

**MICHIGAN
500/1000**

BENEFITS	PPO Network	Non PPO Network
Benefit Period	January 1 st through December 31 st	
Dependent Age Limit	The end of the month of the 23 rd birthday	
Lifetime Maximum	\$3,000,000	
Benefit Period Deductible — Single/Family	\$500/\$1,000	\$1,000/\$2,000
Coinsurance	80%	50%
Coinsurance Out-of-Pocket Maximum — Single/Family	\$2,000/\$4,000	\$4,000/\$8,000
MEDICAL SERVICES		
Medical Necessary Office Visits ¹	\$25 copay per visit then 100%	\$25 copay per visit then 50%
Urgent Care Office Visit ¹	\$25 copay per visit then 100%	\$25 copay per visit then 50%
Routine Office Visit ¹	\$25 copay per visit then 100%	\$25 copay per visit then 50%
Well Child Care Services (to age nine) \$500 maximum per benefit period		
Office Visit ¹	\$25 copay per visit then 100%	\$25 copay per visit then 50% ²
Immunizations	80% after deductible	50% after deductible
Routine Pap Test — One per benefit period	80% after deductible	50% after deductible
Routine Mammogram — One per benefit period	80% after deductible	50% after deductible
Outpatient Diagnostic Services	80% after deductible	50% after deductible
One Routine EKG, chest X-ray, comprehensive metabolic panel, urinalysis and complete blood count per benefit period	80% after deductible	50% after deductible
Outpatient Surgery	80% after deductible	50% after deductible
Physical and Occupational Therapy(\$5,000 combined maximum per benefit period), Speech Therapy (\$5,000 maximum per benefit period) and Chiropractic Services(12 visits per benefit period)	80% after deductible	50% after deductible
Inpatient Hospital/Surgical Services	80% after deductible	50% after deductible
Emergency Use of a Hospital Emergency Room	80% after deductible	80% after deductible
Non-Emergency Use of a Hospital Emergency Room	80% after deductible	50% after deductible
Ambulance Service - \$2,500 maximum per benefit period	80% after deductible	50% after deductible
Private Duty Nursing - \$1,000 maximum per benefit period	80% after deductible	50% after deductible
Home Health Care	80% after deductible	50% ² after deductible
Skilled Nursing - \$10,000 maximum per benefit period	80% after deductible	50% after deductible
Diabetes Education	80% after deductible	50% after deductible
Outpatient Cardiac Rehab (20 visits per benefit period)	80% after deductible	50% after deductible
Hospice	80% after deductible	50% ² after deductible
PRESCRIPTION DRUG – ORAL CONTRACEPTIVES INCLUDED		
Prescription Drug Benefit Period Deductible ³ – Single/Family	\$250/\$500	
Benefit Period Maximum ⁴	\$2,000	
Retail — 30 Day Supply	80% after deductible	50% after deductible
Home Delivery — 90 Day Supply	80% after deductible	Not Covered
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Mental Health Services: 30 days per benefit period	80% after deductible	50% ² after deductible
Outpatient Mental Health Services: 20 visits per benefit period	80% after deductible	50% ² after deductible
Inpatient & Outpatient Substance Abuse Services \$3,440 limit per benefit period ⁶	80% after deductible	50% ² after deductible

OPTIONAL BENEFITS

Maternity Rider

Benefits are payable after 270 days of coverage under the maternity rider with no dollar maximum	80% ² after deductible	50% ² after deductible
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Prescription Drug Rider – Oral Contraceptives Included⁵

Retail – 30 Day Supply	\$15 Generic / \$30 Formulary / \$45 Non-Formulary
Home Delivery – 90 Day Supply	\$30 Generic / \$60 Formulary / \$90 Non-Formulary

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 only apply to the Non PPO Network coinsurance out-of-pocket.

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.

¹ Office visit copay applies to the cost of the office visit only. Copays do not accumulate to deductible or coinsurance limits.

² Coinsurance does not apply to out of pocket maximums. These services will not be covered at 100% once out-of-pocket maximum is met.

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

⁴ The benefit period maximum is combined for both retail and home delivery drugs.

⁵ 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.
- Home Delivery Incentive: When a member chooses to fill a prescription a fourth time at a retail pharmacy within 180 days, the member will pay twice the normal retail copayment.

⁶ The inpatient/outpatient Substance Abuse dollar limit per benefit period may change yearly.