

PERSONAL HEALTH PLANS



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



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PERSONAL HEALTH PLANS FROM CONSUMERS LIFE— 3080 PLANS

BENEFITS	500/1500	750/2250	1000/3000	1500/4500
Benefit Period	January 1 through December 31			
Dependent Age Limit	19 Dependent; 26 Student; Removal upon End of Month			
Lifetime Maximum	\$2,500,000			
Benefit Period Deductible - Single/Family ¹	\$500/\$1500	\$750/\$2250	\$1000/\$3000	\$1500/\$4500
Non Network Benefit Period Deductible - Single/Family	\$1000/\$3000	\$1500/\$4500	\$2000/\$6000	\$3000/\$9000
	NETWORK		NON-NETWORK	
Coinsurance	80%		60%	
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	\$2000/\$6000		Unlimited	
PHYSICIAN/OFFICE SERVICES				
Office Visit (Illness/Injury)	\$30 copay then 100%		60% after deductible	
Urgent Care Office Visit	\$30 copay then 100%		60% after deductible	
Diagnostic Services in a Physician Office	100%		70% after deductible	
Immunizations (tetanus toxoid, rabies vaccine and meningococcal polysaccharide vaccine)	80% after deductible		60% after deductible	
PREVENTIVE SERVICES				
Routine Physical Exam (\$250 maximum per benefit period)	\$30 copay then 100%		60% after deductible	
Well Child Care Services to age six. Office Visit, Immunizations and Labs	\$30 copay then 100%		60%	
Well Child Care Services ages six to nine. (Exams and Well Child Immunizations are limited to \$500 maximum per benefit period). Office Visit Immunizations and Labs	\$30 copay then 100% 100%		60% after deductible 60% after deductible	
Routine Flu Vaccine				
Routine Mammogram (One per benefit period)	80% after deductible		60% after deductible	
Routine Pap Test	100%		70%	
Routine PSA and Chlamydia Screening	100%		70%	
Routine Cholesterol, Colon Cancer Screening Test, Endoscopic Procedures, Ovarian Cancer Screening and Bone Density Testing	100%		70%	
Routine EKG, Chest X-ray, Comprehensive Metabolic panel, Urinalysis and complete blood count (one each per benefit period)	80% after deductible		60% after deductible	
OUTPATIENT SERVICES				
Allergy Testing and Treatment	80% after deductible		60% after deductible	
Diagnostic Services (Other than a physician's office)	80% after deductible		60% after deductible	
Physical Therapy, Occupational Therapy and Chiropractic Services (30 visits combined per benefit period)	80% after deductible		60% after deductible	
Speech Therapy (30 visits per benefit period)	80% after deductible		60% after deductible	
Cardiac Rehabilitation (Facility Only - 20 visits benefit period)	80% after deductible		60% after deductible	
Emergency Use of an Emergency Room ²	\$150 copay, then 80% after deductible			
Non-Emergency Use of an Emergency Room ^{2,3}	\$150 copay, then 80% after deductible		\$150 copay, then 60% after deductible	
Emergency Services	80% after deductible			
INPATIENT FACILITY				
Semi-private Room and Board	80% after deductible		60% after deductible	
Skilled Nursing Facility (30 days per benefit period)	80% after deductible		80% after deductible	
ADDITIONAL SERVICES				
Ambulance Service (\$2500 maximum per benefit period)	80% after deductible			
Diabetic Education	80% after deductible		60% after deductible	
Durable Medical Equipment	80% after deductible		60% after deductible	
Home Health Care (100 visits per benefit period)	80% after deductible			
Hospice (\$10,000 lifetime maximum)	80%		60%	
Organ and Tissue Transplant ⁴	80% after deductible		60% after deductible	
MENTAL HEALTH AND SUBSTANCE ABUSE				
Inpatient Mental Health/Substance Abuse (30 days per benefit period; limited to one admission per benefit period and three admissions per lifetime)	80% after deductible			
Outpatient Mental Health/Substance Abuse (48 visits per benefit period)	80% after deductible		60% after deductible	
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED ⁶				
Prescription Drug Benefit Period Deductible ⁵ (Single/Family)	\$200/\$600			
Retail - 30 Day Supply	\$15 Generic / \$30 Formulary / \$45 Non-Formulary			
Home Delivery - 90 Day Supply	\$30 Generic / \$60 Formulary / \$90 Non-Formulary			
OPTIONAL RIDER				
Maternity Rider - Benefits are payable after 365 days of coverage under Maternity Rider	80% after deductible		60% after deductible	

