



MICHIGAN VALUE PLANS



BASE PLAN	500/1500	1000/3000	1500/4500	2500/7500	5000/15000
Network Benefit Period Deductible — Single/Family	\$500/\$1,500	\$1,000/\$3,000	\$1,500/\$4,500	\$2,500/\$7,500	\$5,000/\$15,000
Non-Network Benefit Period Deductible – Single/Family	\$1,500/\$4,500	\$2,000/\$6,000	\$2,500/\$7,500	\$3,500/\$10,500	\$6,000/\$18,000
Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	\$4,000/\$12,000	\$4,000/\$12,000	\$4,000/\$12,000	\$4,000/\$12,000	\$4,000/\$12,000
Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	\$25,000/\$50,000	\$25,000/\$50,000	\$25,000/\$50,000	\$25,000/\$50,000	\$25,000/\$50,000
Office Visit (OV) Copay	\$35				
Coinsurance – Network/Non-Network	70% / 50%				
Lifetime Maximum	\$2,000,000				

BENEFITS	PPO NETWORK	NON-PPO NETWORK
Benefit Period	January 1 st through December 31 st	
Dependent Age Limit	19 Dependent, 23 Student; Removal upon End of the Month	
Physician/Office Services		
Office & Urgent Care Visits (Illness/Injury)	\$35 copay, then 100%	50% after deductible
Standard Immunizations	70% after deductible	50% after deductible
Preventive Services		
Routine Physical Exam	NOT COVERED	
Well Child Care Services to age nine. Well Child Care exams and immunizations are limited to \$1000 per child to age 1; thereafter, \$150 per child per birth year to age 9.		
Well Child Care Exams	\$35 copay, then 100%	50% after deductible ¹
Well Child Immunizations & Labs	70% after deductible	50% after deductible
Routine Mammogram (one per benefit period)	70% after deductible	50% after deductible
Routine Pap Tests (one per benefit period)	70% after deductible	50% after deductible
Routine PSA Tests	70% after deductible	50% after deductible
Routine EKG, chest X-ray, comprehensive metabolic panel, urinalysis and complete blood count	NOT COVERED	
Outpatient Services		
Allergy Testing and Treatments	NOT COVERED	
Physical Therapy (10 visits per benefit period)	70% after deductible	50% after deductible
Occupational Therapy (10 visits per benefit period)	70% after deductible	50% after deductible
Speech Therapy	NOT COVERED	
Chiropractic Services (6 visits per benefit period)	70% after deductible	50% after deductible
Cardiac Rehab	NOT COVERED	
Emergency Use of an Emergency Room	\$250 copay, then 70% after deductible	
Non-Emergency Use of an Emergency Room	NOT COVERED	
Surgical Services	\$250 copay per day, then 70% after deductible	50% after deductible
Diagnostic Services	\$250 copay per day, then 70% after deductible	50% after deductible
Inpatient Services		
Semi-Private Room and Board	\$250 copay per admission, then 70% after deductible	50% after deductible
Skilled Nursing Facility (\$10,000 maximum per benefit period)	\$250 copay per admission, then 70% after deductible	50% after deductible

BENEFITS	PPO NETWORK	NON-PPO NETWORK
Additional Services		
Ambulance (\$2,500 Maximum per benefit period)	70% after deductible	
Durable Medical Equipment	50% after deductible	
Home Health Care (60 visits per benefit period)	70% after deductible	50% after deductible ¹
Hospice	70% after deductible	50% after deductible ¹
Organ and Tissue Transplants	\$250 copay per admission, then 70% after deductible	50% after deductible
Diabetic Education and Training	70% after deductible	50% after deductible
Mental Health & Substance Abuse		
Inpatient and Outpatient Mental Health	NOT COVERED	
Inpatient and Outpatient Substance Abuse (\$4,500 limit per benefit period)	70% after deductible	50% after deductible ¹
Prescription Drug		
Prescription Drug Benefit Period Deductible	\$100 per person	
Retail – 30 Day Supply	\$10 copay – Generic drugs only ²	
Home Delivery	NOT COVERED	
Optional Rider		
Prescription Drug Rider– Oral Contraceptives Included³		
Prescription Drug Benefit Period Deductible – Single/Family	\$250/\$500 excludes generics	
Prescription Drug Benefit Period Maximum	\$2,000 per person	
Retail – 30 Day Supply	\$15 Generic / \$30 Formulary / 50% with a minimum of \$45 and maximum of \$90 Non-Formulary	
Home Delivery – 90 Day Supply	\$37.50 Generic / \$75 Formulary / \$112.50 Non-Formulary	

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

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

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

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

¹ Coinsurance does not apply to coinsurance out-of-pocket maximums. These services will not be covered at 100% once coinsurance out-of-pocket maximums are met.

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

³ Drug benefit contains the following:

- Rx Selections® Drug List: A list of drugs on the Rx Selections® formulary will be used.
- Generic Incentive: If the member or physician requests a brand-name drug, and a generic equivalent exists, the member pays the generic copayment PLUS the difference between the cost of the generic drug and the brand-name drug.