

PERSONAL HEALTH PLANS



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



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PERSONAL HEALTH PLANS FROM CONSUMERS LIFE

BENEFITS	500/1000	1000/2000	1500/3000
Benefit Period	January 1 through December 31		
Dependent Age Limit	19 Dependent, 23 Student; Removal upon end of month		
Lifetime Maximum	\$2,500,000		
Benefit Period Deductible – Single/Family	\$500/\$1,000	\$1,000/\$2,000	\$1,500/\$3,000
Non-Network Benefit Period Deductible – Single/Family	\$1,000/\$2,000	\$2,000/\$4,000	\$3,000/\$6,000
	NETWORK	NON-NETWORK	
Coinsurance	80%	50%	
Coinsurance Out-of-Pocket Maximum – Single/Family	\$2,000/\$4,000	Unlimited	
PHYSICIAN/OFFICE SERVICES			
Office and Urgent Care Visits (Illness and Injury)	80% after deductible		50% after deductible
Immunizations (tetanus toxoid, rabies vaccine and meningococcal polysaccharide vaccine)	80% after deductible		50% after deductible ¹
PREVENTIVE SERVICES			
Routine Physical Exam	80% after deductible		50% after deductible ¹
Well Child Care Services to age nine. Well Child Care Exams are limited to a \$500 maximum per benefit period.			
Well Child Exam	80% after deductible		50% after deductible ¹
Well Child Immunizations	100%		100%
Well Child 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)	80% after deductible		50% after deductible
OUTPATIENT SERVICES			
Allergy Testing and Treatment	80% after deductible		50% after deductible ¹
Diagnostic Services	80% after deductible		50% after deductible
Surgery	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 maximum 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		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 (30 days per benefit period)	80% after deductible		50% after deductible
ADDITIONAL SERVICES			
Ambulance (\$2,500 maximum per benefit period)	80% after deductible		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 ¹
Hospice	80% after deductible		50% after deductible ¹
Organ and Tissue Transplant ²	80% after deductible		50% after deductible
Diabetes Education	80% after deductible		50% after deductible
MENTAL HEALTH AND SUBSTANCE ABUSE			
Inpatient Mental Health and Substance Abuse (\$7,000 maximum per benefit period) ³	50% after deductible ¹		50% after deductible ¹
Outpatient Mental Health and Substance Abuse (\$2,000 maximum per benefit period) ³	50% after deductible ¹		50% after deductible ¹
Transitional Treatment (\$3,000 maximum per benefit period) ³	50% after deductible ¹		50% after deductible ¹
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED			
Prescription Drug Benefit Period Deductible ⁴ – Single/Family	\$250/\$500		
Benefit Period Maximum ⁵	\$2,000		
Retail — 30-day Supply	80% after deductible		
Mail Order — 90-day Supply	80% after deductible		
OPTIONAL RIDERS			
Prescription Drug Rider – Oral Contraceptives Included ⁶			
Retail – 30-day Supply	\$15 Generic / \$30 Formulary / \$45 Non-Formulary		
Mail Order – 90-day supply	\$30 Generic / \$60 Formulary / \$90 Non-Formulary		
Maternity Rider – Benefits payable after 270 days of coverage under maternity rider	80% after deductible		50% after deductible

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 Inpatient Mental Health and Substance Abuse, Outpatient Mental Health and Substance Abuse and Transitional Treatment are limited to a combined \$7,000 maximum benefit period.

⁴ The Prescription Drug Benefit Period Deductible includes deductibles paid for both retail and mail order drugs.

⁵ The benefit period maximum is combined for both retail and mail order drugs.

⁶ Drug Benefit contains the following:

- Rx Selections® Drug List: A list of drugs on the Rx Selections formulary will be used.
- Generic Incentive: If the member or physician requests a brand-name drug, and a generic equivalent exists, the member pays the generic copayment PLUS the difference between the cost of the generic drug and the brand-name drug.
- Mail Order Incentive: When a member chooses to fill a prescription a fourth time at a retail pharmacy within 180 days, the member will pay twice the normal retail copayment.

