

PERSONAL HEALTH PLANS



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

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PERSONAL HEALTH PLANS FROM CONSUMERS LIFE – 3080 AND 4080 PLANS

BENEFITS	500	750	1000	1500
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	\$500/\$1500	\$750/\$2250	\$1000/\$3000	\$1500/\$4500
Non Network Benefit Period Deductible - Single/Family	\$1000/\$3000	\$1500/\$4500	\$2000/\$6000	\$3000/\$9000
Office Visit Copay Option	\$30 or \$40			
	NETWORK		NON-NETWORK	
Coinsurance	80%		60%	
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	\$2000/\$6000		Unlimited	
PHYSICIAN/OFFICE SERVICES				
Office and Urgent Care Visit (Illness/Injury)	Office visit 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)	Office visit copay then 100%		60% after deductible	
Well Child Care Services to age six.				
Exams	Office visit copay, then 100%		60%	
Immunizations and Labs	100%		60%	
Well Child Care Services ages six to nine. (Exams and Well Child Immunizations are limited to \$500 maximum per benefit period).				
Exams	Office visit copay, then 100%		60% after deductible	
Immunizations and Labs	100%		60% after deductible	
Routine Flu Vaccine	80% after deductible		70%	
Routine Mammogram (One per benefit period)	100%		70%	
Routine Pap Test	100%		70%	
Routine PSA and Chlamydia Screening	100%		100%	
Routine Cholesterol, Colon Cancer Screening Test, Endoscopic Procedures, Ovarian Cancer 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	
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	
Surgical Services	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 (20 visits benefit period)	80% after deductible		60% after deductible	
Emergency Use of an Emergency Room	\$150 copay, then 80% after deductible			
Non-Emergency Use of an Emergency Room	\$150 copay, then 80% after deductible		\$150 copay, then 60% 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		60% after deductible	
ADDITIONAL SERVICES				
Ambulance Service (\$2500 maximum per benefit period)	80% after deductible			
Diabetic Education and Training	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	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		60% after deductible	
Outpatient Mental Health/Substance Abuse (48 visits per benefit period)	Office visit copay, then 100%		60% after deductible	
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED				
Prescription Drug Benefit Period Deductible ³ (Single/Family)	\$200/\$600			
Retail - 30 Day Supply	\$15 Generic / \$30 Formulary / 50% of cost, Non-Formulary (\$45 minimum, \$90 maximum)			
Home Delivery - 90 Day Supply	\$37.50 Generic / \$75 Formulary / \$112.50 Non-Formulary			
OPTIONAL COVERAGE (AT AN ADDITIONAL PREMIUM)				
Maternity Option - Benefits are payable after 270 days of coverage under Maternity Option	80% after deductible		60% after deductible	

STSBPCM-GAIP2406 (without MH)
STSBPCM-GAIP2407 (with MH)
STSBPCM-GAIPS
STP-2100-GA/IPNGY (Rx)
STP-GAIPS (Rx)

PERSONAL HEALTH PLANS FROM CONSUMERS LIFE — 4070 PLANS

BENEFITS	1000	2000	3500	5000
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	\$1,000/\$3,000	\$2,000/\$6,000	\$3,500/\$10,500	\$5000/\$15,000
Non Network Benefit Period Deductible - Single/Family	\$2,000/\$6,000	\$4000/\$12,000	\$7,000/\$21,000	\$10,000/\$30,000
Prescription Drug Plan Deductible - Single/Family	\$200/\$600	\$200/\$600	\$350/\$1,050	\$500/\$1,500
	NETWORK		NON-NETWORK	
Coinsurance	70%		60%	
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	\$2,000/6,000		Unlimited	
PHYSICIAN/OFFICE SERVICES				
Office and Urgent Care Visit (Illness/Injury)	\$40 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)	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. Exams, 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). Exams, 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%		100%	
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	\$150 copay, then 70% after deductible			
Non-Emergency Use of an Emergency Room	\$150 copay, then 70% after deductible		\$150 copay, then 60% after deductible	
Surgical Services	70% after deductible		60% 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		60% after deductible	
Diabetic Education and Training	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	70% after deductible		60% after deductible	
SUBSTANCE ABUSE				
Inpatient and Outpatient Substance Abuse	Not Covered			
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED¹				
Prescription Drug Benefit Period Deductible (Single/Family)	See deductibles listed above.			
Retail - 30 Day Supply	\$15 Generic / \$30 Formulary / 50% of cost, Non-Formulary (\$45 minimum, \$90 maximum)			
Home Delivery - 90 Day Supply	\$37.50 Generic / \$75 Formulary / \$112.50 Non-Formulary			
OPTIONAL RIDERS (AT AN ADDITIONAL PREMIUM)				
Mental Health	70% after deductible		70% after deductible	
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	

