

# TOTAL HEALTH CARE, INC.

## Summary of Benefits for State of Michigan Employees

**EFFECTIVE AFTER 10/13/02**

### SERVICES IN THE HOSPITAL

Number of Days of Care	Unlimited
Semi-Private Room & Intensive Care	Covered
Miscellaneous Hospital Services	Covered
Surgery & All Related Services	Covered
Laboratory Tests & X-rays	Covered
Medicines & Drugs	Covered

### EMERGENCY MEDICAL CARE

Physician & Hospital Emergency Room Services	
At participating hospitals	Covered, Copayment May Apply
Other hospitals in plan service area	Covered, Copayment May Apply
Other hospitals outside plan service area	Covered, Copayment May Apply

### AMBULANCE SERVICE

	Covered When Life Threatening or Approved
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### PHYSICIAN SERVICES

Routine Office Visits	Covered after \$10 co-pay
Consulting Specialist Care When Necessary	Covered after \$10 co-pay
Annual Physical Examination	Covered after \$10 co-pay
Dermatology Services	Covered after \$10 co-pay

### MATERNITY SERVICES

Prenatal & Postnatal Care	Covered after \$10 co-pay
Delivery in Hospital	Covered
Well Baby Care in Hospital	Covered
Home Delivery	Not Covered

### PRESCRIPTIONS

Prescription Drugs	\$5 co-pay for generic
Prescription Drugs	\$10 co-pay for brand name
Birth Control Pills	\$5 co-pay for generic
Birth Control Pills	\$10 co-pay for brand name

### DIAGNOSTIC & THERAPEUTIC PROCEDURES

Laboratory Tests	Covered
Radiation Therapy	Covered
Diagnostic X-Rays	Covered

### PREVENTATIVE SERVICES

Hearing & Vision Screening	Covered
Immunizations	Covered after \$10 office visit co-pay
Voluntary Family Planning	Covered after \$10 office visit co-pay
Sterilization	Covered
Infertility Counseling & Treatment	Covered after \$10 office visit co-pay

### MENTAL HEALTH CARE

Outpatient Visits	20 Visits/Year
Inpatient Psychiatric Hospital	45 Days, Renewable
Services	After 60 Days

### ALCOHOLISM & DRUG ABUSE SERVICES

Outpatient & Intermediate Care	To State Mandated Levels
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### ALTERNATE MEDICAL SYSTEMS

Nursing Services in the Home	100 Visits Year
Home Health Aide Care	Covered
Skilled Nursing Home Care	Covered, 730 Days
Custodial Care	Not Covered

### HOSPICE CARE

	Covered
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### HEARING SERVICES

Hearing Examination	Covered
Hearing Aid Evaluation Test	Covered
Hearing Aid (1 every 3 years)	Covered

### VISION

Eye Examination (1 per year)	Covered
Eyeglasses (1 pair every other year)	Covered

### APPLIANCES & PROSTHETIC DEVICES

When Medically Necessary	Covered
When Body's Growth or Development Necessitates Replacement	Covered
Normal Wear & Damage	Covered

### DURABLE MEDICAL EQUIPMENT

	Covered
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### MISCELLANEOUS

Major Medical Deductible	None
Major Medical Copayments	\$10 co-pay for office visits \$50 co-pay for emergency room (unless admitted); \$5 for generic drugs and \$10 for brand name drugs
Conversion Option	Yes
Claim Forms	None
Worldwide Coverage	Yes, Emergencies
Coverage for Incapacitated Employee Over 65 Coverage	Yes
Coverage After Retirement	No