PERSONAL HEALTH PLANS FROM CONSUMERS LIFE

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	\$2,500,000	
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	Unlimited
PHYSICIAN/OFFICE SERVICES		
Office and Urgent Care Visit (Illness and Injury)	100% after deductible	50% after deductible
Immunizations (tetanus toxoid, rabies vaccine and meningococcal polysaccharide vaccine)	100% after deductible	50% after deductible ¹
PREVENTIVE SERVICES		
Routine Physical Exam	100% after deductible	50% after deductible ¹
Well Child Care Services to age nine. Well Child Care Exams are limited to a \$500 maximum per benefit period.		
Well Child Exam	100% after deductible	50% after deductible ¹
Well Child Immunizations	100%	100%
Well Child 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)	100% after deductible	50% after deductible
OUTPATIENT SERVICES		
Allergy Testing and Treatment	100% after deductible	50% after deductible ¹
Diagnostic Services	100% after deductible	50% after deductible
Surgery	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 maximum 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	100% after deductible	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 (30 days per benefit period)	100% after deductible	50% after deductible
ADDITIONAL SERVICES		
Ambulance (\$2,500 maximum per benefit period)	100% after deductible	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 ¹
Hospice	100% after deductible	50% after deductible ¹
Organ and Tissue Transplant ²	100% after deductible	50% after deductible
Diabetes Education	100% after deductible	50% after deductible
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Mental Health and Substance Abuse (\$7,000 maximum per benefit period) ³	50% after deductible ¹	50% after deductible ¹
Outpatient Mental Health and Substance Abuse (\$2,000 maximum per benefit period) ³	50% after deductible ¹	50% after deductible ¹
Transitional Treatment (\$3,000 maximum per benefit period) ³	50% after deductible ¹	50% after deductible ¹
PRESCRIPTION DRUG – ORAL CONTRACEPTIVES INCLUDED		
Prescription Drug Benefit Period Deductible ⁴ – Single/Family	\$250/\$500	
Benefit Period Maximum ⁵	\$2,000	
Retail — 30-day Supply	100% after deductible	
Mail Order — 90-day Supply	100% after deductible	
OPTIONAL RIDERS		
Prescription Drug Rider – Oral Contraceptives Included ⁶		
Retail – 30-day Supply	\$15 Generic / \$30 Formulary / \$45 Non-Formulary	
Mail Order – 90-day supply	\$30 Generic / \$60 Formulary / \$90 Non-Formulary	
Maternity Rider – Benefits payable after 270 days of coverage under maternity rider	100% after deductible	50% after deductible

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.

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⁶ Drug Benefit contains the following:

- Rx Selections® Drug List: A list of drugs on the Rx Selections formulary will be used.
- Generic Incentive: If the member or physician requests a brand-name drug, and a generic equivalent exists, the member pays the generic copayment PLUS the difference between the cost of the generic drug and the brand-name drug.
- Mail Order Incentive: When a member chooses to fill a prescription a fourth time at a retail pharmacy within 180 days, the member will pay twice the normal retail copayment.

PERSONAL HEALTH PLANS FROM CONSUMERS LIFE — COPAY OPTIONS

BENEFITS	500/1000	1000/2000	1500/3000
Benefit Period	January 1 through December 31		
Dependent Age Limit	19 Dependent; 23 Student; Removal upon End of Month		
Lifetime Maximum	\$2,500,000		
Benefit Period Deductible – Single/Family	\$500/\$1,000	\$1,000/\$2,000	\$1,500/\$3,000
Non-Network Benefit Period Deductible – Single/Family	\$1,000/\$2,000	\$2,000/\$4,000	\$3,000/\$6,000
	NETWORK	NON-NETWORK	
Coinsurance	80%	50%	
Coinsurance Out-of-Pocket Maximum – Single/Family	\$2,000/\$4,000	Unlimited	
PHYSICIAN/OFFICE SERVICES			
Office and Urgent Care Visits (Illness and Injury)	\$25 copay then 100%	50% after deductible	
Immunizations (tetanus toxoid, rabies vaccine and meningococcal polysaccharide vaccine)	80% after deductible	50% after deductible ¹	
PREVENTIVE SERVICES			
Routine Physical Exam	\$25 copay then 100%	50% after deductible ¹	
Well Child Care Services to age nine. Well Child Care Exams are limited to a \$500 maximum per benefit period.			
Well Child Exam	\$25 copay then 100%	50% after deductible ¹	
Well Child Immunizations	100%	100%	
Well Child 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)	80% after deductible	50% after deductible	
OUTPATIENT SERVICES			
Allergy Testing and Treatments	80% after deductible	50% after deductible ¹	
Diagnostic Services	80% after deductible	50% after deductible	
Surgery	80% after deductible	50% after deductible	
Physical, Speech and Occupational Therapy (20 visits per benefit period per therapy type)	\$25 copay then 80%	50% after deductible	
Chiropractic Services (12 visits per benefit period)	\$25 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	80% after deductible	80% after deductible	
Non-Emergency Use of a Hospital Emergency Room	80% after deductible	50% after deductible	
INPATIENT FACILITY			
Semi-Private Room and Board	80% after deductible	50% after deductible	
Skilled Nursing Facility (30 days per benefit period)	80% after deductible	50% after deductible	
ADDITIONAL SERVICES			
Ambulance Services (\$2,500 maximum per benefit period)	80% after deductible	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 ¹	
Hospice	80% after deductible	50% after deductible ¹	
Organ and Tissue Transplants ²	80% after deductible	50% after deductible	
Diabetes Education	80% after deductible	50% after deductible	
MENTAL HEALTH AND SUBSTANCE ABUSE			
Inpatient Mental Health and Substance Abuse (\$7,000 maximum per benefit period) ³	50% after deductible ¹	50% after deductible ¹	
Outpatient Mental Health and Substance Abuse (\$2,000 maximum per benefit period) ³	50% after deductible ¹	50% after deductible ¹	
Transitional Treatment (\$3,000 maximum per benefit period) ³	50% after deductible ¹	50% after deductible ¹	
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED			
Prescription Drug Benefit Period Deductible ⁴ – Single/Family	\$250/\$500		
Benefit Period Maximum ⁵	\$2,000		
Retail — 30-day Supply	80% after deductible		
Mail Order — 90-day Supply	80% after deductible		
OPTIONAL RIDERS			
Prescription Drug Rider – Oral Contraceptives Included ⁶			
Retail – 30-day Supply	\$15 Generic / \$30 Formulary / \$45 Non-Formulary		
Mail Order – 90-day supply	\$30 Generic / \$60 Formulary / \$90 Non-Formulary		
Maternity Rider – Benefits payable after 270 days of coverage under maternity rider	80% after deductible	50% after deductible	