STSBPCM-GAIP2406 (without MH)
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PERSONAL HEALTH PLANS FROM CONSUMERS LIFE – 4070 PLANS

BENEFITS		10000	
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	\$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 and Urgent Care Visit (Illness/Injury)	\$40 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)	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. Exams, 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). Exams, 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%	100%	
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	
Surgical Services	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 (20 visits benefit period)	70% after deductible	60% after deductible	
Emergency Use of an Emergency Room	\$150 copay, then 70% after deductible		
Non-Emergency Use of an Emergency Room	\$150 copay, then 70% after deductible	\$150 copay, then 60% 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	60% after deductible	
ADDITIONAL SERVICES			
Ambulance Service (\$2500 maximum per benefit period)	70% after deductible		
Diabetic Education and Training	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	70% after deductible	
MENTAL HEALTH AND SUBSTANCE ABUSE			
Inpatient and Outpatient Substance Abuse	Not Covered		
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED			
Prescription Drug Benefit Period Deductible (Single/Family)	\$1,000/\$3,000		
Retail - 30 Day Supply	\$15 Generic / \$30 Formulary / 50% of cost, Non-Formulary (\$45 minimum, \$90 maximum)		
Home Delivery - 90 Day Supply	\$37.50 Generic / \$75 Formulary / \$112.50 Non-Formulary		
OPTIONAL RIDERS (AT AN ADDITIONAL PREMIUM)			
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	

STSBPCM-GAIP2406 (without MH)
 STSBPCM-GAIP2407 (with MH)
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 STP-GAIPS (Rx)

PERSONAL HEALTH PLANS — HEALTH SAVINGS ACCOUNT COMPATIBLE PLANS

BENEFITS	HSA 1200	HSA 2200
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	\$1,200/\$2,400	\$2,200/\$4,400
Non-Network Benefit Period Deductible - Single/Family	\$2,400/\$4,800	\$4,400/\$8,800
	NETWORK	NON-NETWORK
Coinsurance	80%	60%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	\$2,000/\$4,000	\$4,000/\$8,000
PHYSICIAN/OFFICE SERVICES		
Office and Urgent Care Visit (Illness/Injury)	80% after deductible	60% 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)	80%	60%
Well Child Care Services to age six. Exams, Immunizations and Labs	80%	60%
Well Child Care Services ages six to nine. (Exams and Well Child Immunizations are limited to \$500 maximum per benefit period). Exams, Immunizations and Labs	80% after deductible	60% after deductible
Routine Flu Vaccine	80% after deductible	60% after deductible
Routine Mammogram (One per benefit period)	80% after deductible	60% after deductible
Routine Pap Test	80% after deductible	60% after deductible
Routine Cholesterol, Colon Cancer Screening Test, Endoscopic Procedures, Ovarian Cancer Screening, Bone Density Testing, PSA and Chlamydia	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
OUTPATIENT SERVICES		
Allergy Testing and Treatment	80% after deductible	60% after deductible
Diagnostic Services	80% after deductible	60% after deductible
Surgical Services	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	80% after deductible	
Non-Emergency Use of an Emergency Room	80% after deductible	60% 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	60% after deductible
ADDITIONAL SERVICES		
Ambulance Service (\$2500 maximum per benefit period)	80% after deductible	60% after deductible
Diabetic Education and Training	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Home Healthcare (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 Transplant	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	60% after deductible
Outpatient Mental Health/Substance Abuse (48 visits per benefit period)	80% after deductible	60% after deductible
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED¹		
Retail - 90 Day Supply	80% after deductible	
Home Delivery - 90 Day Supply	80% after deductible	

STSBPCM-GAIP2404 (without agg ded) and STSBPCM-GAIP2405 (with agg ded)
STP-2100-GA/IPNGY (Rx), STP-GAIPS (Rx) and STSBPCM-GAIPS

