



State of Michigan Employees - Actives

| SUMMARY OF BENEFITS AND COVERAGE | State of Michigan Employees |
|---|-------------------------------|
| PHYSICIAN SERVICES / PREVENTATIVE SERVICES | |
| Primary care office visits | \$10 Co-pay |
| Specialist office visits | \$10 Co-pay |
| Annual physical exam | \$10 Co-pay |
| Annual well woman visit | \$10 Co-pay |
| Hearing and vision screening | \$10 Co-pay |
| Immunizations (pediatric) | \$10 Co-pay |
| PSA screening | \$10 Co-pay |
| Well child care | \$10 Co-pay |
| Allergy test, treatments, and injections | \$10 Co-pay |
| Chiropractic care (20 visits per year) | \$10 Co-pay |
| Nutritional counseling and education | \$10 Co-pay |
| Health education and counseling | \$10 Co-pay |
| MATERNITY SERVICE | |
| Prenatal & postnatal care | \$10 Co-pay (one time Co-pay) |
| Delivery in hospital | Covered |
| Well baby care in hospital | Covered |
| INPATIENT HOSPITAL SERVICES | |
| Unlimited days in a semi-private room; surgery, all physicians and other ancillary services; related drug therapy; lab tests and x-rays | Covered |
| OUTPATIENT PROCEDURES | |
| Surgery and all invasive procedures conducted in any outpatient setting, including physicians and other ancillary services; related drug therapy; lab tests and xrays | Covered |
| EMERGENCY MEDICAL SERVICES | |
| Physician and hospital emergency room services (Co-pay waived if admitted) | \$50 Co-pay |
| Ambulance services (when medically necessary) | Covered |
| AFTER HOURS MEDICAL SERVICES | |
| Participating after-hours care centers (Urgent Care) | Covered |
| DIAGNOSTIC & THERAPEUTIC SERVICES | |
| Outpatient lab tests; diagnostic x-rays; and radiation therapy at a hospital | Covered |
| Chemotherapy | Covered |
| Physical, occupational and speech therapy | Covered |
| Non-preventative diagnostics including lab, x-ray, pathology, and special diagnostics in a non-hospital setting | Covered |
| Mammograms | Covered |
| MENTAL HEALTH CARE | |
| Outpatient treatment | Covered |
| Inpatient psychiatric hospital services | Covered |
| SUBSTANCE ABUSE TREATMENT | |
| Outpatient Care | Covered |
| Intermediate Care | Covered |
| OTHER SERVICES | |
| Home Health Care (limited to 100 visits/year) | Covered |
| Hospice care | Covered |
| Skilled Nursing Care Facility (limited to 120 days per calendar year) | Covered |
| DURABLE MEDICAL EQUIPMENT / PROSTHETIC DEVICES | |
| Covered when medically necessary | Covered |
| HEARING SERVICES | |
| Hearing exam and hearing aid testing | Covered |
| Hearing aid (limited to one every three years) | Covered |
| VISION SERVICES | |
| Eye exam (limited to one year) | Covered |
| Eyeglasses (limited to one pair every two years) | Covered |
| PRESCRIPTION DRUG SERVICES | |
| Formulary medications prescribed by a THC participating provider and through a THC participating pharmacy | \$5 Generic \$10 Brand |
| *When <u>no</u> Generic equivalent is available | |

The benefits described above are intended to be only a summary description. For details, please review the Certificate of Coverage Agreement.