

PERSONAL HEALTH PLANS



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



**CONSUMERS LIFE  
INSURANCE COMPANY®**  
A MEDICAL MUTUAL OF OHIO COMPANY

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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	19 Dependent, 23 Student; 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				
Coinsurance Option	80%/50% or 70%/50%				
	<b>NETWORK</b>			<b>NON-NETWORK</b>	
Coinsurance Out-of-Pocket Maximum – Single/Family – 80% Coinsurance	\$3,000/\$9,000			\$25,000/\$50,000	
Coinsurance Out-of-Pocket Maximum – Single/Family – 70% Coinsurance	\$5,000/\$15,000			\$25,000/\$50,000	
<b>PHYSICIAN/OFFICE SERVICES</b>					
Office & Urgent Care Visits (Illness & Injury)	OV copay then 100%			50% after deductible	
Immunizations	Coinsurance after deductible			50% after deductible	
<b>PREVENTIVE SERVICES</b>					
Routine Physical Exam	OV copay then 100%			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	OV copay then 100%			50% after deductible <sup>1</sup>	
Well Child Immunizations and 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), routine PSA screening (starting at age 50)	Coinsurance after deductible			50% after deductible	
<b>OUTPATIENT SERVICES</b>					
Allergy Testing and Treatment	Coinsurance after deductible			50% after deductible <sup>1</sup>	
Diagnostic Services	Coinsurance after deductible			50% after deductible	
Surgical Services	Coinsurance after deductible			50% after deductible	
Physical, Speech and Occupational Therapy (20 visits per benefit period per therapy type)	OV copay then Coinsurance			50% after deductible	
Chiropractic Services (12 visits per benefit period)	OV copay then Coinsurance			50% after deductible	
Cardiac Rehabilitation (20 visits per benefit period)	Coinsurance after deductible			50% after deductible	
Emergency Use of a Hospital Emergency Room	\$150 copay, the network coinsurance after deductible				
Non-Emergency Use of a Hospital Emergency Room	\$300 copay, then Coinsurance after deductible		\$300 copay, then Coinsurance after deductible		
<b>INPATIENT SERVICES</b>					
Semi-private Room and Board	Coinsurance after deductible			50% after deductible	
Skilled Nursing Facility (\$10,000 maximum per benefit period)	Coinsurance after deductible			50% after deductible	
<b>ADDITIONAL SERVICES</b>					
Ambulance (\$2,500 maximum per benefit period)	Coinsurance after deductible				
Durable Medical Equipment	Coinsurance after deductible			50% after deductible	
Home Healthcare (60 visits per benefit period)	Coinsurance after deductible			50% after deductible <sup>1</sup>	
Hospice	Coinsurance after deductible			50% after deductible <sup>1</sup>	
Organ and Tissue Transplant	Coinsurance after deductible			50% after deductible	
<b>MENTAL HEALTH &amp; SUBSTANCE ABUSE</b>					
Inpatient Mental Health Services (30 days per benefit period)	Coinsurance after deductible			50% after deductible <sup>1</sup>	
Outpatient Mental Health Services (20 days per benefit period)	Coinsurance after deductible			50% after deductible <sup>1</sup>	
Inpatient and Outpatient Substance Abuse Services (\$4,500 limit per benefit period)	Coinsurance after deductible			50% after deductible <sup>1</sup>	
<b>PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED<sup>2</sup></b>					
Prescription Drug Benefit Period Deductible – Single/Family	\$250/\$500 (Deductible waived for Generic)				
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				
<b>OPTIONAL RIDERS</b>					
Maternity Rider (Benefits are payable after 270 days of coverage under maternity rider)	Coinsurance after deductible			50% after deductible	
Preventive Services Rider	100% for the first \$500 per benefit period, then Coinsurance 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					
Prescription Drug Benefit Period Deductible – Single/Family	\$250/\$500 (Deductible waived for Generic)				
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.

<sup>1</sup> 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.

<sup>2</sup> 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	19 Dependent, 23 Student; 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
	<b>NETWORK</b>			<b>NON-NETWORK</b>	
Coinsurance	80%			50%	
Coinsurance Out-of-Pocket Maximum – Single/Family	\$3,000/\$9,000			\$25,000/\$50,000	
<b>PHYSICIAN/OFFICE SERVICES</b>					
Office & Urgent Care Visits (Illness & Injury)	80% after deductible			50% after deductible	
Immunizations	80% after deductible			50% after deductible	
<b>PREVENTIVE SERVICES</b>					
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 <sup>1</sup>	
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	
<b>OUTPATIENT SERVICES</b>					
Allergy Testing and Treatment	80% after deductible			50% after deductible <sup>1</sup>	
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 (12 visits per benefit period)	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	\$300 copay, then 80% after deductible		\$300 copay, then 50% after deductible		
<b>INPATIENT SERVICES</b>					
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	
<b>ADDITIONAL SERVICES</b>					
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 <sup>1</sup>	
Hospice	80% after deductible			50% after deductible <sup>1</sup>	
Organ and Tissue Transplant	80% after deductible			50% after deductible	
<b>MENTAL HEALTH &amp; SUBSTANCE ABUSE</b>					
Inpatient Mental Health Services (30 days per benefit period)	80% after deductible			50% after deductible <sup>1</sup>	
Outpatient Mental Health Services (20 days per benefit period)	80% after deductible			50% after deductible <sup>1</sup>	
Inpatient and Outpatient Substance Abuse Services (\$4,500 limit per benefit period)	80% after deductible			50% after deductible <sup>1</sup>	
<b>PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED<sup>2</sup></b>					
Prescription Drug Benefit Period Deductible – Single/Family	\$250/\$500 (Deductible waived for Generic)				
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				
<b>OPTIONAL RIDERS</b>					
Maternity Rider (Benefits are payable after 270 days of coverage under maternity rider)	80% after deductible			50% after deductible	
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					
Prescription Drug Benefit Period Deductible – Single/Family	\$250/\$500 (Deductible waived for Generic)				
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.

