MICHIGAN STATE PAINTERS INSURANCE FUND
BENEFITS AND ELIGIBILITY AT A GLANCE

		In-Network	**Out-of-Network**
Deductible		$250 for one member, $500 for the family each calendar year	$1,000 for one member, $2,000 for the family each calendar year
Co-payments	Fixed dollar co-pays	$20 for office visits $50 for emergency room visits	$50 for emergency room visits
	Percent co-pays	50% of approved amount for mental health care, substance abuse treatment and private duty nursing 20% of approved amount for most other covered services (co-pay is waived if service is performed in a PPO office)	40% of approved amount for general services 50% of approved amount for mental health care substance abuse treatment, and private duty nursing
Co-payment dollar maximums	Percent co-pays	20% co-pays limited to $1,500 for one member $3,000 for two or more members each calendar year	40% out-of-network co-pays limited to an out-of-pocket maximum of $3,000 per member or $6,000 for the family each calendar year. Once the co-pay maximum has been reached, out-of-network claims are to be reimbursed at 100% of the approved amount for the remainder of the year.
Preventive Care Services			
Health Maintenance exam – includes chest x-ray, EKG, and select lab procedures; one per member, per calendar year		Covered – 100% of approved amount *	Not covered
Gynecological exam – one per calendar year		Covered – 100% of approved amount *	Not covered
Well baby and Child care visits (up to age 19) · 6 visits, birth through 35 months · 2 visits, 36 through 47 months		Covered – 100% of approved amount (no deductible or co-pay) Visits beyond 47 months are limited to one per member per calendar year under the health maintenance benefit	Not covered
Childhood Immunizations		Covered – 100% of approved amount *	Not covered
Fecal occult blood screening, Flexible Sigmoidoscopy exam & Prostate specific antigen (PSA)		Covered – 100% of approved amount *	Not covered

*** No deductible or co-pay; one per member per calendar year.**

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	In-Network	Out-of-Network
Mammography		
Mammography screening – one per calendar year, no age restrictions	Covered – 100% of approved amount	Not covered
Physician Office services		
Office visits, office consultations, urgent care visits	Covered - $20 co-pay	Covered – 60% of approved amount after deductible, must be medically necessary
Outpatient & home medical care visits	Covered – 80% of approved amount after deductible	Covered – 60% of approved amount after deductible, must be medically necessary
Emergency Medical care		
Hospital Emergency room	Covered - $50 co-pay for facility charges (waived if admitted or if injury is the result of an accidental injury)	Covered - $50 co-pay for facility charges (waived if admitted or if injury is the result of an accidental injury)
Ambulance services – must be medically necessary	Covered – 80% of approved amount after deductible	Covered – 80% of approved amount after deductible
Diagnostic Services		
Laboratory & pathology services	Covered – 80% of approved amount after deductible	Covered – 60% of approved amount after deductible
Diagnostic tests & X-rays	Covered – 80% of approved amount after deductible	Covered – 60% of approved amount after deductible
Therapeutic radiology	Covered – 80% of approved amount after deductible	Covered – 60% of approved amount after deductible
Maternity Services		
Prenatal & Postnatal care	Covered – 100% of approved amount (no deductible or co-pay)	Covered – 60% of approved amount after deductible
Delivery & Nursery care	Covered – 80% of approved amount after deductible	Covered – 60% of approved amount after deductible
Hospital Care		
Semiprivate room, inpatient physician care, general nursing care, hospital services & supplies – unlimited days	Covered – 80% of approved amount after deductible	Covered – 60% of approved amount after deductible
Inpatient consultations	Covered – 80% of approved amount after deductible	Covered – 60% of approved amount after deductible
Chemotherapy	Covered – 80% of approved amount after deductible	Covered – 60% of approved amount after deductible
Alternatives to Hospital Care		
Skilled nursing care – up to 120 days per member per calendar year	Covered – 80% of approved amount after deductible	Covered – 80% of approved amount after deductible

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Alternatives to Hospital Care		
Hospice care – limited to dollar maximum that is reviewed & adjusted periodically	Covered at 100% (no deductible or co-pay)	Covered at 100% (no deductible or co-pay)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only; limited to dollar maximum that is reviewed & adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care – must be medically necessary & provided & billed by a participating home health care agency	Covered at 80% after deductible	Covered at 80% after deductible
Home infusion therapy – must be medically necessary & given by participating home infusion therapy providers	Covered at 80% after deductible	Covered at 80% after deductible
Surgical Services		
Surgery – includes related surgical services & medically necessary facility services by a participating ambulatory surgery facility	Covered at 80% after deductible	Covered at 60% after deductible
Presurgical consultations	Covered at 100% (no deductible or co-pay)	Covered at 60% after deductible
Colonoscopy	Covered at 80% after deductible	Covered at 60% after deductible
Voluntary sterilization	Covered at 80% after deductible	Covered at 60% after deductible
Human organ transplants		
Specified human organ transplants – in designated facilities only, when coordinated through BCBSM Human Organ Transplant Program	Covered at 100% (no deductible or co-pay)	Covered at 100% (no deductible or co-pay)
Bone marrow transplants – when coordinated through BCBSM Human Organ Transplant Program	Covered at 80% after deductible	Covered at 60% after deductible