PERSONAL HEALTH PLANS FROM CONSUMERS LIFE— 4070 PLANS

BENEFITS	1000/3000	2000/6000	3500/10500	5000/15000
Benefit Period	January 1 through December 31			
Dependent Age Limit	19 Dependent; 26 Student; Removal upon End of Month			
Lifetime Maximum	\$2,500,000			
Benefit Period Deductible - Single/Family ¹	\$1000/\$3000	\$2000/\$6000	\$3500/\$10500	\$5000/\$15000
Non Network Benefit Period Deductible - Single/Family	\$2000/\$6000	\$4000/\$12000	\$7000/\$21000	\$10000/\$30000
	NETWORK		NON-NETWORK	
Coinsurance	70%		60%	
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	\$2000/\$6000		Unlimited	
PHYSICIAN/OFFICE SERVICES				
Office Visit (Illness/Injury)	\$40 copay then 100%		70% after deductible	
Urgent Care Office Visit	\$40 copay then 100%		70% after deductible	
Diagnostic Services in a Physician Office	100%			
Immunizations (tetanus toxoid, rabies vaccine and meningococcal polysaccharide vaccine)	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. Office Visit, Immunizations and Labs	70%		60%	
Well Child Care Services ages six to nine. (Exams and Well Child Immunizations are limited to \$500 maximum per benefit period). Office Visit Immunizations and 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 Test	100%		70%	
Routine PSA and Chlamydia Screening	100%		70%	
Routine Cholesterol, Colon Cancer Screening Test, Endoscopic Procedures, 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 Treatment	70% after deductible		60% after deductible	
Diagnostic Services (Other than a physician's office)	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 (Facility Only - 20 visits benefit period)	70% after deductible		60% after deductible	
Emergency Use of an Emergency Room ²	\$150 copay, then 70% after deductible			
Non-Emergency Use of an Emergency Room ^{2,3}	\$150 copay, then 70% after deductible		\$150 copay, then 60% after deductible	
Emergency Services	70% after deductible			
INPATIENT FACILITY				
Semi-private Room and Board	70% after deductible		60% after deductible	
Skilled Nursing Facility (30 days per benefit period)	70% after deductible		70% after deductible	
ADDITIONAL SERVICES				
Ambulance Service (\$2500 maximum per benefit period)	70% after deductible			
Diabetic Education	70% after deductible		60% after deductible	
Durable Medical Equipment	70% after deductible		60% after deductible	
Home Health Care (100 visits per benefit period)	70% after deductible			
Hospice (\$10,000 lifetime maximum)	70%		60%	
Organ and Tissue Transplant ⁴	70% after deductible		60% after deductible	
SUBSTANCE ABUSE				
Inpatient and Outpatient Substance Abuse	Not covered			
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED				
Prescription Drug Benefit Period Deductible ⁵ (Single/Family)	Please refer to foot note 7.			
Retail - 30 Day Supply	\$15 Generic / \$30 Formulary / \$45 Non-Formulary			
Home Delivery - 90 Day Supply	\$30 Generic / \$60 Formulary / \$90 Non-Formulary			
OPTIONAL RIDER				
Mental Health				
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 (48 visits per benefit period)	70% after deductible		70% after deductible	

PERSONAL HEALTH PLANS FROM CONSUMERS LIFE — 4070 PLANS

BENEFITS	10000/30000	
Benefit Period	January 1 through December 31	
Dependent Age Limit	19 Dependent; 26 Student; Removal upon End of Month	
Lifetime Maximum	\$2,500,000	
Benefit Period Deductible - Single/Family ¹	\$10,000/\$30,000	
Non Network Benefit Period Deductible - Single/Family	\$20,000/\$60,000	
	NETWORK	NON-NETWORK
Coinsurance	70%	60%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	\$5,000/15,000	Unlimited
PHYSICIAN/OFFICE SERVICES		
Office Visit (Illness/Injury)	\$40 copay then 100%	70% after deductible
Urgent Care Office Visit	\$40 copay then 100%	70% after deductible
Diagnostic Services in a Physician Office	100%	70% after deductible
Immunizations (tetanus toxoid, rabies vaccine and meningococcal polysaccharide vaccine)	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. Office Visit, Immunizations and Labs	70%	60%
Well Child Care Services ages six to nine. (Exams and Well Child Immunizations are limited to \$500 maximum per benefit period). Office Visit Immunizations and 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 Test	100%	70%
Routine PSA and Chlamydia Screening	100%	70%
Routine Cholesterol, Colon Cancer Screening Test, Endoscopic Procedures, 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 Treatment	70% after deductible	60% after deductible
Diagnostic Services (Other than a physician's office)	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 (Facility Only - 20 visits benefit period)	70% after deductible	60% after deductible
Emergency Use of an Emergency Room ²	\$150 copay, then 70% after deductible	
Non-Emergency Use of an Emergency Room ^{2,3}	\$150 copay, then 70% after deductible	\$150 copay, then 60% after deductible
Emergency Services	70% after deductible	
INPATIENT FACILITY		
Semi-private Room and Board	70% after deductible	60% after deductible
Skilled Nursing Facility (30 days per benefit period)	70% after deductible	70% after deductible
ADDITIONAL SERVICES		
Ambulance Service (\$2500 maximum per benefit period)	70% after deductible	
Diabetic Education	70% after deductible	60% after deductible
Durable Medical Equipment	70% after deductible	60% after deductible
Home Health Care (100 visits per benefit period)	70% after deductible	
Hospice (\$10,000 lifetime maximum)	70%	60%
Organ and Tissue Transplant ⁴	70% after deductible	60% after deductible
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient and Outpatient Substance Abuse	Not covered	
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED		
Prescription Drug Benefit Period Deductible ⁵ (Single/Family)	\$1,000/\$3,000	
Retail - 30 Day Supply	\$15 Generic / \$30 Formulary / \$45 Non-Formulary	
Home Delivery - 90 Day Supply	\$30 Generic / \$60 Formulary / \$90 Non-Formulary	
OPTIONAL RIDER		
Mental Health		
Inpatient Mental Health (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 (48 visits per benefit period)	70% after deductible	70% after deductible

