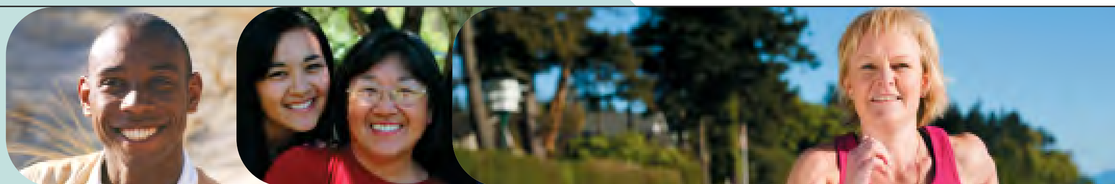
PRODUCTS AND SERVICES



Small-Group Health Insurance

CONSUMERS LIFE INSURANCE COMPANY®
A MEDICAL MUTUAL OF OHIO COMPANY

CONSUMERS LIFE INSURANCE COMPANY

Georgia
2580 Plan
Accident & Sickness Coverage

Base Plan	2580-500
Network Benefit Period Deductible — Single/Family	$500/$1,500
Non-Network Benefit Period Deductible – Single/Family	$1,000/$3,000
Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	$2,000/$6,000
Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	$8,000/$24,000
Coinsurance – Network/Non-Network	80% / 60%
Office Visit (OV) Copay Network/Non-Network	$25 / $35
Lifetime Maximum	$5,000,000

Benefits	PPO Network	Non-PPO Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	26; Removal upon End of the Month	
Physician/Office Services		
Office & Urgent Care Visits (Illness/Injury)	OV copay, then 100%	OV copay, then 70%
Diagnostic Services in a Physician's Office	100%	70% after deductible
Standard Immunizations	100%	70% after deductible
Preventive Services		
Routine Physical Exam	OV copay, then 100%	OV copay, then 70%
Well Child Care Services (To age 6) Well Child Exams Well Child Immunizations and Labs	OV copay, then 100% 100%	70%
Well Child Care Services (Ages 6 to 9) Exams & Immunizations are limited to a $500 maximum per benefit period. Well Child Care exams Well Child Immunizations and Labs	OV copay, then 100% 100%	70% after deductible
Routine Mammogram (one per benefit period)	100%	70% after deductible
Routine Pap Tests	100%	70% after deductible
Routine PSA (age 40 and over) Cholesterol, Colon Cancer Screening, Endoscopic Services, Ovarian Cancer Screening, Chlamydia Screening and Bone Density Testing	100%	70% after deductible
Routine Colonoscopies (no medical diagnosis)	100%	70% after deductible
Routine EKG, Chest X-ray, Comprehensive Metabolic panel, Urinalysis and Complete Blood Count (one each per benefit period)	100%	70% after deductible
Outpatient Services		
Allergy Testing and Treatments	coinsurance after deductible	coinsurance after deductible
Physical & Occupational Therapy (40 visits per benefit period)	$50 copay, then 100%	$60 copay, then 70%
Speech Therapy (20 visits per benefit period)	$50 copay, then coinsurance	$60 copay, then 70%

Georgia
2580 Plan
Accident & Sickness Coverage

Benefits	PPO Network	Non-PPO Network
Chiropractic Services (12 visits per benefit period)	$50 copay, then coinsurance	$60 copay, then 70%
Cardiac Rehab (20 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Emergency Use of an Emergency Room	$150 copay, then coinsurance	
Non-Emergency Use of an Emergency Room	$300 copay, then coinsurance	$300 copay, then coinsurance
Emergency Services	coinsurance after deductible	
Surgical Services	coinsurance after deductible	coinsurance after deductible
Diagnostic Services (other than a physician's office)	coinsurance after deductible	coinsurance after deductible
Colonoscopies (with medical diagnosis)	coinsurance after deductible	coinsurance after deductible
Inpatient Services		
Semi-Private Room and Board	coinsurance after deductible	coinsurance after deductible
Skilled Nursing Facility (100 days per benefit period)	coinsurance after deductible	coinsurance after deductible
Additional Services		
Ambulance	$50 copay, then coinsurance	$50 copay, then coinsurance
Durable Medical Equipment ($5,000 maximum per benefit period)	coinsurance after deductible	coinsurance after deductible
Home Health Care (120 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Hospice ($10,000 lifetime maximum)	coinsurance after deductible	coinsurance after deductible
Organ and Tissue Transplants	coinsurance after deductible	coinsurance after deductible
TMJ Services ($15,000 lifetime maximum)	coinsurance after deductible	coinsurance after deductible
Diabetic Education and Training	coinsurance after deductible	coinsurance after deductible
Private Duty Nursing ($1,000 maximum per benefit period)	coinsurance after deductible	coinsurance after deductible
Mental Health & Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period with a 6 day limit for detox)	coinsurance after deductible	coinsurance after deductible
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	$50 copay, then 100%	$60 copay, then 70%
Prescription Drug – Choose one of the freestanding drug options available. Premium varies by the option 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 expenses incurred for services by a PPO Network provider will only apply to the PPO Network deductible. Deductible expenses incurred for services by a Non PPO Network provider will only apply to the Non PPO Network deductible.

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

Consumers Life Insurance Company
2060 East 9th Street
Cleveland, OH 44115-2263
Visit ConsumersLife.com
877/254-2669

MEDICAL 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. This does not apply, however, if in accordance with federal law, this coverage is primary and Medicare is the secondary payer of your health care expenses.
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.
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 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 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.
23. For weight loss drugs.
24. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss.
25. For weight loss Surgery including complications related to this Surgery.
26. For water aerobics.
27. For residential care rendered by a Residential Treatment Facility, except as specified.
28. For marital counseling.
29. For the medical treatment of sexual problems not caused by a biological Condition.
30. For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
31. For reverse sterilization.
32. For artificial insemination or in vitro fertilization.
33. For any medication prescribed to induce ovulation or spermatogenesis.
34. 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.
35. For treatments associated with teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) Surgery, except as specified.
36. For treatment with intraoral prosthetic devices or by any other method, to alter vertical dimension.
37. For treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis.

Medical Benefit Exclusions and Limitations (cont'd)

38. For personal hygiene and convenience items.
39. 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.
40. 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).
41. For all services related to hearing loss including hearing aids or examinations for prescribing or fitting them.
42. For immunizations, other than those specified as covered in the Routine and Wellness Services section of the Certificate.
43. For massotherapy or massage therapy.
44. For hypnosis and acupuncture.
45. For After Hours Care.
46. For telephone consultations, online consultations, missed appointments, completion of claim forms or copies of medical records.
47. For fraudulent or misrepresented claims.
48. For blood which is available without charge. For Outpatient blood storage services.
49. For Prescription Drugs, except as specified.
50. For over the counter drugs, vitamins or herbal remedies.
51. For specialized camps.
52. For Routine Services, except as specified.
53. For non-covered services or services specifically excluded in the text of the Certificate.

Preexisting Condition Definition and Exclusion Period

Preexisting Condition means any physical or mental Condition, sickness, impairment or ailment, regardless of cause, for which medical advice, diagnosis, care or treatment was received within the six month period ending on the effective date of coverage under a group health plan, the date of enrollment under a group health insurance plan or the first date of a waiting period for a group health insurance plan, whichever is earliest. In no case shall any of the following be considered a preexisting Condition: (1) pregnancy, or (2) genetic information in the absence of a diagnosis related to such information.

If a Preexisting Condition existed at any time during the six (6) month period immediately preceding your Enrollment Date, Consumers Life will provide benefits for the Preexisting Condition for Covered Services Incurred after twelve (12) months following your Enrollment Date.

If you had other health care coverage prior to your Enrollment Date, and you did not experience a Significant Break in Coverage, your prior coverage will be credited toward the twelve (12) month exclusion period. A Significant Break in Coverage is a period of 90 consecutive days during which you did not have any other health care coverage, except that waiting periods are carved out. The standard method, which does not consider specific benefits, is used to determine creditable coverage.