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³ Inpatient Mental Health and Substance Abuse, Outpatient Mental Health and Substance Abuse and Transitional Treatment are limited to a combined \$7,000 maximum benefit period.

⁴ The Prescription Drug Benefit Period Deductible includes deductibles paid for both retail and mail order drugs.

⁵ The benefit period maximum is combined for both retail and mail order drugs.

⁶ Drug Benefit contains the following:

- Rx Selections® Drug List: A list of drugs on the Rx Selections formulary will be used.
- Generic Incentive: If the member or physician requests a brand-name drug, and a generic equivalent exists, the member pays the generic copayment PLUS the difference between the cost of the generic drug and the brand-name drug.
- Mail Order Incentive: When a member chooses to fill a prescription a fourth time at a retail pharmacy within 180 days, the member will pay twice the normal retail copayment.

PERSONAL HEALTH VALUE PLANS

BENEFITS	500/1000	1000/2000	1500/3000
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/\$1,000	\$1,000/\$2,000	\$1,500/\$3,000
Non-Network Benefit Period Deductible – Single/Family	\$1,500/\$3,000	\$2,000/\$4,000	\$2,500/\$5,000
Coinsurance Out-of-Pocket Maximum – Single/Family	\$3,500/\$7,000	\$4,000/\$8,000	\$4,500/\$9,000
Non-Network Coinsurance Out-of-Pocket Maximum – Single/Family	Unlimited	Unlimited	Unlimited
	NETWORK	NON-NETWORK	
Coinsurance	70%	50%	
PHYSICIAN/OFFICE SERVICES			
Office Visit (Illness and Injury)	70% after deductible	50% after deductible	
Urgent Care Office Visit	70% after deductible	50% after deductible	
Immunizations (tetanus toxoid, rabies vaccine and meningococcal polysaccharide vaccine)	70% after deductible	50% after deductible ¹	
PREVENTIVE SERVICES			
Routine Physical Exam		Not Covered	
Well Child Care Services to age nine. Well Child Care Exams are limited to a \$500 per child to age one; thereafter, \$150 per child from birth to age nine	70% after deductible	50% after deductible	
Well Child Exam	70% after deductible	50% after deductible	
Well Child Immunizations	100%	100%	
Well Child Labs	70% after deductible	70% 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 EKG, Chest X-ray, Comprehensive Metabolic panel, Urinalysis and complete blood count (one each per benefit period)		Not Covered	
OUTPATIENT SERVICES			
Allergy Testing and Treatments	70% after deductible	50% after deductible ¹	
Diagnostic Services	70% after deductible	50% after deductible	
Surgery	70% after deductible	50% after deductible	
Physical, Speech and Occupational Therapy (10 visits per benefit period per therapy type)	70% after deductible	50% after deductible	
Chiropractic Therapy (6 visits per benefit period)	70% after deductible	50% after deductible	
Emergency Use of a Hospital Emergency Room		70% after deductible	
Non-Emergency Use of a Hospital Emergency Room		Not Covered	
INPATIENT FACILITY			
Semi-Private Room and Board	70% after deductible	50% after deductible	
Skilled Nursing Facility (30 days per benefit period)	70% after deductible	50% after deductible	
ADDITIONAL SERVICES			
Ambulance Services (\$2,500 maximum per benefit period)	70% after deductible	70% after deductible	
Durable Medical Equipment	50% after deductible	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 ²	70% after deductible	50% after deductible	
Diabetes Education	70% after deductible	50% after deductible	
MENTAL HEALTH AND SUBSTANCE ABUSE			
Inpatient Mental Health and Substance Abuse (\$7,000 maximum per benefit period) ³	50% after deductible ¹	50% after deductible ¹	
Outpatient Mental Health and Substance Abuse (\$2,000 maximum per benefit period) ³	50% after deductible ¹	50% after deductible ¹	
Transitional Treatment (\$3,000 maximum per benefit period) ³	50% after deductible ¹	50% after deductible ¹	
PRESCRIPTION DRUG			
Benefit Period Maximum		\$500	
Retail — 30-day Supply		\$15 copay – Generic drugs only ⁴	
Mail Order		NOT COVERED	