PERSONAL HEALTH PLANS — HEALTH SAVINGS ACCOUNT COMPATIBLE PLANS

BENEFITS	HSA 2500	HSA 3000	HSA 4000	HSA 5000
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	\$2,500/\$5,000	\$3,000/\$6,000	\$4,000/\$8,000	\$5,000/\$10,000
Non-Network Benefit Period Deductible - Single/Family	\$5,000/\$10,000	\$6,000/\$12,000	\$8,000/\$16,000	\$10,000/\$20,000
	NETWORK		NON-NETWORK	
Coinsurance	100%		70%	
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	N/A		\$4,000/\$8,000	
PHYSICIAN/OFFICE SERVICES				
Office and Urgent Care Visit (Illness/Injury)	100% after deductible		70% after deductible	
Immunizations (tetanus toxoid, rabies vaccine and meningococcal polysaccharide vaccine)	100% after deductible		70% after deductible	
PREVENTIVE SERVICES				
Routine Physical Exam (\$250 maximum per benefit period)	100%		70%	
Well Child Care Services to age six. Exams, Immunizations and Labs	100%		70%	
Well Child Care Services ages six to nine. (Exams and Well Child Immunizations are limited to \$500 maximum per benefit period). Exams, Immunizations and Labs	100% after deductible		70% after deductible	
Routine Flu Vaccine	100% after deductible		70% after deductible	
Routine Mammogram (One per benefit period)	100% after deductible		70% after deductible	
Routine Pap Test	100% after deductible		70% after deductible	
Routine Cholesterol, Colon Cancer Screening Test, Endoscopic Procedures, Ovarian Cancer Screening, Bone Density Testing, PSA and Chlamydia Screening	100% after deductible		70% after deductible	
Routine EKG, chest X-ray, comprehensive metabolic panel, urinalysis and complete blood count (one each per benefit period)	100% after deductible		70% after deductible	
OUTPATIENT SERVICES				
Allergy Testing and Treatment	100% after deductible		70% after deductible	
Diagnostic Services	100% after deductible		70% after deductible	
Physical Therapy, Occupational Therapy and Chiropractic Services (30 visits combined per benefit period)	100% after deductible		70% after deductible	
Speech Therapy (30 visits per benefit period)	100% after deductible		70% after deductible	
Cardiac Rehabilitation (20 visits benefit period)	100% after deductible		70% after deductible	
Emergency Use of an Emergency Room	100% after deductible			
Non-Emergency Use of an Emergency Room	100% after deductible		70% after deductible	
INPATIENT FACILITY				
Semi-private Room and Board	100% after deductible		70% after deductible	
Skilled Nursing Facility (30 days per benefit period)	100% after deductible		70% after deductible	
ADDITIONAL SERVICES				
Ambulance Service (\$2500 maximum per benefit period)	100% after deductible		70% after deductible	
Diabetic Education and Training	100% after deductible		70% after deductible	
Durable Medical Equipment	100% after deductible		70% after deductible	
Home Healthcare (100 visits per benefit period)	100% after deductible		70% after deductible	
Hospice (\$10,000 lifetime maximum)	100% after deductible		70% after deductible	
Organ and Tissue Transplant	100% after deductible		70% 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	100% after deductible		70% after deductible	
Outpatient Mental Health/Substance Abuse (48 visits per benefit period)	100% after deductible		70% after deductible	
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED¹				
Retail - 90 Day Supply				
Home Delivery - 90 Day Supply	100% after deductible			
	100% after deductible			

STSBPCM-GAIP2404 (without agg ded) and STSBPCM-GAIP2405 (with agg ded)
STP-2100-GA/IPNGY (Rx), STP-GAIPS (Rx) and STSBPCM-GAIPS

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

*at an additional premium
 STV-GAIP-0000R (vision)
 STV-GAIP-0001S (vision)
 STD-GAIP-0000R (dental)
 STD-GAIP-0000S (dental)

STANDARD 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, except as mandated by state or federal law. If a drug is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration and criteria mandated by state law is met, coverage will be provided.
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, unless legally required to pay.
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.
16. For Surgery to correct a deformity or birth defect for psychological reasons where there is no function impairment except for newly born children or adopted children that require necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.
17. For the removal of tattoos.
18. For dietary and/or nutritional guidance or training, except as specified.
19. For Outpatient educational, vocational or training purposes except for coverage for training materials and education related to diabetes as mandated by state or federal law.
20. For treatment of Conditions related to developmental delay, learning disabilities, hyperkinetic syndromes, behavioral problems or mental retardation, except as specified.
21. For topical anesthetics, unless on the advice of a Physician.
22. For minor nonoperative endoscopic procedures which include, but are not limited to, anoscopy.
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 services for normal pregnancy and elective abortions unless the maternity services option is elected.
35. For treatments associated with teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) Surgery, except as specified.
36. For oral implants considered part of a dental process or dental treatment including preparation of the mouth for any type of dental prosthetic except when due to trauma, accident or as deemed Medically Necessary by Consumers Life.
37. For treatment with intraoral prosthetic devices or by any other method, to alter vertical dimension.
38. For treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis.
39. For personal hygiene and convenience items.
40. For eyeglasses, contact lenses or examinations for prescribing or fitting them, except those for aphakic patients, keratoconus, and soft lenses or sclera shells for use as corneal bandages when needed as a result of Surgery.
41. For any surgical procedure for the correction of a visual refractive problem including, but not limited to, radial keratotomy and LASIK (laser in situ keratomileusis).
42. For all services related to hearing loss including hearing aids or examinations for prescribing or fitting them.
43. For immunizations, other than those specified as covered in the Routine and Wellness Services section of the Policy.
44. For massotherapy or massage therapy.
45. For hypnosis and acupuncture.
46. For After Hours Care.
47. For missed appointments, completion of claim forms or copies of medical records.