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Georgia
3080 Plans
Accident & Sickness Coverage

Base Plan	3080-1000	3080-1500	3080-2000	3080-2500	3080-3000	3080-5000
Network Benefit Period Deductible — Single/Family	$1,000/$3,000	$1,500/$4,500	$2,000/$6,000	$2,500/$7,500	$3,000/$9,000	$5,000/$15,000
Non-Network Benefit Period Deductible – Single/Family	$2,000/$6,000	$3,000/$9,000	$4,000/$12,000	$5,000/$15,000	$6,000/$18,000	$10,000/$30,000
Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	$2,000/$6,000			$3,000/$9,000		
Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	$8,000/$24,000			$12,000/$24,000		
Coinsurance – Network/Non-Network	80%/ 60%					
Office Visit (OV) Copay Network/Non-Network	$30/ $40					
Lifetime Maximum	$5,000,000					

Benefits	PPO Network	Non-PPO Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	26; Removal upon End of the Month	
Physician/Office Services		
Office & Urgent Care Visits (Illness/Injury)	OV copay, then 100%	OV copay, then 70%
Diagnostic Services in a Physician's Office	100%	70% after deductible
Standard Immunizations	100%	70% after deductible
Preventive Services		
Routine Physical Exam	OV copay, then 100%	OV copay, then 70%
Well Child Care Services (To age 6) Well Child Exams Well Child Immunizations and Labs	100%	70% after deductible
Well Child Care Services (Ages 6 to 9) Exams & Immunizations are limited to a $500 maximum per benefit period. Well Child Care exams Well Child Immunizations and Labs	OV copay, then 100% 100%	70% after deductible
Routine Mammogram (one per benefit period)	100%	70% after deductible
Routine Pap Tests	100%	70% after deductible
Routine PSA (age 40 and over), Cholesterol, Colon Cancer Screening, Endoscopic Services, Ovarian Cancer Screening, Chlamydia Screening and Bone Density Testing	100%	70% after deductible
Routine Colonoscopies (no medical diagnosis)	100%	70% after deductible
Routine EKG, Chest X-ray, Comprehensive Metabolic panel, Urinalysis and Complete Blood Count (one each per benefit period)	100%	70% after deductible
Outpatient Services		
Allergy Testing and Treatments	coinsurance after deductible	coinsurance after deductible
Physical & Occupational Therapy (40 visits per benefit period)	$50 copay, then 100%	$60 copay, then 70%
Speech Therapy (20 visits per benefit period)	$50 copay, then 100%	$60 copay, then 70%

Georgia
3080 Plans
Accident & Sickness Coverage

Benefits	PPO Network	Non-PPO Network
Chiropractic Services (12 visits per benefit period)	$50 copay, then 100%	$60 copay, then 70%
Cardiac Rehab (20 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Emergency Use of an Emergency Room	$150 copay, then coinsurance	
Non-Emergency Use of an Emergency Room	$300 copay, then coinsurance	$300 copay, then coinsurance
Emergency Services	coinsurance after deductible	
Surgical Services	coinsurance after deductible	coinsurance after deductible
Diagnostic Services (other than a physician's office)	coinsurance after deductible	coinsurance after deductible
Colonoscopies (with medical diagnosis)	coinsurance after deductible	coinsurance after deductible
Inpatient Services		
Semi-Private Room and Board	coinsurance after deductible	coinsurance after deductible
Skilled Nursing Facility (100 days per benefit period)	coinsurance after deductible	coinsurance after deductible
Additional Services		
Ambulance	$50 copay, then coinsurance	$50 copay, then coinsurance
Durable Medical Equipment ($5,000 maximum per benefit period)	coinsurance after deductible	coinsurance after deductible
Home Health Care (120 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Hospice ($10,000 lifetime maximum)	coinsurance after deductible	coinsurance after deductible
Organ and Tissue Transplants	coinsurance after deductible	coinsurance after deductible
TMJ Services ($15,000 lifetime maximum)	coinsurance after deductible	coinsurance after deductible
Diabetic Education and Training	coinsurance after deductible	coinsurance after deductible
Private Duty Nursing ($1,000 maximum per benefit period)	coinsurance after deductible	coinsurance after deductible
Mental Health & Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period with a 6 day limit for detox)	coinsurance after deductible	coinsurance after deductible
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	$50 copay, then 100%	$60 copay, then 70%
Prescription Drug – Choose one of the freestanding drug options available. Premium varies by the option selected.		

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

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

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Medical Benefit Exclusions and Limitations

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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. This does not apply, however, if in accordance with federal law, this coverage is primary and Medicare is the secondary payer of your health care expenses.
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.
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 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 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.
23. For weight loss drugs.
24. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss.
25. For weight loss Surgery including complications related to this Surgery.
26. For water aerobics.
27. For residential care rendered by a Residential Treatment Facility, except as specified.
28. For marital counseling.
29. For the medical treatment of sexual problems not caused by a biological Condition.
30. For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
31. For reverse sterilization.
32. For artificial insemination or in vitro fertilization.
33. For any medication prescribed to induce ovulation or spermatogenesis.
34. 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.
35. For treatments associated with teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) Surgery, except as specified.
36. For treatment with intraoral prosthetic devices or by any other method, to alter vertical dimension.
37. For treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis.

MEDICAL BENEFIT EXCLUSIONS AND LIMITATIONS (CONT'D)

38. For personal hygiene and convenience items.
39. 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.
40. 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).
41. For all services related to hearing loss including hearing aids or examinations for prescribing or fitting them.
42. For immunizations, other than those specified as covered in the Routine and Wellness Services section of the Certificate.
43. For massotherapy or massage therapy.
44. For hypnosis and acupuncture.
45. For After Hours Care.
46. For telephone consultations, online consultations, missed appointments, completion of claim forms or copies of medical records.
47. For fraudulent or misrepresented claims.
48. For blood which is available without charge. For Outpatient blood storage services.
49. For Prescription Drugs, except as specified.
50. For over the counter drugs, vitamins or herbal remedies.
51. For specialized camps.
52. For Routine Services, except as specified.
53. For non-covered services or services specifically excluded in the text of the Certificate.

PREEXISTING CONDITION DEFINITION AND EXCLUSION PERIOD

Preexisting Condition means any physical or mental Condition, sickness, impairment or ailment, regardless of cause, for which medical advice, diagnosis, care or treatment was received within the six month period ending on the effective date of coverage under a group health plan, the date of enrollment under a group health insurance plan or the first date of a waiting period for a group health insurance plan, whichever is earliest. In no case shall any of the following be considered a preexisting Condition: (1) pregnancy, or (2) genetic information in the absence of a diagnosis related to such information.

If a Preexisting Condition existed at any time during the six (6) month period immediately preceding your Enrollment Date, Consumers Life will provide benefits for the Preexisting Condition for Covered Services Incurred after twelve (12) months following your Enrollment Date.

If you had other health care coverage prior to your Enrollment Date, and you did not experience a Significant Break in Coverage, your prior coverage will be credited toward the twelve (12) month exclusion period. A Significant Break in Coverage is a period of 90 consecutive days during which you did not have any other health care coverage, except that waiting periods are carved out. The standard method, which does not consider specific benefits, is used to determine creditable coverage.

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Georgia
4080 Plans
Accident & Sickness Coverage

Base Plan	4080-500	4080-1000	4080-1500	4080-2000	4080-2500	4080-3000	4080-5000
Network Benefit Period Deductible — Single/Family	$500/$1,500	$1,000/$3,000	$1,500/$4,500	$2,000/$6,000	$2,500/$7,500	$3,000/$9,000	$5,000/$15,000
Non-Network Benefit Period Deductible – Single/Family	$1,000/$3,000	$2,000/$6,000	$3,000/$9,000	$4,000/$12,000	$5,000/$15,000	$6,000/$18,000	$10,000/$30,000
Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	$3,000/$9,000						
Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	$9,000/$27,000			$12,000/$24,000			
Coinsurance – Network/Non-Network	80%/60%						
Office Visit (OV) Copay Network/Non-Network	$40/$50						
Lifetime Maximum	$5,000,000						

Benefits	PPO Network	Non-PPO Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	26; Removal upon End of the Month	
Physician/Office Services		
Office & Urgent Care Visits (Illness/Injury)	OV copay, then 100%	OV copay, then 70%
Diagnostic Services in a Physician's Office	100%	70% after deductible
Standard Immunizations	100%	70% after deductible
Preventive Services		
Routine Physical Exam	OV copay, then 100%	OV copay, then 70%
Well Child Care Services (To age 6) Well Child Exams Well Child Immunizations and Labs	100%	70% after deductible
Well Child Care Services (Ages 6 to 9) Exams & Immunizations are limited to a $500 maximum per benefit period. Well Child Care exams Well Child Immunizations and Labs	OV copay, then 100% 100%	70% after deductible
Routine Mammogram (one per benefit period)	100%	70% after deductible
Routine Pap Tests	100%	70% after deductible
Routine PSA (age 40 and over), Cholesterol, Colon Cancer Screening, Ovarian Cancer Screening and Chlamydia Screening	100%	70% after deductible
Routine Colonoscopies and Endoscopic Services (no medical diagnosis)	coinsurance after deductible	coinsurance after deductible
Routine Bone Density Testing	coinsurance after deductible	coinsurance after deductible
Routine EKG, Chest X-ray, Comprehensive Metabolic panel, Urinalysis and Complete Blood Count (one each per benefit period)	100%	70% after deductible
Outpatient Services		
Allergy Testing and Treatments	coinsurance after deductible	coinsurance after deductible
Physical & Occupational Therapy (40 visits per benefit period)	coinsurance after deductible	$60 copay, then 70%
Speech Therapy (20 visits per benefit period)	coinsurance after deductible	$60 copay, then 70%