<sup>1</sup> 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.

<sup>2</sup> 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	19 Dependent, 23 Student; 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 <sup>1</sup>
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 <sup>1</sup>
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 (12 visits per benefit period)	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	\$300 copay, then 100% after deductible	\$300 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 <sup>1</sup>
Hospice	100% after deductible	50% after deductible <sup>1</sup>
Organ and Tissue Transplant	100% after deductible	50% after deductible
MENTAL HEALTH & SUBSTANCE ABUSE		
Inpatient Mental Health Services (30 days per benefit period)	100% after deductible	50% after deductible <sup>1</sup>
Outpatient Mental Health Services (20 days per benefit period)	100% after deductible	50% after deductible <sup>1</sup>
Inpatient and Outpatient Substance Abuse Services (\$4,500 limit per benefit period)	100% after deductible	50% after deductible <sup>1</sup>
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED <sup>2</sup>		
Prescription Drug Benefit Period Deductible – Single/Family	\$250/\$500 (Deductible waived for Generic)	
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		
Maternity Rider (Benefits are payable after 270 days of coverage under maternity rider)	80% after deductible	50% after deductible
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		
Prescription Drug Benefit Period Deductible – Single/Family	\$250/\$500 (Deductible waived for Generic)	
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.

<sup>1</sup> 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.

<sup>2</sup> 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	19 Dependent, 23 Student; 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				
	<b>NETWORK</b>		<b>NON-NETWORK</b>		
Coinsurance	70%		50%		
<b>PHYSICIAN/OFFICE SERVICES</b>					
Office and Urgent Care Visits	\$35 copay then 100%		50% after deductible		
Immunizations	70% after deductible		50% after deductible		
<b>PREVENTIVE SERVICES</b>					
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%		50% after deductible <sup>1</sup>		
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		
<b>OUTPATIENT SERVICES</b>					
Allergy Testing and Treatments	Not Covered				
Diagnostic Services	\$250 copay per day, then 70% after deductible		50% after deductible <sup>1</sup>		
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 (6 visits per benefit period)	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				
<b>INPATIENT FACILITY</b>					
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		
<b>ADDITIONAL SERVICES</b>					
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 <sup>1</sup>		
Hospice	70% after deductible		50% after deductible <sup>1</sup>		
Organ and Tissue Transplants	\$250 copay per admission, then 70% after deductible		50% after deductible		
<b>MENTAL HEALTH &amp; SUBSTANCE ABUSE</b>					
Inpatient and Outpatient Mental Health	Not Covered				
Inpatient and Outpatient Substance Abuse (\$4,500 limit per benefit period)	70% after deductible		50% after deductible <sup>1</sup>		
<b>PRESCRIPTION DRUG</b>					
Benefit Period Deductible	\$100 per person				
Retail – 30 Day Supply	\$10 Copay – Generic drugs only <sup>2</sup>				
Home Delivery	Not Covered				
<b>OPTIONAL RIDER</b>					
<b>PRESCRIPTION DRUG RIDER – ORAL CONTRACEPTIVES INCLUDED<sup>3</sup></b>					
Prescription Drug Benefit Period Deductible – Single/Family	\$250/\$500 (Deductible waived for Generic)				
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.

<sup>1</sup> 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.

<sup>2</sup> This prescription drug benefit does not cover brand-name prescriptions under any circumstance. This applies even if a brand name drug is medically necessary and a generic substitute is not available. This also applies even when your doctor writes “dispense as written” on your prescription.

<sup>3</sup> 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 HSA COMPATIBLE WELLNESS PLANS