PERSONAL HEALTH PLANS TRADITIONAL VISION

BENEFITS

Benefit Period	January 1 through December 31
Dependent Age Limit	19 Dependent; 26 Student; Removal upon End of Month

EXAMINATIONS

Vision Examinations (One per benefit period)	\$40 per exam
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FRAMES

Basic Frames (One per two benefit period)	\$60 per frame
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PRESCRIPTION LENSES

Single Vision Lenses	\$60 per pair
Bifocal Lenses	\$70 per pair
Trifocal Lenses	\$100 per pair
Lenticular Single Lenses	\$70 per pair
Lenticular Bifocal Lenses	\$90 per pair
Lenticular Trifocal Lenses	\$110 per pair

CONTACTS IN LIEU OF LENSES

Medically Necessary	\$175 per pair
Cosmetic	\$100 per pair

PERSONAL HEALTH PLANS TRADITIONAL DENTAL

BENEFITS

Benefit Period	January 1st through December 31st
Dependent Age Limit	19 Dependent; 26 Student; Removal upon End of Month
Annual Maximum (per member)	\$1,000 per benefit period
Benefit Period Deductible	\$50 per individual

PREVENTIVE SERVICES

Oral Examinations (Two per benefit period)	100% UCR
Bite Wing X-Rays (Two sets per benefit period)	100% UCR
Prophylaxis (Cleaning - Two per benefit period)	100% UCR
Flouride Treatment (One treatment per benefit period)	100% UCR
Space Maintainers	100% UCR
Emergency Palliative Treatment - Includes emergency oral exam	100% UCR

RESTORATIVE SERVICES

Fillings	80% UCR after deductible
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STANDARD BENEFIT EXCLUSIONS AND LIMITATIONS

Personal Health Plans coverage is not provided for services and supplies:

- Incurred before the policy effective date.
- Incurred after the policy termination date.
- For experimental or investigation of drugs, devices, medical treatments or procedures, except as mandated by state or federal law.
- That are not medically necessary.
- To the extent governmental units or their agencies provide benefits, except Health Departments, as determined by Consumers Life.
- For a condition that occurs as a result of any act of war, declared or undeclared.
- Received from a member of your immediate family.
- For which payment was made or would have been made under Medicare Parts A or B if benefits were claimed.
- Received in a military facility for a military service-related condition, unless legally required to pay.
- 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 surgery), except as specified.
- For treatment of a condition related to learning disabilities, hyperkinetic syndromes, behavioral problems or mental retardation, except as specified.
- 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 of flatfeet, subluxations, corns, bunions (except capsular and bone surgery), calluses and toenails.
- For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss.
- For marital counseling.
- For the medical treatment of sexual problems not caused by a biological condition.
- For transsexual surgery or any treatment leading to, or in connection with, transsexual surgery.
- For reverse sterilization.
- For artificial insemination or in vitro fertilization.
- For hypnosis and acupuncture.
- 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).

Consult your Certificate of Coverage for a complete listing of benefits and exclusions.

Deductible expenses incurred for services by a PPO Network provider will only apply to the PPO Network deductible. Deductible expenses incurred for services by a Non-PPO Network provider will only apply to the Non-PPO Network deductible.

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

Services requiring a copayment are not subject to the single/family deductible.

Benefits will be determined based on Consumers Life's medical and administrative policies and procedures.

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 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. This policy may not be canceled or non-renewed except as provided in the sections of your Policy describing Fraud, Grace Period and Non-Payment and Reinstatement.

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

NOTE: Vision and Dental benefits will be determined based on Consumers Life's medical and administrative policies and procedures.

- 1 Maximum family deductible. Member deductible is the same as single deductible.
- 2 Copay waived if admitted.
- 3 The copay applies to room charges only. All other charges are covered subject to deductible and coinsurance.
- 4 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 except for heart transplants and bone marrow transplants for the treatment of breast cancer and Hodgkin's disease. There will be a \$10,000 non-network penalty for failure to use a Consumers Life facility or a Designated Organ Transplant Network provider except for heart transplants and bone marrow transplants for the treatment of breast cancer and Hodgkin's disease. The Case Manager may waive this penalty if the proper pre-determination procedures are followed.
- 5 The prescription drug benefit period deductible includes deductibles paid for both retail and home delivery drugs.
- 6 The drug benefit contains the following: Rx Selections® formulary will be used.
- 7 Prescription Drug benefit period deductible varies by product. They are as follows:

1,000/3,000 – \$200 single/\$600 family
2,000/6,000 – \$200 single/\$600 family
3,500/10,500 – \$350 single/\$1,050 family
5,000/15,000 – \$500 single/\$1,500 family