during the Benefit Period. (Applies only to Short Term plans.)
58. For Outpatient cardiac rehabilitation. (Applies only to the Value plans.)
59. For allergy tests and treatment. (Applies only to the Value plans.)
60. For speech therapy services. (Applies only to the Value plans.)
61. For Inpatient and Outpatient Mental Health Care, Drug Abuse, and Alcoholism Services. (Applies only to the Value plans.)
62. For Non-Emergency use of a Hospital Emergency room including all other related services. (Applies only to the Value plans.)

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.

This document is not a contract of insurance. It is only a partial listing of healthcare benefits. Refer to your certificate for a complete listing of healthcare benefits. No person other than an officer of Consumers Life Insurance Company may agree, verbally or in writing, to change the benefits listed here. The contract or certificate will contain the complete listing of covered services. Benefits will be determined based on Consumers Life Insurance Company medical and administrative policies and procedures.

In certain instances, Consumers Life Insurance Company's payment may not equal the percentage listed above. However, the covered person's coinsurance will always be based on the lesser of the healthcare professional's billed charges or Consumers Life Insurance Company's negotiated rate with the healthcare professional.