Georgia
4080 Plans
Accident & Sickness Coverage

Benefits	PPO Network	Non-PPO Network
Chiropractic Services (12 visits per benefit period)	$50 copay, then coinsurance	$50 copay, then coinsurance
Cardiac Rehab (20 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Emergency Use of an Emergency Room	$150 copay, then coinsurance	
Non-Emergency Use of an Emergency Room	$300 copay, then coinsurance	$300 copay, then coinsurance
Emergency Services	coinsurance after deductible	
Surgical Services	coinsurance after deductible	coinsurance after deductible
Diagnostic Services (other than a physician's office)	coinsurance after deductible	coinsurance after deductible
Colonoscopies and Endoscopic Services(with medical diagnosis)	coinsurance after deductible	coinsurance after deductible
Inpatient Services		
Semi-Private Room and Board	coinsurance after deductible	coinsurance after deductible
Skilled Nursing Facility (100 days per benefit period)	coinsurance after deductible	coinsurance after deductible
Additional Services		
Ambulance	$50 copay, then coinsurance	$50 copay, then coinsurance
Durable Medical Equipment ($5,000 maximum per benefit period)	coinsurance after deductible	coinsurance after deductible
Home Health Care (120 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Hospice ($10,000 lifetime maximum)	coinsurance after deductible	coinsurance after deductible
Organ and Tissue Transplants	coinsurance after deductible	coinsurance after deductible
TMJ Services ($15,000 lifetime maximum)	coinsurance after deductible	coinsurance after deductible
Diabetic Education and Training	coinsurance after deductible	coinsurance after deductible
Private Duty Nursing ($1,000 maximum per benefit period)	coinsurance after deductible	coinsurance after deductible
Mental Health & Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period with a 6 day limit for detox)	coinsurance after deductible	coinsurance after deductible
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	$50 copay, then 100%	$60 copay, then 70%
Prescription Drug – Choose one of the freestanding drug options available. Premium varies by the option 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 expenses incurred for services by a PPO Network provider will only apply to the PPO Network deductible. Deductible expenses incurred for services by a Non PPO Network provider will only apply to the Non PPO Network deductible.

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

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MEDICAL 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. This does not apply, however, if in accordance with federal law, this coverage is primary and Medicare is the secondary payer of your health care expenses.
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.
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 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 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.
23. For weight loss drugs.
24. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss.
25. For weight loss Surgery including complications related to this Surgery.
26. For water aerobics.
27. For residential care rendered by a Residential Treatment Facility, except as specified.
28. For marital counseling.
29. For the medical treatment of sexual problems not caused by a biological Condition.
30. For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
31. For reverse sterilization.
32. For artificial insemination or in vitro fertilization.
33. For any medication prescribed to induce ovulation or spermatogenesis.
34. 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.
35. For treatments associated with teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) Surgery, except as specified.
36. For treatment with intraoral prosthetic devices or by any other method, to alter vertical dimension.
37. For treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis.

Medical Benefit Exclusions and Limitations (cont'd)

38. For personal hygiene and convenience items.
39. 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.
40. 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).
41. For all services related to hearing loss including hearing aids or examinations for prescribing or fitting them.
42. For immunizations, other than those specified as covered in the Routine and Wellness Services section of the Certificate.
43. For massotherapy or massage therapy.
44. For hypnosis and acupuncture.
45. For After Hours Care.
46. For telephone consultations, online consultations, missed appointments, completion of claim forms or copies of medical records.
47. For fraudulent or misrepresented claims.
48. For blood which is available without charge. For Outpatient blood storage services.
49. For Prescription Drugs, except as specified.
50. For over the counter drugs, vitamins or herbal remedies.
51. For specialized camps.
52. For Routine Services, except as specified.
53. For non-covered services or services specifically excluded in the text of the Certificate.

Preexisting Condition Definition and Exclusion Period

Preexisting Condition means any physical or mental Condition, sickness, impairment or ailment, regardless of cause, for which medical advice, diagnosis, care or treatment was received within the six month period ending on the effective date of coverage under a group health plan, the date of enrollment under a group health insurance plan or the first date of a waiting period for a group health insurance plan, whichever is earliest. In no case shall any of the following be considered a preexisting Condition: (1) pregnancy, or (2) genetic information in the absence of a diagnosis related to such information.

If a Preexisting Condition existed at any time during the six (6) month period immediately preceding your Enrollment Date, Consumers Life will provide benefits for the Preexisting Condition for Covered Services Incurred after twelve (12) months following your Enrollment Date.

If you had other health care coverage prior to your Enrollment Date, and you did not experience a Significant Break in Coverage, your prior coverage will be credited toward the twelve (12) month exclusion period. A Significant Break in Coverage is a period of 90 consecutive days during which you did not have any other health care coverage, except that waiting periods are carved out. The standard method, which does not consider specific benefits, is used to determine creditable coverage.

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	GEORGIA **25100 PLAN** **ACCIDENT & SICKNESS COVERAGE**
BASE PLAN	25100-500
Network Benefit Period Deductible Single/Family (does not apply to Professional Services)	$500/$1,500
Non-Network Benefit Period Deductible Single/Family	$1,000/$3,000
Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	N/A
Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	$4,000/$12,000
Coinsurance Network/Non-Network	100% / 70%
Office Visit (OV) Copay Network/Non-Network	$25 / $35
Lifetime Maximum	$5,000,000

BENEFITS	PPO NETWORK	NON PPO NETWORK
Benefit Period	January 1st through December 31st	
Dependent Age Limit	26; Removal upon End of the Month	
Physician/Office Services		
Office & Urgent Care Visits (Illness/Injury)	OV copay, then 100%	OV copay, then coinsurance
Standard Immunizations	100%	coinsurance after deductible
Preventive Services		
Routine Physical Exam	OV copay, then 100%	OV copay, then coinsurance
Well Child Care Services (To age 6) Well Child Exams Well Child Immunizations and Labs	100%	coinsurance
Well Child Care Services (Ages 6 to 9) Exams & Immunizations are limited to a $500 maximum per benefit period. Well Child Care exams Well Child Immunizations and Labs	OV copay, then 100% 100%	coinsurance after deductible
Routine Mammogram (one per benefit period)	100%	coinsurance after deductible
Routine Pap Test (one per benefit period)	100%	coinsurance after deductible
Routine PSA (age 40 and over), Cholesterol, Colon Cancer Screening Tests, Endoscopic Services, Ovarian Cancer Screening, Chlamydia Screening and Bone Density Testing	100%	coinsurance after deductible
Routine Colonoscopies (no medical diagnosis)	100%	coinsurance after deductible
Routine EKG, Chest X-ray, Comprehensive Metabolic Panel, Urinalysis and Complete Blood Count (one each per benefit period)	100%	coinsurance after deductible
Outpatient Services		
Allergy Testing and Treatments	coinsurance after deductible	coinsurance after deductible
Physical & Occupational Therapies (40 visits per benefit period)	$35 copay, then coinsurance	$45 copay, then coinsurance
Speech Therapy (20 visits per benefit period)	$35 copay, then coinsurance	$45 copay, then coinsurance

BENEFITS	PPO NETWORK	NON PPO NETWORK
Chiropractic Services (12 visits per benefit period)	$35 copay, then coinsurance	$45 copay, then coinsurance
Cardiac Rehabilitation (20 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Emergency Use of an Emergency Room	$150 copay, then network coinsurance	

Georgia
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Non-Emergency Use of an Emergency Room	$300 copay, then coinsurance	$300 copay, then coinsurance
Emergency Services	network coinsurance	
Surgical Services	coinsurance after deductible	coinsurance after deductible
Diagnostic Services	coinsurance after deductible	coinsurance after deductible
Colonoscopies (with a medical diagnosis)	coinsurance after deductible	coinsurance after deductible
Inpatient Services		
Semi-Private Room and Board	coinsurance after deductible	coinsurance after deductible
Maternity	coinsurance after deductible	coinsurance after deductible
Skilled Nursing Facility (100 days per benefit period)	coinsurance after deductible	coinsurance after deductible
Additional Services		
Ambulance	$50 copay, then coinsurance	$50 copay, then coinsurance
Durable Medical Equipment ($5,000 maximum per benefit period)	coinsurance after deductible	coinsurance after deductible
Home Health Care (120 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Hospice ($10,000 lifetime maximum)	coinsurance after deductible	coinsurance after deductible
Organ and Tissue Transplants	coinsurance after deductible	coinsurance after deductible
TMJ Services ($15,000 lifetime maximum)	coinsurance after deductible	coinsurance after deductible
Private Duty Nursing ($1,000 maximum per benefit period)	100%	coinsurance after deductible
Mental Health & Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; with a 6 day limit for detox)	coinsurance after deductible	coinsurance after deductible
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	$35 copay, then coinsurance	$45 copay, then coinsurance
Prescription Drug - Choose one of the freestanding drug options available. Premium varies by the option 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 expenses incurred for services by a PPO Network provider will only apply to the PPO Network deductible. Deductible expenses incurred for services by a Non PPO Network provider will only apply to the Non PPO Network deductible.