STANDARD BENEFIT EXCLUSIONS AND LIMITATIONS (CONT'D)

48. For fraudulent misstatements or claims related to the specific type of loss or disability for which the claim is made.
49. For blood which is available without charge. For Outpatient blood storage services.
50. For Prescription Drugs, except as specified.
51. For over the counter drugs, vitamins or herbal remedies.
52. For Private Duty Nursing Services.
53. For specialized camps.
54. For Routine Services, except as specified.
55. For non-covered services or services specifically excluded in the text of the Policy

Additional Exclusions and Limitations for Vision, Dental and Prescription Drug Benefits

Vision Exclusions:

1. For diagnostic services, drugs or medications not part of a vision examination
2. For medical or surgical treatment.
3. That Consumers Life determines are special or unusual; such as orthoptics, vision training and low vision aids.
4. For the replacement of Lenses or Frames except as specified in the Schedule of Benefits.
5. For Lenses which are not prescribed.
6. For safety glass and safety goggles.
7. For tints other than Number One or Two.
8. For tints with photosensitive or antireflective properties.
9. For an eye examination, or materials ordered as a result of an eye examination, prior to your Effective Date.

Dental Exclusions:

1. For charges in excess of the amount Consumers Life determines to be allowable.
2. Rendered by more than one Dental Provider. If you change Dental Providers during a Course of Treatment or if more than one Dental Provider treats you for a procedure, additional benefits are not provided.
3. For appliances or restorations needed to increase the vertical dimension or to restore or correct the occlusion.
4. For the repair of a damaged space maintainer or replacement of a lost or stolen space maintainer.
5. For endodontics, including pulpotomy, pulp capping and root canal treatment.
6. For diagnostic x-rays.
7. For periodontal scaling and root planing.
8. For inlays.
9. For onlays.
10. For crowns that are not part of a fixed partial denture, including stainless steel crowns.
11. For extractions.
12. For apicoectomy (surgical removal of the apex of the tooth root).
13. For alveolectomy (surgery performed on the alveolar bone, including flap entry and closure).
14. For vestibuloplasty.
15. For removal of gum tissue around the necks of the teeth and the recontouring of the gum tissue.
16. For procedures to prevent and treat diseases of the pulp and gums.
17. For dentures, full and partial.
18. For denture adjustments and relining.
19. For fixed partial dentures (bridges), fixed and removable.
20. For repair of prosthetics (dentures, crowns, partial fixed dentures).
21. For general anesthesia.
22. Related to Othodontic treatment.

Formulary/Non-Formulary Prescription Drug Exclusions:

1. For any medication prescribed to induce ovulation or spermatogenesis.
2. For drugs dispensed for cosmetic purposes; used solely for beautifying or altering one's appearance in the absence of any underlying Condition.
3. For therapeutic devices.
4. For artificial appliances.
5. For disposable insulin needles and syringes which are not prescribed.
6. For hypodermic needles, syringes or comparable devices or appliances, except as specified.
7. For drugs you can buy without a Prescription Order.
8. For more than the number of Prescription Drug refills specified by the Physician.
9. For any refill of a Prescription Drug dispensed after one year from the date of the original Prescription Order.
10. For charges for more than the days supply of a Prescription Drug, as specified in the Prescription Drug Schedule of Benefits unless the Prescription Drug is a prescribed inhalant used in the treatment of asthma and other life-threatening bronchial ailments.
11. For a Prescription Drug which is entirely consumed or administered at the time and place where the Prescription Order is issued.
12. For fees for administering or injecting Prescription Drugs.

NOTES:

This amount of benefits provided depends upon the plan selected. Premiums will vary with the amount of benefits selected.

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 **Drug benefit contains the following:** Rx Selections® drug list: A list of drugs on the Rx Selections formulary list will be used.
- 2 **Maximum family deductible.** Family deductible must be met before benefits are provided on a family contract. The single deductible applies to single contracts.
- 3 **Maximum family coinsurance out-of-pocket.** Family coinsurance out-of-pocket must be met before all benefits are paid at 100 percent on a family contract. The single coinsurance out-of-pocket applies to single contracts.

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