

**WAYNE COUNTY FOUR STAR HEALTH PROGRAM
SCHEDULE OF MEDICAL COVERAGE**

January 2012

Benefits (Employee and Spouse Only; Children Covered upon Proof of Denial by MIChild)

In-Network benefits are based on the Four Star Provider Organization's approved amount. Out-of-Network benefits are not provided except for life-threatening emergencies and are then based on the Alliance Health and Life fee schedule. Benefits are determined after applicable Copay and Coinsurance, and are subject to Daily, Annual, Lifetime, and Other Maximums, General Exclusions and other applicable limitations.

Annual Maximum, All Benefits Combined, regardless of individual service maximums \$35,000 Lifetime Maximum, All Benefits Combined, regardless of individual service maximums \$250,000		
*Benefits are provided Out-of-Network only for Life-Threatening Emergencies	In-Network Plan Pays after Member's Copay and Coinsurance	Out-of-Network *Benefits are provided Out-of- Network only for Life-Threatening Emergencies
Inpatient Hospital Services		
(Semi-Private Room and Board, Intensive Care Unit, Ancillary Services)		
General Conditions \$25,000 Annual Maximum 20 Day Annual Maximum	\$100 Copay per Admission	Not Covered*
Psychiatric Treatment 5 Day Annual Maximum	\$100 Copay per Admission	Not Covered*
Substance Abuse Care	Not Covered	Not Covered*
Maternity Per Delivery Maximum of \$3,000; 4 Day Annual Maximum	\$100 Copay per Admission	Not Covered*
Newborn, including Nursery	Not Covered	Not Covered
Emergency Services		
Emergency Room (\$1,000 Per Visit Maximum Facility & Professional Charges)	\$50 Copay	Covered for emergencies only
Outpatient Services		
	\$3,500 Annual Maximum, Regardless of Individual line limits	
Urgent Care Center	\$25 Copay per visit	Not Covered*
Ambulance	10% Coinsurance	Not Covered*
Surgery Facility (includes Anesthesia) Charge, \$1,500 per Surgery Maximum	No Copay or Coinsurance	Not Covered*
Laboratory, X-ray, Radiology, Pathology	No Copay or Coinsurance	Not Covered*
Prosthetic Devices, Durable Medical Equipment and Medical Supplies - \$1,500 Annual Maximum	\$50 Copay for DME and Prosthetics only	Not Covered*
Physical, Speech and Occupational Therapy	Not Covered	Not Covered*
Private Duty Nursing (R.N. only)	Not Covered	Not Covered*
Extended Care Facility	Not Covered	Not Covered*
Hospice Care Program	Not Covered	Not Covered*
Home Health Agency, 10 visit Annual Maximum	No Copay or Coinsurance	Not Covered*
Psychiatric Services, including testing, (Intervention & Stabilization Only) 6 visits Annual Maximum	\$15 Copay	Not Covered*
Physician Surgical procedures, \$10,000 Annual Maximum	No Copay or Coinsurance	Not Covered*
Physician Services - anesthesia, \$2,500 Annual Maximum	No Copay or Coinsurance	Not Covered*
Physician in Hospital Consultations & Emergency Room	No Copay or Coinsurance	Not Covered*
Physician Office Visits	\$15 Copay	Not Covered*
Physician Maternity care including pre & postnatal	\$15 per visit	Not Covered*
Chiropractic Care, including x-rays	Not Covered	Not Covered*
Non Surgical Podiatric Care, all services	Not Covered	Not Covered*
Services (not included elsewhere)		
Intermediate/Outpatient Substance Abuse Care, \$3,500 Annual Maximum	20% Coinsurance	Not Covered*
Prescription Drugs \$2,500 Annual Maximum		
(Wayne County Four Star Plan Formulary)		
Brand Name, no generic available, \$25 minimum	50% Coinsurance	Not Covered
Generic	\$5 Copay	Not Covered