The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual case manager (except for corneal transplants.) Failure to contact the case manager prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

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Medical Benefit Exclusions and Limitations

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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. This does not apply, however, if in accordance with federal law, this coverage is primary and Medicare is the secondary payer of your health care expenses.
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.
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 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 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.
23. For weight loss drugs.
24. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss.
25. For weight loss Surgery including complications related to this Surgery.
26. For water aerobics.
27. For residential care rendered by a Residential Treatment Facility, except as specified.
28. For marital counseling.
29. For the medical treatment of sexual problems not caused by a biological Condition.
30. For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
31. For reverse sterilization.
32. For artificial insemination or in vitro fertilization.
33. For any medication prescribed to induce ovulation or spermatogenesis.
34. 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.
35. For treatments associated with teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) Surgery, except as specified.
36. For treatment with intraoral prosthetic devices or by any other method, to alter vertical dimension.
37. For treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis.

Medical Benefit Exclusions and Limitations (cont'd)

38. For personal hygiene and convenience items.
39. 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.
40. 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).
41. For all services related to hearing loss including hearing aids or examinations for prescribing or fitting them.
42. For immunizations, other than those specified as covered in the Routine and Wellness Services section of the Certificate.
43. For massotherapy or massage therapy.
44. For hypnosis and acupuncture.
45. For After Hours Care.
46. For telephone consultations, online consultations, missed appointments, completion of claim forms or copies of medical records.
47. For fraudulent or misrepresented claims.
48. For blood which is available without charge. For Outpatient blood storage services.
49. For Prescription Drugs, except as specified.
50. For over the counter drugs, vitamins or herbal remedies.
51. For specialized camps.
52. For Routine Services, except as specified.
53. For non-covered services or services specifically excluded in the text of the Certificate.

Preexisting Condition Definition and Exclusion Period

Preexisting Condition means any physical or mental Condition, sickness, impairment or ailment, regardless of cause, for which medical advice, diagnosis, care or treatment was received within the six month period ending on the effective date of coverage under a group health plan, the date of enrollment under a group health insurance plan or the first date of a waiting period for a group health insurance plan, whichever is earliest. In no case shall any of the following be considered a preexisting Condition: (1) pregnancy, or (2) genetic information in the absence of a diagnosis related to such information.

If a Preexisting Condition existed at any time during the six (6) month period immediately preceding your Enrollment Date, Consumers Life will provide benefits for the Preexisting Condition for Covered Services Incurred after twelve (12) months following your Enrollment Date.

If you had other health care coverage prior to your Enrollment Date, and you did not experience a Significant Break in Coverage, your prior coverage will be credited toward the twelve (12) month exclusion period. A Significant Break in Coverage is a period of 90 consecutive days during which you did not have any other health care coverage, except that waiting periods are carved out. The standard method, which does not consider specific benefits, is used to determine creditable coverage.

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Georgia
30100 Plans
Accident & Sickness Coverage

Base Plan	30100-1000	30100-1500	30100-2000	30100-2500	30100-3500	30100-5000
Network Benefit Period Deductible Single/Family (does not apply to Professional Services)	$1,000/$3,000	$1,500/$4,500	$2,000/$6,000	$2,500/$7,500	$3,500/$10,500	$5,000/$15,000
Non-Network Benefit Period Deductible Single/Family	$2,000/$6,000	$3,000/$9,000	$4,000/$12,000	$5,000/$15,000	$7,000/$21,000	$10,000/$30,000
Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	N/A	N/A	N/A	N/A	N/A	N/A
Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	$4,000/$12,000	$4,000/$12,000	$4,000/$12,000	$6,000/$18,000	$8,000/$24,000	$12,000/$24,000
Coinsurance Network/Non-Network	100% / 70%					
Office Visit (OV) Copay Network/Non-Network	$30 / $40					
Lifetime Maximum	$5,000,000					

Benefits	PPO Network	Non PPO Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	26; Removal upon End of the Month	
Physician/Office Services		
Office & Urgent Care Visits (Illness/Injury)	OV copay, then 100%	OV copay, then coinsurance
Standard Immunizations	100%	coinsurance after deductible
Preventive Services		
Routine Physical Exam	OV copay, then 100%	OV copay, then coinsurance
Well Child Care Services (To age 6) Well Child Exams Well Child Immunizations and Labs	100%	coinsurance
Well Child Care Services (Ages 6 to 9) Exams & Immunizations are limited to a $500 maximum per benefit period. Well Child Care exams Well Child Immunizations and Labs	OV copay, then 100% 100%	coinsurance after deductible
Routine Mammogram (one per benefit period)	100%	coinsurance after deductible
Routine Pap Test (one per benefit period)	100%	coinsurance after deductible
Routine PSA (age 40 and older), Cholesterol, Colon Cancer Screening Tests, Endoscopic Services, Ovarian Cancer Screening, Chlamydia Screening and Bone Density Testing	100%	coinsurance after deductible
Routine Colonoscopies (no medical diagnosis)	100%	coinsurance after deductible
Routine EKG, Chest X-ray, Comprehensive Metabolic Panel, Urinalysis and Complete Blood Count (one each per benefit period)	100%	coinsurance after deductible
Outpatient Services		
Allergy Testing and Treatments	coinsurance after deductible	coinsurance after deductible
Physical & Occupational Therapies (40 visits per benefit period)	$35 copay, then coinsurance	$45 copay, then coinsurance
Speech Therapy (20 visits per benefit period)	$35 copay, then coinsurance	$45 copay, then coinsurance

Georgia
30100 Plans
Accident & Sickness Coverage

Benefits	PPO Network	Non PPO Network

Chiropractic Services (12 visits per benefit period)	$35 copay, then coinsurance	$45 copay, then coinsurance
Cardiac Rehabilitation (20 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Emergency Use of an Emergency Room	$150 copay, then network coinsurance	
Non-Emergency Use of an Emergency Room	$300 copay, then coinsurance	$300 copay, then coinsurance
Emergency Services	network coinsurance	
Surgical Services	coinsurance after deductible	coinsurance after deductible
Diagnostic Services	coinsurance after deductible	coinsurance after deductible
Colonoscopies (with a medical diagnosis)	coinsurance after deductible	coinsurance after deductible
Inpatient Services		
Semi-Private Room and Board	coinsurance after deductible	coinsurance after deductible
Maternity	coinsurance after deductible	coinsurance after deductible
Skilled Nursing Facility (100 days per benefit period)	coinsurance after deductible	coinsurance after deductible
Additional Services		
Ambulance	$50 copay, then coinsurance	$50 copay, then coinsurance
Durable Medical Equipment ($5,000 maximum per benefit period)	coinsurance after deductible	coinsurance after deductible
Home Health Care (120 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Hospice ($10,000 lifetime maximum)	coinsurance after deductible	coinsurance after deductible
Organ and Tissue Transplants	coinsurance after deductible	coinsurance after deductible
TMJ Services ($15,000 lifetime maximum)	coinsurance after deductible	coinsurance after deductible
Private Duty Nursing ($1,000 maximum per benefit period)	100%	coinsurance after deductible
Mental Health & Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; with a 6 day limit for detox)	coinsurance after deductible	coinsurance after deductible
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	$35 copay, then coinsurance	$45 copay, then coinsurance
Prescription Drug - Choose one of the freestanding drug options available. Premium varies by the option selected.		

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

The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual case manager (except for corneal transplants.) Failure to contact the case manager prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

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Medical Benefit Exclusions and Limitations

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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. This does not apply, however, if in accordance with federal law, this coverage is primary and Medicare is the secondary payer of your health care expenses.
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.
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 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 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.
23. For weight loss drugs.
24. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss.
25. For weight loss Surgery including complications related to this Surgery.
26. For water aerobics.
27. For residential care rendered by a Residential Treatment Facility, except as specified.
28. For marital counseling.
29. For the medical treatment of sexual problems not caused by a biological Condition.
30. For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
31. For reverse sterilization.
32. For artificial insemination or in vitro fertilization.
33. For any medication prescribed to induce ovulation or spermatogenesis.
34. 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.
35. For treatments associated with teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) Surgery, except as specified.
36. For treatment with intraoral prosthetic devices or by any other method, to alter vertical dimension.
37. For treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis.

