

## Georgia 80% HSA Plans

Base Plan	HSA 1200	HSA 2200
Network Benefit Period Deductible — Single/Family <sup>1</sup>	\$1,200/\$2,400	\$2,200/\$4,400
Non-Network Benefit Period Deductible — Single/Family <sup>1</sup>	\$2,400/\$4,800	\$4,400/\$8,800
Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) — Single/Family <sup>2</sup>	\$2,000/\$4000	\$2,000/\$4000
Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) — Single/Family <sup>2</sup>	\$4,000/\$8,000	\$4,000/\$8,000
Coinsurance – Network/Non-Network	80% / %60	
Overall Annual Benefit Period Maximum	\$2,500,000	

Benefits	PPO Network	Non-PPO Network
Benefit Period	January 1 <sup>st</sup> through December 31 <sup>st</sup>	
Dependent Age Limit	26; Removal upon End of the Month	
<b>Physician/Office Services</b>		
Office & Urgent Care Visits (Illness/Injury)	80% after deductible	60% after deductible
Standard Immunizations	80% after deductible	60% after deductible
<b>Preventive Services</b>		
Routine Physical Exam (\$250 maximum per benefit period)	80%	60%
Well Child Care Services (to age six) Well Child Care Exams, Immunizations & Labs	80%	60%
Well Child Care Services (ages six to nine) Exams and Well Child Immunizations are limited to a \$500 maximum per benefit period. Well Child Care Exams, Immunizations & Labs	80% after deductible	60% after deductible
Routine Mammogram (one per benefit period)	80% after deductible	60% after deductible
Routine Pap Tests	80% after deductible	60% after deductible
Routine Flu Vaccine	80% after deductible	60% after deductible
Routine Cholesterol, Colon Cancer Screening Tests, Endoscopic Services, Ovarian Cancer Screening, PSA Test, Chlamydia Screening and Bone Density Testing	80% after deductible	60% after deductible
Routine EKG, chest X-ray, comprehensive metabolic panel, urinalysis and complete blood count (one each per benefit period)	80% after deductible	60% after deductible
<b>Outpatient Services</b>		
Allergy Testing and Treatments	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 Rehab (20 visits per benefit period)	80% after deductible	60% after deductible
Emergency Use of an Emergency Room	80% after deductible	
Non-Emergency Use of an Emergency Room	80% after deductible	60% after deductible
Surgical Services	80% after deductible	60% after deductible
Diagnostic Services	80% after deductible	60% after deductible

Benefits	PPO Network	Non-PPO Network
<b>Inpatient Services</b>		
Semi-Private Room and Board	80% after deductible	60% after deductible
Skilled Nursing Facility (30 days per benefit period)	80% after deductible	60% after deductible
<b>Additional Services</b>		
Ambulance (\$2,500 Maximum per benefit period)	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	60% after deductible
Hospice (\$10,000 lifetime maximum)	80% after deductible	60% after deductible
Organ and Tissue Transplants	80% after deductible	60% after deductible
Diabetic Education and Training	80% after deductible	60% after deductible
<b>Mental Health &amp; Substance Abuse</b>		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; limited to one admission per benefit period and three admissions per lifetime)	80% after deductible	60% after deductible
Outpatient Mental Health and Substance Abuse Services (48 visits per benefit period)	80% after deductible	60% after deductible
<b>Prescription Drug – Oral Contraceptives Included (Failure to present an ID card may result in increased cost.)</b>		
Retail – 90 Day Supply	80% after deductible	
Home Delivery – 90 Day Supply	80% after deductible	

*This document is not a contract of insurance. It is a partial listing of healthcare benefits. Refer to your certificate for a complete listing of healthcare benefits. Benefits are determined based on Consumers Life Insurance Company's medical and administrative policies and procedures. No person other than an officer of Consumers Life Insurance Company may agree, orally or in writing, to change the benefits listed here. The contract or certificate will contain the complete listing of covered services. In certain instances, Consumers Life Insurance Company payment may not equal the percentage listed in these charts. However, the covered person's coinsurance will always be based on the lesser of the provider's billed charges or Consumers Life Insurance Company's negotiated rate with the provider.*

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

The coinsurance for non-contracting institutional providers will be the same coinsurance percentage as the Non PPO Network provider. However, you may be subject to balance billing by the non-contracting provider.

The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Consumers Life Case Manager (except for corneal transplants).

Failure to contact Care Management prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

1 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.