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	In-Network	Out-of-Network
Human organ transplants		
Specified oncology clinical trials	Covered at 80% after deductible	Covered at 60% after deductible
Kidney, cornea & skin transplants	Covered at 80% after deductible	Covered at 60% after deductible
Mental health care & substance abuse treatment		
Inpatient mental health care & inpatient substance abuse treatment (unlimited days)	Covered at 80% after deductible	Covered at 50% after deductible
Outpatient mental health care: · Facility & clinic · Physician's office	Covered at 80% after deductible	Covered at 50% after deductible; in participating facilities only
Outpatient substance abuse treatment – in approved facilities only	Covered at 80% after deductible	Covered at 50% after deductible
Other covered services		
Outpatient Diabetes Management Program **Note**: Effective July 1, 2011, when you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	Covered at 80% after deductible	Covered at 60% after deductible
Allergy testing and therapy	Covered at 100% (no deductible or co-pay)	Covered at 60% after deductible
Chiropractic spinal manipulation – Limited to a maximum of 24 visits per member per calendar year	Covered at 100% (no deductible or co-pay)	Covered at 60% after deductible
Outpatient physical, speech and occupational therapy – provided for rehabilitation. Limited to a combined maximum of 60 visits per member per calendar year	Covered at 80% after deductible	Covered at 60% after deductible **Note**: Services at nonparticipating outpatient physical therapy facilities are not covered
Durable medical equipment	Covered at 80% after deductible	Covered at 80% after deductible
Prosthetic and Orthotic appliances	Covered at 80% after deductible	Covered at 80% after deductible
Private duty nursing	Covered at 50% after deductible	Covered at 50% after deductible

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Prescription Drugs		**90-day retail network pharmacy**	***Network mail order provider**	**Network pharmacy (not part of the 90-day retail network)**	**Non-network pharmacy**
Generic drugs	1 to 30-day period	$15 co-pay	$15 co-pay	$15 co-pay	$15 co-pay plus additional 25% of BCBSM approved amount for the drug
	31 to 83 day-period	No coverage	$30 co-pay	No coverage	No coverage
	84 to 90-day period	$30 co-pay	$30 co-pay	No coverage	No coverage
Brand-name drugs	1 to 30-day period	$30 co-pay	$30 co-pay	$30 co-pay	$30 co-pay plus additional 25% of BCBSM approved amount for the drug
	31 to 83 day-period	No coverage	$60 co-pay	No coverage	No coverage
	84 to 90-day period	$60 co-pay	$60 co-pay	No coverage	No coverage
FDA-approved drugs		100% of approved amount less plan co-pay	100% of approved amount less plan co-pay	100% of approved amount less plan co-pay	75% of approved amount less plan co-pay
State controlled drugs		100% of approved amount less plan co-pay	100% of approved amount less plan co-pay	100% of approved amount less plan co-pay	75% of approved amount less plan co-pay
Disposable needles & syringes – when dispensed with insulin or other covered injectable legend drugs		100% of app amt less plan co-pay for insulin or other covered injectable legend drugs	100% of approved amount less plan co-pay for the insulin or other covered injectable legend drugs	100% of app amt less plan co-pay for insulin or other covered injectable legend drugs	75% of approved amount less plan co-pay for the insulin or other covered injectable legend drugs
Life Style Drugs (7/1/14)		100% of app amt less plan co-pay	100% of app amt less plan co-pay	100% of app amt less plan co-pay	100% of approved amount less plan co-pay