MEDICAL BENEFIT EXCLUSIONS AND LIMITATIONS (CONT'D)

38. For personal hygiene and convenience items.
39. 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.
40. 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).
41. For all services related to hearing loss including hearing aids or examinations for prescribing or fitting them.
42. For immunizations, other than those specified as covered in the Routine and Wellness Services section of the Certificate.
43. For massotherapy or massage therapy.
44. For hypnosis and acupuncture.
45. For After Hours Care.
46. For telephone consultations, online consultations, missed appointments, completion of claim forms or copies of medical records.
47. For fraudulent or misrepresented claims.
48. For blood which is available without charge. For Outpatient blood storage services.
49. For Prescription Drugs, except as specified.
50. For over the counter drugs, vitamins or herbal remedies.
51. For specialized camps.
52. For Routine Services, except as specified.
53. For non-covered services or services specifically excluded in the text of the Certificate.

PREEXISTING CONDITION DEFINITION AND EXCLUSION PERIOD

Preexisting Condition means any physical or mental Condition, sickness, impairment or ailment, regardless of cause, for which medical advice, diagnosis, care or treatment was received within the six month period ending on the effective date of coverage under a group health plan, the date of enrollment under a group health insurance plan or the first date of a waiting period for a group health insurance plan, whichever is earliest. In no case shall any of the following be considered a preexisting Condition: (1) pregnancy, or (2) genetic information in the absence of a diagnosis related to such information.

If a Preexisting Condition existed at any time during the six (6) month period immediately preceding your Enrollment Date, Consumers Life will provide benefits for the Preexisting Condition for Covered Services Incurred after twelve (12) months following your Enrollment Date.

If you had other health care coverage prior to your Enrollment Date, and you did not experience a Significant Break in Coverage, your prior coverage will be credited toward the twelve (12) month exclusion period. A Significant Break in Coverage is a period of 90 consecutive days during which you did not have any other health care coverage, except that waiting periods are carved out. The standard method, which does not consider specific benefits, is used to determine creditable coverage.

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Georgia
Vital Access 80% Plans
Accident & Sickness Coverage

Base Plan	2580-3500	2580-5000	2580-7500	2580-10000
Network Benefit Period Deductible Single/Family (does not apply to Professional Services)	$3,500/$7,000	$5,000/$10,000	$7,500/$15,000	$10,000/$20,000
Non-Network Benefit Period Deductible Single/Family	$9,000/$18,000	$10,000/$20,000	$12,000/$24,000	$15,000/$30,000
Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	$4,000/$8,000			
Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	$8,000/$16,000			
Coinsurance Network/Non-Network	80% / 60%			
Office Visit (OV) Copay Network	$25			
Urgent Care (UC) and Specialist (SP) Copay Network	$75			
Lifetime Maximum	$5,000,000			

Benefits	PPO Network	Non PPO Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	26, Removal upon End of Month	
Physician/Office Services		
Office Visits	OV copay, then 100%	coinsurance after deductible
Urgent Care Visits (Illness/Injury)	UC copay, then 100%	UC copay, then 100%
Specialist Visits	SP copay, then 100%	coinsurance after deductible
Standard Immunizations	coinsurance	coinsurance after deductible
Preventive Services		
Routine Physical Exam	OV copay, then 100%	coinsurance after deductible
Well Child Care Services (To age 6) Well Child Exams Well Child Immunizations and Labs	coinsurance	coinsurance
Well Child Care Services (Ages 6 to 9) Exams & Immunizations are limited to a $1,000 maximum per benefit period. Well Child Care exams Well Child Immunizations and Labs	OV copay, then 100% 100%	coinsurance after deductible
Routine Mammogram (one per benefit period)	coinsurance	coinsurance after deductible
Routine Pap Test (one per benefit period)	coinsurance	coinsurance after deductible
Routine Professional PSA (age 40 and over), Cholesterol, Colon Cancer Screening Tests, Ovarian Cancer Screening, Chlamydia Screening, Bone Density Testing	coinsurance	coinsurance after deductible
Routine Professional Comprehensive Metabolic Panel, Urinalysis, Complete Blood Count (one each per benefit period)	coinsurance	coinsurance after deductible
Routine Facility PSA (age 40 and over), Cholesterol, Colon Cancer Screening Tests, Ovarian Cancer Screening, Chlamydia Screening	coinsurance after deductible	coinsurance after deductible
Routine Facility Comprehensive Metabolic Panel, Urinalysis, Complete Blood Count (one each per benefit period)	coinsurance after deductible	coinsurance after deductible
Routine EKG and Chest X-ray (one each per benefit period)	coinsurance after deductible	coinsurance after deductible
Routine Endoscopic Services	coinsurance after deductible	coinsurance after deductible

Georgia
Vital Access 80% Plans
Accident & Sickness Coverage

Benefits	PPO Network	Non PPO Network
Outpatient Services		
Allergy Testing	coinsurance after deductible	coinsurance after deductible
Allergy Treatments	coinsurance	coinsurance after deductible
Physical & Occupational Therapies (40 visits per benefit period)	$50 copay, then 100%	$45 copay, then coinsurance
Speech Therapy (20 visits per benefit period)	$50 copay, then 100%	$45 copay, then coinsurance
Chiropractic Services (12 visits per benefit period)	$50 copay, then 100%	$45 copay, then coinsurance
Cardiac Rehabilitation (20 visits per benefit period)	$50 copay, then 100%	coinsurance after deductible
Emergency Use of an Emergency Room	$200 copay, then network coinsurance	
Non-Emergency Use of an Emergency Room	$400 copay, then coinsurance	$400 copay, then coinsurance
Emergency Services	network coinsurance after deductible	
Surgical Services	coinsurance after deductible	coinsurance after deductible
Diagnostic Labs (Facility) X-rays and Medical Tests	coinsurance after deductible	coinsurance after deductible
Diagnostic Professional Labs	coinsurance	coinsurance after deductible
Inpatient Services		
Semi-Private Room and Board	coinsurance after deductible	coinsurance after deductible
Maternity	coinsurance after deductible	coinsurance after deductible
Skilled Nursing Facility (60 days per benefit period)	coinsurance after deductible	coinsurance after deductible
Additional Services		
Ambulance	network coinsurance	
Durable Medical Equipment ($5,000 maximum benefit per period)	coinsurance after deductible	coinsurance after deductible
Home Health Care (60 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Hospice (180 days maximum per lifetime)	coinsurance after deductible	coinsurance after deductible
Organ and Tissue Transplants	coinsurance after deductible	coinsurance after deductible
TMJ Services ($15,000 lifetime maximum)	coinsurance after deductible	coinsurance after deductible
Mental Health & Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; with a 6 day limit for detox)	coinsurance after deductible	coinsurance after deductible
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	$75 copay, then 100%	coinsurance after deductible
Prescription Drug - Choose one of the freestanding drug options available. Premium varies by the option 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 expenses incurred for services by a PPO Network provider will only apply to the PPO Network deductible. Deductible expenses incurred for services by a Non PPO Network provider will only apply to the Non PPO Network deductible.

The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual case manager (except for corneal transplants.) Failure to contact the case manager prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

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Medical 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. This does not apply, however, if in accordance with federal law, this coverage is primary and Medicare is the secondary payer of your health care expenses.
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.
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 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 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.
23. For weight loss drugs.
24. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss.
25. For weight loss Surgery including complications related to this Surgery.
26. For water aerobics.
27. For residential care rendered by a Residential Treatment Facility, except as specified.
28. For marital counseling.
29. For the medical treatment of sexual problems not caused by a biological Condition.
30. For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
31. For reverse sterilization.
32. For artificial insemination or in vitro fertilization.
33. For any medication prescribed to induce ovulation or spermatogenesis.
34. 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.
35. For treatments associated with teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) Surgery, except as specified.
36. For treatment with intraoral prosthetic devices or by any other method, to alter vertical dimension.
37. For treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis.

Medical Benefit Exclusions and Limitations (cont'd)

38. For personal hygiene and convenience items.
39. 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.
40. 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).
41. For all services related to hearing loss including hearing aids or examinations for prescribing or fitting them.
42. For immunizations, other than those specified as covered in the Routine and Wellness Services section of the Certificate.
43. For massotherapy or massage therapy.
44. For hypnosis and acupuncture.
45. For After Hours Care.
46. For telephone consultations, online consultations, missed appointments, completion of claim forms or copies of medical records.
47. For fraudulent or misrepresented claims.
48. For blood which is available without charge. For Outpatient blood storage services.
49. For Prescription Drugs, except as specified.
50. For over the counter drugs, vitamins or herbal remedies.
51. For specialized camps.
52. For Routine Services, except as specified.
53. For non-covered services or services specifically excluded in the text of the Certificate.