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³ Inpatient Mental Health and Substance Abuse, Outpatient Mental Health and Substance Abuse and Transitional Treatment are limited to a combined \$7,000 maximum benefit period.

⁴ The 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.

PERSONAL HEALTH PLANS SHORT-TERM BENEFITS

BENEFITS	NETWORK	NON-NETWORK
Benefit Period	January 1 through December 31	
Dependent Age Limit	19 Dependent, 23 Student; 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	Unlimited
PHYSICIAN/OFFICE SERVICES		
Office and Urgent Care Visits	\$15 copay, then 100%	\$15 copay, then 50%
Immunizations (tetanus toxoid, rabies vaccine and meningococcal polysaccharide vaccine)	80% after deductible	50% after deductible ¹
PREVENTIVE SERVICES		
Well Child Care Services to age nine. Well Child Exams are limited to a \$500 maximum per benefit period.		
Well Child Exams	50% after deductible	50% after deductible
Well Child Immunizations	100%	100%
Well Child 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		
Allergy Testing and Treatments	80% after deductible	50% after deductible ¹
Diagnostic Services	80% after deductible	50% after deductible
Outpatient Surgery	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 (10 visits per benefit period)	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%	\$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%
Diabetes Education	80% after deductible	50% after deductible
Home Healthcare (60 visits per benefit period)	80% after deductible	50% after deductible ¹
Hospice	80% after deductible	50% after deductible ¹
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Mental Health and Substance Abuse (\$7,000 maximum per benefit period) ²	50% after deductible ¹	50% after deductible ¹
Outpatient Mental Health and Substance Abuse (\$2,000 maximum per benefit period) ²	50% after deductible ¹	50% after deductible ¹
Transitional Treatment (\$3,000 maximum per benefit period) ²	50% after deductible ¹	50% after deductible ¹
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED		
Prescription Drug Benefit Period Deductible ³	\$250/\$500	
Benefit Period Maximum ⁴	\$2,000	
Retail — 30-day Supply	80% after deductible	
Mail Order — 90-day Supply	80% after deductible	

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 coinsurance out-of-pocket maximum is met.

² Inpatient Mental Health and Substance Abuse, Outpatient Mental Health and Substance Abuse and Transitional Treatment are limited to a combined \$7,000 maximum benefit period.

³ The Prescription Drug Benefit Period Deductible includes deductibles paid for both retail and mail order drugs.

⁴ The benefit period maximum is combined for both retail and mail order drugs.

PERSONAL HEALTH PLANS VISION EYEMED ACCESS NETWORK

BENEFITS	NETWORK	NON-NETWORK ¹
Dependent Age Limit	19 Dependent, 23 Student; 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*
Anti-reflective coating	\$45
Glass	20% off retail price
Photochromic	20% off retail price
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 or medically necessary contact lenses.
2. Use the mail-order Vision One Contact Lens Replacement Program and apply discounts when ordering contacts by mail.

*Discounted price is in addition to the \$15 copayment listed above. Discounts available through EyeMed Access providers only.

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 contract or certificate will contain 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 provider.



PERSONAL HEALTH PLANS DENTAL BENEFITS

BENEFITS	NETWORK	NON-NETWORK
Benefit Period	January 1 through December 31	
Dependent Age Limit	19 Dependent, 23 Student; 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 and Adjustments of Prosthetics
- Simple Extractions
- Impactions
- Alveoplasty
- Minor Oral Surgery Services
- General Anesthesia
- Gold Foil Restoration
- Inlays, Onlays
- Crowns
- Bridgework (Pontics and 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 dental professionals, 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.

STANDARD AND SHORT-TERM 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.
- 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.
- 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.
- For treatment of a condition related to autistic disease of childhood, development delay, learning disabilities, hyperkinetic syndromes, behavioral problems or mental retardation, except as specified.
- For arch supports and other foot care or foot support devices used 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 artificial insemination or in vitro fertilization.
- For hypnosis and acupuncture.
- For fraudulent or misrepresented claims.
- 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).
- For Private Duty Nursing Services.

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

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. Refer to your certificate for a complete listing of healthcare benefits. Benefits will be determined based on Consumers Life Insurance Company medical and administrative policies and procedures.

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.

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.