BENEFITS	1200/2400	2000/4000
Benefit Period	January 1 through December 31	
Dependent Age Limit	19 Dependent, 23 Student; Removal upon End of Month	
Lifetime Maximum	\$7,500,000	
Network Benefit Period Deductible — Single/Family	\$1,200/\$2,400 <sup>1</sup>	\$2,000/\$4,000 <sup>1</sup>
Non-Network Benefit Period Deductible — Single/Family	\$2,400/\$4,800 <sup>1</sup>	\$4,000/\$8,000 <sup>1</sup>
	IN-NETWORK	OUT-OF-NETWORK
Coinsurance — Single/Family	80%	50%
Coinsurance Out-of-Pocket Maximum – Single/Family	\$2,000/\$4,000 <sup>2</sup>	\$4,000/\$8,000 <sup>2</sup>
PHYSICIAN/OFFICE SERVICES		
Office & Urgent Care Visits (Illness/Injury)	80% after deductible	50% after deductible
Immunizations	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 (12 visits per benefit period)	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 & SUBSTANCE ABUSE		
Inpatient Mental Health Services (30 days per benefit period)	80% after deductible	50% after deductible <sup>3</sup>
Outpatient Mental Health Services (20 visits per benefit period)	80% after deductible	50% after deductible <sup>3</sup>
Inpatient and Outpatient Substance Abuse Services (\$4,500 limit per benefit period)	80% after deductible	50% after deductible <sup>3</sup>
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED		
Retail — 90 day Supply	80% after deductible	
Home Delivery — 90 day Supply	80% after deductible	

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

<sup>2</sup> 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.

<sup>3</sup> 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	19 Dependent, 23 Student; Removal upon End of Month			
Lifetime Maximum	\$7,500,000			
Network Benefit Period Deductible — Single/Family <sup>1</sup>	\$2,500/\$5,000	\$3,000/\$6,000	\$4,000/\$8,000	\$5,000/\$10,000
Non-Network Benefit Period Deductible — Single/Family <sup>1</sup>	\$5,000/\$10,000	\$6,000/\$12,000	\$8,000/\$16,000	\$10,000/\$20,000
	<b>IN-NETWORK</b>		<b>OUT-OF-NETWORK</b>	
Coinsurance — Single/Family	100%		50%	
Coinsurance Out-of-Pocket Maximum – Single/Family	N/A		\$4,000/\$8,000	
<b>PHYSICIAN/OFFICE SERVICES</b>				
Office & Urgent Care Visits (Illness/Injury)	100% after deductible		50% after deductible	
Immunizations	100% after deductible		50% after deductible	
<b>PREVENTIVE SERVICES</b>				
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	
<b>OUTPATIENT SERVICES</b>				
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 (12 visits per benefit period)	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	
<b>INPATIENT SERVICES</b>				
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	
<b>ADDITIONAL SERVICES</b>				
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	
<b>MENTAL HEALTH &amp; SUBSTANCE ABUSE</b>				
Inpatient Mental Health Services (30 days per benefit period)	80% after deductible		50% after deductible <sup>1</sup>	
Outpatient Mental Health Services (20 visits per benefit period)	80% after deductible		50% after deductible <sup>1</sup>	
Inpatient and Outpatient Substance Abuse Services (\$4,500 limit per benefit period)	80% after deductible		50% after deductible <sup>1</sup>	
<b>PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED</b>				
Retail — 90 day Supply	100% after deductible			
Home Delivery — 90 day Supply	100% after deductible			

<sup>1</sup> 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 <sup>1</sup>
Dependent Age Limit	24; Removal upon end of month	
<b>PROFESSIONAL SERVICES (ONE EVERY 12 MONTHS)</b>		
Spectacle exam	\$15 copayment	\$15 maximum
Contact lens exam	\$15 copayment + any amount over spectacle exam	\$15 maximum
<b>MATERIALS</b>		
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.

<sup>1</sup> 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 drugs, devices, 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 or birth defect for psychological reasons where there is no function impairment.
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 an autistic disease of childhood, developmental delay, learning disabilities, hyperkinetic syndromes, behavioral problems or mental retardation, except as specified.
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, except as specified.
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 any medication prescribed to induce ovulation or spermatogenesis.
35. For services for normal pregnancy and elective abortions.
36. Incurred as a result of any Covered Person acting as or contracting to be, a surrogate parent.
37. For treatments associated with teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) Surgery, except as specified.
38. 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.

39. For treatment with intraoral prosthetic devices or by any other method, to alter vertical dimension.
40. For treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis.
41. For personal hygiene and convenience items.
42. 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.
43. 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).
44. For all services related to hearing loss including hearing aids or examinations for prescribing or fitting them.
45. For immunizations, other than those specified as covered in the Routine and Wellness Services section of the Policy.
46. For massotherapy or massage therapy.
47. For hypnosis and acupuncture.
48. For After Hours Care.
49. For telephone consultations, online consultations, missed appointments, completion of claim forms or copies of medical records.
50. For fraudulent or misrepresented claims.
51. For blood which is available without charge. For Outpatient blood storage services.
52. For Prescription Drugs, except as specified.
53. For over the counter drugs, vitamins or herbal remedies.
54. For Private Duty Nursing Services.
55. For specialized camps.
56. For Routine Services, except as specified.
57. For non-covered services or services specifically excluded in the text of this Policy.
58. For any medication prescribed to induce ovulation or spermatogenesis. (Applies only to HSA Wellness plans.)
59. For Outpatient cardiac rehabilitation. (Applies only to the Value plans.)
60. For allergy tests and treatment. (Applies only to the Value plans.)
61. For speech therapy services. (Applies only to the Value plans.)
62. For Inpatient and Outpatient Mental Health Care, Drug Abuse, and Alcoholism Services. (Applies only to the Value plans.)
63. 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.