Preexisting Condition Definition and Exclusion Period

Preexisting Condition means any physical or mental Condition, sickness, impairment or ailment, regardless of cause, for which medical advice, diagnosis, care or treatment was received within the six month period ending on the effective date of coverage under a group health plan, the date of enrollment under a group health insurance plan or the first date of a waiting period for a group health insurance plan, whichever is earliest. In no case shall any of the following be considered a preexisting Condition: (1) pregnancy, or (2) genetic information in the absence of a diagnosis related to such information.

If a Preexisting Condition existed at any time during the six (6) month period immediately preceding your Enrollment Date, Consumers Life will provide benefits for the Preexisting Condition for Covered Services Incurred after twelve (12) months following your Enrollment Date.

If you had other health care coverage prior to your Enrollment Date, and you did not experience a Significant Break in Coverage, your prior coverage will be credited toward the twelve (12) month exclusion period. A Significant Break in Coverage is a period of 90 consecutive days during which you did not have any other health care coverage, except that waiting periods are carved out. The standard method, which does not consider specific benefits, is used to determine creditable coverage.

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Georgia
Vital Access 100% Plans
Accident & Sickness Coverage

Base Plan	25100-3500	25100-5000	25100-7500	25100-10000
Network Benefit Period Deductible Single/Family (does not apply to Professional Services)	$3,500/$7,000	$5,000/$10,000	$7,500/$15,000	$10,000/$20,000
Non-Network Benefit Period Deductible Single/Family	$9,000/$18,000	$10,000/$20,000	$12,000/$24,000	$15,000/$30,000
Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	N/A	N/A	N/A	N/A
Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	$8,000/$16,000			
Coinsurance Network/Non-Network	100% / 70%			
Office Visit (OV) Copay Network	$25			
Urgent Care (UC) and Specialist (SP) Copay Network	$75			
Lifetime Maximum	$5,000,000			

Benefits	PPO Network	Non PPO Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	26, Removal upon End of Month	
Physician/Office Services		
Office Visits	OV copay, then 100%	coinsurance after deductible
Urgent Care Visits (Illness/Injury)	UC copay, then 100%	UC copay, then 100%
Specialist Visits	SP copay, then 100%	coinsurance after deductible
Standard Immunizations	coinsurance	coinsurance after deductible
Preventive Services		
Routine Physical Exam	OV copay, then 100%	coinsurance after deductible
Well Child Care Services (To age 6) Well Child Exams Well Child Immunizations and Labs	coinsurance	coinsurance
Well Child Care Services (Ages 6 to 9) Exams & Immunizations are limited to a $1,000 maximum per benefit period. Well Child Care exams Well Child Immunizations and Labs	OV copay, then 100% coinsurance	coinsurance after deductible
Routine Mammogram (one per benefit period)	coinsurance	coinsurance after deductible
Routine Pap Test (one per benefit period)	coinsurance	coinsurance after deductible
Routine Professional PSA (40 and over), Cholesterol, Colon Cancer Screening Tests, Ovarian Cancer Screening, Chlamydia Screening, Bone Density Testing	coinsurance	coinsurance after deductible
Routine Professional Comprehensive Metabolic Panel, Urinalysis, Complete Blood Count (one each per benefit period)	coinsurance	coinsurance after deductible
Routine Facility PSA (40 and over), Cholesterol, Colon Cancer Screening Tests, Ovarian Cancer Screening, Chlamydia Screening, Bone Density Testing	coinsurance after deductible	coinsurance after deductible
Routine Facility Comprehensive Panel, Urinalysis, Complete Blood Count (one each per benefit period)	coinsurance after deductible	coinsurance after deductible
Routine EKG and Chest X-ray (one each per benefit period)	coinsurance after deductible	coinsurance after deductible
Routine Endoscopic Services	coinsurance after deductible	coinsurance after deductible

Georgia
Vital Access 100% Plans
Accident & Sickness Coverage

Benefits	PPO Network	Non PPO Network
Outpatient Services		
Allergy Testing	coinsurance after deductible	coinsurance after deductible
Allergy Treatments	coinsurance	coinsurance after deductible
Physical & Occupational Therapies (40 visits per benefit period)	$50 copay, then 100%	$45 copay, then coinsurance
Speech Therapy (20 visits per benefit period)	$50 copay, then 100%	$45 copay, then coinsurance
Chiropractic Services (12 visits per benefit period)	$50 copay, then 100%	$45 copay, then coinsurance
Cardiac Rehabilitation (20 visits per benefit period)	$50 copay, then 100%	coinsurance after deductible
Emergency Use of an Emergency Room	$200 copay, then network coinsurance	
Non-Emergency Use of an Emergency Room	$400 copay, then coinsurance	$400 copay, then coinsurance
Emergency Services	network coinsurance after deductible	
Surgical Services	coinsurance after deductible	coinsurance after deductible
Diagnostic Labs (Facility), X-rays and Medical Tests	coinsurance after deductible	coinsurance after deductible
Diagnostic Professional Labs	coinsurance	coinsurance after deductible
Inpatient Services		
Semi-Private Room and Board	coinsurance after deductible	coinsurance after deductible
Maternity	coinsurance after deductible	coinsurance after deductible
Skilled Nursing Facility (60 days per benefit period)	coinsurance after deductible	coinsurance after deductible
Additional Services		
Ambulance	network coinsurance	
Durable Medical Equipment ($5,000 maximum benefit per period)	coinsurance after deductible	coinsurance after deductible
Home Health Care (60 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Hospice (180 days maximum per lifetime)	coinsurance after deductible	coinsurance after deductible
Organ and Tissue Transplants	coinsurance after deductible	coinsurance after deductible
TMJ Services ($15,000 lifetime maximum)	coinsurance after deductible	coinsurance after deductible
Mental Health & Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; with a 6 day limit for detox)	coinsurance after deductible	coinsurance after deductible
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	$75 copay, then 100%	coinsurance after deductible
Prescription Drug - Choose one of the freestanding drug options available. Premium varies by the option 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 expenses incurred for services by a PPO Network provider will only apply to the PPO Network deductible. Deductible expenses incurred for services by a Non PPO Network provider will only apply to the Non PPO Network deductible.

The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual case manager (except for corneal transplants.) Failure to contact the case manager prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

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MEDICAL 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. This does not apply, however, if in accordance with federal law, this coverage is primary and Medicare is the secondary payer of your health care expenses.
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.
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 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 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.
23. For weight loss drugs.
24. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss.
25. For weight loss Surgery including complications related to this Surgery.
26. For water aerobics.
27. For residential care rendered by a Residential Treatment Facility, except as specified.
28. For marital counseling.
29. For the medical treatment of sexual problems not caused by a biological Condition.
30. For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
31. For reverse sterilization.
32. For artificial insemination or in vitro fertilization.
33. For any medication prescribed to induce ovulation or spermatogenesis.
34. 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.
35. For treatments associated with teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) Surgery, except as specified.
36. For treatment with intraoral prosthetic devices or by any other method, to alter vertical dimension.
37. For treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis.

Medical Benefit Exclusions and Limitations (cont'd)

38. For personal hygiene and convenience items.
39. 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.
40. 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).
41. For all services related to hearing loss including hearing aids or examinations for prescribing or fitting them.
42. For immunizations, other than those specified as covered in the Routine and Wellness Services section of the Certificate.
43. For massotherapy or massage therapy.
44. For hypnosis and acupuncture.
45. For After Hours Care.
46. For telephone consultations, online consultations, missed appointments, completion of claim forms or copies of medical records.
47. For fraudulent or misrepresented claims.
48. For blood which is available without charge. For Outpatient blood storage services.
49. For Prescription Drugs, except as specified.
50. For over the counter drugs, vitamins or herbal remedies.
51. For specialized camps.
52. For Routine Services, except as specified.
53. For non-covered services or services specifically excluded in the text of the Certificate.

Preexisting Condition Definition and Exclusion Period

Preexisting Condition means any physical or mental Condition, sickness, impairment or ailment, regardless of cause, for which medical advice, diagnosis, care or treatment was received within the six month period ending on the effective date of coverage under a group health plan, the date of enrollment under a group health insurance plan or the first date of a waiting period for a group health insurance plan, whichever is earliest. In no case shall any of the following be considered a preexisting Condition: (1) pregnancy, or (2) genetic information in the absence of a diagnosis related to such information.

If a Preexisting Condition existed at any time during the six (6) month period immediately preceding your Enrollment Date, Consumers Life will provide benefits for the Preexisting Condition for Covered Services Incurred after twelve (12) months following your Enrollment Date.

If you had other health care coverage prior to your Enrollment Date, and you did not experience a Significant Break in Coverage, your prior coverage will be credited toward the twelve (12) month exclusion period. A Significant Break in Coverage is a period of 90 consecutive days during which you did not have any other health care coverage, except that waiting periods are carved out. The standard method, which does not consider specific benefits, is used to determine creditable coverage.