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	VSP network doctor	Non-VSP provider
Member's responsibility (co-pays)		
Eye exam	$5 co-pay	$5 co-pay applies to charge
Prescription glasses (lenses and/or frames)	A combined $10 co-pay	Member responsible for difference between approved amount & provider's charge, less $10 co-pay
Medically necessary contact lenses	$10 co-pay	Member responsible for difference between approved amount & provider's charge, less $10 co-pay
Eye Exam		
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing & other tests necessary to determine the overall visual health of the patient/	$5 co-pay; one eye exam in any period of 12 consecutive months	Reimbursement up to predetermined amount based on lense type less $10 co-pay (member responsible for any difference)
Lenses & frames		
Standard lenses (must not exceed 60mm in diameter) prescribed & dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism & special base curve lenses when medically necessary.	$10 co-pay (one co-pay applies to both lenses & frames) One pair of lenses, with or without frames, in any period of 12 consecutive months	Reimbursement up to predetermined amount based on lense type less $10 co-pay
Standard frames – one frame in any period of 12 consecutive months	$10 co-pay (one co-pay applies to both lenses & frames)	Reimbursement up to $45 less $10 co-pay (member responsible for any difference)
Contact lenses		
Medically necessary contact lenses (requires prior authorization approval from VSP & must meet certain criteria of medically necessary)	$10 co-pay One pair of contact lenses in any period of 12 consecutive months	Reimbursement up to $210 less $10 co-pay (member responsible for any difference)
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	$130 allowance that is applied toward contact lens exam (fitting & materials) & the contact lenses	$105 allowance that is applied toward contact lens exam (fitting & materials) & the contact lenses

Dental Coverage – ACTIVE PARTICIPANTS ONLY

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Benefits	**PPO Dentist**	**Premier Dentist**	**Non-Par Dentist**
Co-pay	20% of approved amount		
Dollar maximum	$1,500 per member, per calendar year		
Class I Services			
Benefits	**Plan Pays**	**Plan Pays**	**Plan Pays**
Diagnostic & Preventive Services – includes exams, cleanings, fluoride, & space maintainers	80%	80%	80%
Emergency Palliative Treatment – to temporarily relieve pain	80%	80%	80%
Sealants – to prevent decay of permanent teeth	80%	80%	80%
Brush Biopsy – to detect oral cancer	80%	80%	80%
Radiograph – x-rays	80%	80%	80%
Class II Services			
Major Restorative Services – includes crowns	80%	80%	80%
Minor Restorative Services – includes fillings	80%	80%	80%
Periodontic Services – to treat gum disease	80%	80%	80%
Endodontic Services – includes root canals	80%	80%	80%
Oral Surgery Services – extractions & dental surgery	80%	80%	80%
Relines & Repairs – to bridges & dentures	80%	80%	80%
Other Basic Services – misc. services	80%	80%	80%
Class III Services			
Prosthodontic Services – includes bridges & dentures	80%	80%	80%

Orthodontic Coverage – ACTIVE PARTICIPANTS ONLY

Benefits	PPO Dentist	Premier Dentist	Non-Par Dentist
Class IV Services			
Orthodontic Services – includes braces	80%	80%	80%
Orthodontic Age Limit	To age 20	To age 20	To age 20

◀Oral exams are payable twice per calendar year.
◀Prophylaxes (cleanings) are payable twice per calendar year.
◀Fluoride treatments are payable twice per calendar year with no age limit.
◀Benefits for space maintainers are unlimited for people up to age 18.
◀Bitewing x-rays are payable twice per calendar year and full mouth x-rays (which include bitewing x-rays) are payable once in any three (3) year period.
◀Two sealants are payable per calendar year for the occlusal surface of any tooth. The surface must be free from decay & restorations.
◀Composite resin (white) restorations are optional treatment of posterior teeth.
◀Porcelain crowns are optional treatment on posterior teeth.
◀Implants and related services are not Covered Services.

Hearing Care	In-Network	Out-of-Network
Deductible	None	Not applicable
Co-pay	None	Not applicable
Audiometric exam – one every 36 months	Covered – 100% of approved amount	Not covered
Hearing aid evaluation – one every 36 months	Covered – 100% of approved amount	Not covered
Ordering & fitting for a monaural or binaural hearing aid – one every 36 months	Covered – 100% of approved amount	Not covered
Hearing aid conformity test – one every 36 months	Covered – 100% of approved amount	Not covered
Additional Information		
Eligibility	**Initial**: 450 hours within six (6) consecutive months or less, skip one month for bookkeeping, eligible the following month. **Continuing**: 130 hours in one (1) month, skip two (2) months for bookkeeping, eligible the following month. **Re-Establish:** 260 hours within three (3) months, skip one month for bookkeeping, eligible the following month. (Termination date must be within twelve (12) months or less otherwise member must meet initial hour eligibility)	
Death Benefits	Active Participants (Member only) - $10,000 AD&D (Member only) – available up to $10,000 Retiree (Member only) - $2,500	
Disability Benefits	Active Participants only, pays $200 per week for up to twenty-six (26) weeks (6 months).	