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Georgia
SuperMed Plus HSA Compatible Plans
Accident & Sickness Coverage

Base Plan	2500	3000	4000	5000
Network 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	$3,000/$6,000	$3,500/$7,000	$4,500/$9,000	$5,500/$11,000
Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	N/A	N/A	N/A	N/A
Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	$5,000/$10,000			
Coinsurance Network/Non-Network	100%/70%			
Lifetime Maximum	$,5,000,000			

Benefits	PPO Network	Non PPO Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	26; Removal upon End of the Month	
Physician/Office Services		
Office Visit (Illness/Injury)	coinsurance after deductible	coinsurance after deductible
Urgent Care Office Visit	coinsurance after deductible	coinsurance after deductible
Standard Immunizations	100%	coinsurance after deductible
Preventive Services		
Routine Physical Exam	100%	coinsurance after deductible
Well Child Care Services To age 6 – Unlimited Ages 6 to 9 – Exams & Well Child Immunizations limited to $500 benefit period maximum	100%	coinsurance after deductible
Routine Mammogram (one per benefit period)	100%	coinsurance after deductible
Routine Pap Test (one per benefit period)	100%	coinsurance after deductible
Routine PSA (age 40 and over), Cholesterol, Colon Cancer Screening Tests, Endoscopic Services, Ovarian Cancer Screening, Chlamydia Screening and Bone Density Testing	100%	coinsurance after deductible
Routine Colonoscopies (no medical diagnosis)	100%	coinsurance after deductible
Routine EKG, Chest X-ray, Comprehensive Metabolic Panel, Urinalysis and Complete Blood Count (one each per benefit period)	100%	coinsurance after deductible
Outpatient Services		
Allergy Testing and Treatments	coinsurance after deductible	coinsurance after deductible
Physical & Occupational Therapies (40 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Speech Therapy (20 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Chiropractic Services (12 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Cardiac Rehabilitation (20 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Emergency Use of an Emergency Room	network coinsurance after deductible	
Non-Emergency Use of an Emergency Room	coinsurance after deductible	coinsurance after deductible

Georgia
SuperMed Plus HSA Compatible Plans
Accident & Sickness Coverage

Benefits	PPO Network	Non PPO Network
Emergency Services	network coinsurance after deductible	
Surgical Services	coinsurance after deductible	coinsurance after deductible
Diagnostic Services	coinsurance after deductible	coinsurance after deductible
Colonoscopies (with a medical diagnosis)	coinsurance after deductible	coinsurance after deductible
Inpatient Services		
Semi-Private Room and Board	coinsurance after deductible	coinsurance after deductible
Maternity	coinsurance after deductible	coinsurance after deductible
Skilled Nursing Facility (100 days per benefit period)	coinsurance after deductible	coinsurance after deductible
Additional Services		
Ambulance	coinsurance after deductible	coinsurance after deductible
Durable Medical Equipment ($5,000 maximum per benefit period)	coinsurance after deductible	coinsurance after deductible
Home Health Care	coinsurance after deductible	coinsurance after deductible
Hospice	coinsurance after deductible	coinsurance after deductible
Organ and Tissue Transplants	coinsurance after deductible	coinsurance after deductible
Private Duty Nursing ($1,000 maximum per benefit period)	coinsurance after deductible	coinsurance after deductible
Mental Health & Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; with a 6 day limit for detox)	coinsurance after deductible	coinsurance after deductible
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Prescription Drug - Oral Contraceptives Included (Failure to present an ID card may result in increased cost)		
Retail - 90 Day Supply	network coinsurance after deductible	
Home Delivery – 90 Day Supply	network coinsurance 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 expenses incurred for services by a PPO Network provider will only apply to the PPO Network deductible. Deductible expenses incurred for services by a Non PPO Network provider will only apply to the Non PPO Network deductible.

The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual case manager (except for corneal transplants.) Failure to contact the case manager prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

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Medical 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. This does not apply, however, if in accordance with federal law, this coverage is primary and Medicare is the secondary payer of your health care expenses.
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.
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 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 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.
23. For weight loss drugs.
24. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss.
25. For weight loss Surgery including complications related to this Surgery.
26. For water aerobics.
27. For residential care rendered by a Residential Treatment Facility, except as specified.
28. For marital counseling.
29. For the medical treatment of sexual problems not caused by a biological Condition.
30. For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
31. For reverse sterilization.
32. For artificial insemination or in vitro fertilization.
33. For any medication prescribed to induce ovulation or spermatogenesis.
34. 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.
35. For treatments associated with teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) Surgery, except as specified.
36. For treatment with intraoral prosthetic devices or by any other method, to alter vertical dimension.
37. For treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis.

Medical Benefit Exclusions and Limitations (cont'd)

38. For personal hygiene and convenience items.
39. 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.
40. 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).
41. For all services related to hearing loss including hearing aids or examinations for prescribing or fitting them.
42. For immunizations, other than those specified as covered in the Routine and Wellness Services section of the Certificate.
43. For massotherapy or massage therapy.
44. For hypnosis and acupuncture.
45. For After Hours Care.
46. For telephone consultations, online consultations, missed appointments, completion of claim forms or copies of medical records.
47. For fraudulent or misrepresented claims.
48. For blood which is available without charge. For Outpatient blood storage services.
49. For Prescription Drugs, except as specified.
50. For over the counter drugs, vitamins or herbal remedies.
51. For specialized camps.
52. For Routine Services, except as specified.
53. For non-covered services or services specifically excluded in the text of the Certificate.

Preexisting Condition Definition and Exclusion Period

Preexisting Condition means any physical or mental Condition, sickness, impairment or ailment, regardless of cause, for which medical advice, diagnosis, care or treatment was received within the six month period ending on the effective date of coverage under a group health plan, the date of enrollment under a group health insurance plan or the first date of a waiting period for a group health insurance plan, whichever is earliest. In no case shall any of the following be considered a preexisting Condition: (1) pregnancy, or (2) genetic information in the absence of a diagnosis related to such information.

If a Preexisting Condition existed at any time during the six (6) month period immediately preceding your Enrollment Date, Consumers Life will provide benefits for the Preexisting Condition for Covered Services Incurred after twelve (12) months following your Enrollment Date.

If you had other health care coverage prior to your Enrollment Date, and you did not experience a Significant Break in Coverage, your prior coverage will be credited toward the twelve (12) month exclusion period. A Significant Break in Coverage is a period of 90 consecutive days during which you did not have any other health care coverage, except that waiting periods are carved out. The standard method, which does not consider specific benefits, is used to determine creditable coverage.

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Georgia SuperMed Plus HSA Compatible Value Plans

Base Plan	2500	3000	4000	5000
Network 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	$3,000/$6,000	$3,500/$7,000	$4,500/$9,000	$5,500/$11,000
Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	$3,300/$6,600	$2,800/$5,600	$1,800/$3,600	$800/$1,600
Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	$3,800/$7,600	$3,300/$6,600	$2,300/$4,600	$1,300/$2,600
Coinsurance Network/Non-Network	80%/60%			
Lifetime Maximum	$5,000,000			

Benefits	PPO Network	Non PPO Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	26; Removal upon End of the Month	
Physician/Office Services		
Office Visit (Illness/Injury)	coinsurance after deductible	coinsurance after deductible
Urgent Care Office Visit	coinsurance after deductible	coinsurance after deductible
Standard Immunizations	coinsurance after deductible	coinsurance after deductible
Preventive Services		
Routine Physical Exam	coinsurance after deductible	coinsurance after deductible
Well Child Care Services To age 6 – Unlimited Ages 6 to 9 – Exams & Well Child Immunizations limited to $500 benefit period maximum	 coinsurance coinsurance after deductible	coinsurance after deductible
Routine Mammogram (one per benefit period)	coinsurance after deductible	coinsurance after deductible
Routine Pap Test (one per benefit period)	coinsurance after deductible	coinsurance after deductible
Routine PSA (age 40 and over), Cholesterol, Colon Cancer Screening Tests, Endoscopic Services, Ovarian Cancer Screening, Chlamydia Screening and Bone Density Testing	coinsurance after deductible	coinsurance after deductible
Routine Colonoscopies (no medical diagnosis)	coinsurance after deductible	coinsurance after deductible
Routine EKG, Chest X-ray, Comprehensive Metabolic Panel, Urinalysis and Complete Blood Count (one each per benefit period)	coinsurance after deductible	coinsurance after deductible
Outpatient Services		
Allergy Testing and Treatments	coinsurance after deductible	coinsurance after deductible
Physical & Occupational Therapies (40 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Speech Therapy (20 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Chiropractic Services (12 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Cardiac Rehabilitation (20 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Emergency Use of an Emergency Room	network coinsurance after deductible	
Non-Emergency Use of an Emergency Room	coinsurance after deductible	coinsurance after deductible

Georgia
SuperMed Plus HSA Compatible
Value Plans

Benefits	PPO Network	Non PPO Network
Emergency Services	network coinsurance after deductible	
Surgical Services	coinsurance after deductible	coinsurance after deductible
Diagnostic Services	coinsurance after deductible	coinsurance after deductible
Colonoscopies (with a medical diagnosis)	coinsurance after deductible	coinsurance after deductible
Inpatient Services		
Semi-Private Room and Board	coinsurance after deductible	coinsurance after deductible
Maternity	coinsurance after deductible	coinsurance after deductible
Skilled Nursing Facility (100 days per benefit period)	coinsurance after deductible	coinsurance after deductible
Additional Services		
Ambulance	coinsurance after deductible	coinsurance after deductible
Durable Medical Equipment ($5,000 maximum per benefit period)	coinsurance after deductible	coinsurance after deductible
Home Health Care	coinsurance after deductible	coinsurance after deductible
Hospice	coinsurance after deductible	coinsurance after deductible
Organ and Tissue Transplants	coinsurance after deductible	coinsurance after deductible
Private Duty Nursing ($1,000 maximum per benefit period)	coinsurance after deductible	coinsurance after deductible
Mental Health & Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; with a 6 day limit for detox)	coinsurance after deductible	coinsurance after deductible
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Prescription Drug - Oral Contraceptives Included (Failure to present an ID card may result in increased cost)		
Retail - 90 Day Supply	network coinsurance after deductible	
Home Delivery – 90 Day Supply	network coinsurance 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 expenses incurred for services by a PPO Network provider will only apply to the PPO Network deductible. Deductible expenses incurred for services by a Non PPO Network provider will only apply to the Non PPO Network deductible.

The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual case manager (except for corneal transplants.) Failure to contact the case manager prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

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Medical 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. This does not apply, however, if in accordance with federal law, this coverage is primary and Medicare is the secondary payer of your health care expenses.
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.
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 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 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.
23. For weight loss drugs.
24. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss.
25. For weight loss Surgery including complications related to this Surgery.
26. For water aerobics.
27. For residential care rendered by a Residential Treatment Facility, except as specified.
28. For marital counseling.
29. For the medical treatment of sexual problems not caused by a biological Condition.
30. For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
31. For reverse sterilization.
32. For artificial insemination or in vitro fertilization.
33. For any medication prescribed to induce ovulation or spermatogenesis.
34. 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.
35. For treatments associated with teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) Surgery, except as specified.
36. For treatment with intraoral prosthetic devices or by any other method, to alter vertical dimension.
37. For treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis.

38. For personal hygiene and convenience items.
39. 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.
40. 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).
41. For all services related to hearing loss including hearing aids or examinations for prescribing or fitting them.
42. For immunizations, other than those specified as covered in the Routine and Wellness Services section of the Certificate.
43. For massotherapy or massage therapy.
44. For hypnosis and acupuncture.
45. For After Hours Care.
46. For telephone consultations, online consultations, missed appointments, completion of claim forms or copies of medical records.
47. For fraudulent or misrepresented claims.
48. For blood which is available without charge. For Outpatient blood storage services.
49. For Prescription Drugs, except as specified.
50. For over the counter drugs, vitamins or herbal remedies.
51. For specialized camps.
52. For Routine Services, except as specified.
53. For non-covered services or services specifically excluded in the text of the Certificate.

PREEXISTING CONDITION DEFINITION AND EXCLUSION PERIOD

Preexisting Condition means any physical or mental Condition, sickness, impairment or ailment, regardless of cause, for which medical advice, diagnosis, care or treatment was received within the six month period ending on the effective date of coverage under a group health plan, the date of enrollment under a group health insurance plan or the first date of a waiting period for a group health insurance plan, whichever is earliest. In no case shall any of the following be considered a preexisting Condition: (1) pregnancy, or (2) genetic information in the absence of a diagnosis related to such information.

If a Preexisting Condition existed at any time during the six (6) month period immediately preceding your Enrollment Date, Consumers Life will provide benefits for the Preexisting Condition for Covered Services Incurred after twelve (12) months following your Enrollment Date.

If you had other health care coverage prior to your Enrollment Date, and you did not experience a Significant Break in Coverage, your prior coverage will be credited toward the twelve (12) month exclusion period. A Significant Break in Coverage is a period of 90 consecutive days during which you did not have any other health care coverage, except that waiting periods are carved out. The standard method, which does not consider specific benefits, is used to determine creditable coverage.

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Georgia
Rx Option I
Prescription Drug Program

Benefits	Copay	Day Supply
Benefit Period	January 1st through December 31st	
Dependent Age Limit	26, Removal upon End of Month	
Retail Program with Oral Contraceptive Coverage [1,2]		
Generic Copayment	$15	30
Formulary Copayment	$30	30
Non-Formulary Copayment	$50	30
Home Delivery Program with Oral Contraceptive Coverage [1,2]		
Generic Copayment	$37.50	90
Formulary Copayment	$75	90
Non-Formulary Copayment	$125	90

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

This document is only a partial listing of benefits. This is not a contract of insurance. No person other than an officer of Consumers Life may agree, orally or in writing, to change the benefits listed here. The contract or certificate will contain the complete listing of covered services.

[1] Rx Selections® Drug List: A list of drugs on the Rx Selections® formulary will be used.
[2] 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.

Prescription Drug Benefit Exclusions and Limitations

In addition to the exclusions and limitations explained in the Prescription Drug Benefits section and your Certificate, coverage is not provided for services and supplies:

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.
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.
13. For non-covered services or services specifically excluded in the text of the Prescription Drug Rider.

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Georgia
Rx Option 2
Prescription Drug Program

Benefits	Copay	Day Supply
Benefit Period	January 1st through December 31st	
Dependent Age Limit	26, Removal upon End of Month	
Deductible	$200 per person per benefit period; excludes generics	
Retail Program with Oral Contraceptive Coverage [1,2]		
Generic Copayment	$10	30
Formulary Copayment	$30	30
Non-Formulary Copayment	$50	30
Home Delivery Program with Oral Contraceptive Coverage [1,2]		
Generic Copayment	$30	90
Formulary Copayment	$90	90
Non-Formulary Copayment	$150	90

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

This document is only a partial listing of benefits. This is not a contract of insurance. No person other than an officer of Consumers Life may agree, orally or in writing, to change the benefits listed here. The contract or certificate will contain the complete listing of covered services.

[1] Rx Selections® Drug List: A list of drugs on the Rx Selections® formulary will be used.
[2] 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.

Prescription Drug Benefit Exclusions and Limitations

In addition to the exclusions and limitations explained in the Prescription Drug Benefits section and your Certificate, coverage is not provided for services and supplies:

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.
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.
13. For non-covered services or services specifically excluded in the text of the Prescription Drug Rider.

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Georgia
RX Option 3
Prescription Drug Program

Benefits	Copay	Day Supply
Benefit Period	January 1st through December 31st	
Dependent Age Limit	26, Removal upon End of Month	
Benefit Period Maximum	$5,000 per person	
Retail Program with Oral Contraceptive Coverage [1]		
Generic Copayment [2]	$10	30
Formulary Copayment [2]	$40	30
Non-Formulary Copayment [2]	$60	30
Prescriptions over $500	20%	30
Home Delivery Program with Oral Contraceptive Coverage [1]		
Generic Copayment [2]	$30	90
Formulary Copayment [2]	$120	90
Non-Formulary Copayment [2]	$180	90
Prescriptions over $1500	20%	90

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

This document is only a partial listing of benefits. This is not a contract of insurance. No person other than an officer of Consumers Life may agree, orally or in writing, to change the benefits listed here. The contract or certificate will contain the complete listing of covered services.

[1] Rx Selections® Drug List: A list of drugs on the Rx Selections® formulary will be used.
[2] 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.

Prescription Drug Benefit Exclusions and Limitations

In addition to the exclusions and limitations explained in the Prescription Drug Benefits section and your Certificate, coverage is not provided for services and supplies:

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.
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.
13. For non-covered services or services specifically excluded in the text of the Prescription Drug Rider.

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2060 East 9th Street
Cleveland, OH 44115-2263
Visit ConsumersLife.com
877/254-2669

Georgia
Rx Option 4
Prescription Drug Program

Benefits	Copay	Day Supply
Benefit Period	January 1st through December 31st	
Dependent Age Limit	26, Removal upon End of Month	
Benefit Period Maximum	$5,000 per person	
Retail Program with Oral Contraceptive Coverage [1,2]		
Generic Copayment	$10	30
Formulary Copayment	20%	30
Non-Formulary Copayment	30%	30
Home Delivery Program with Oral Contraceptive Coverage [1,2]		
Generic Copayment	$30	90
Formulary Copayment	20%	90
Non-Formulary Copayment	30%	90

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

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