

# **University of Maine System**

## **HMO Choice Point of Service Plan for Early Retirees Under Age 65**

### **2008 Benefit Summary and Amendment Number 08-01**

*This document is your January 1, 2008 Benefit Summary and Amendment to the University of Maine System HMO Choice Summary Plan Description/Certificate of Coverage for early Retirees Under Age 65 (form #6321ME). The University of Maine System Summary Plan Description/Certificate of Coverage for Early Retirees Under Age 65 (form #6321) is now the Benefit Booklet. When accompanied by the Benefit Booklet, this document (along with the Benefit Booklet) becomes the medical plan portion of the Plan. Any references in the Benefit Booklet to Anthem Blue Cross and Blue Shield (Anthem) as the insurer are deleted. The University of Maine System health plan is a self-funded plan. Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. This document describes the Plan as in effect on January 1, 2008.*

## BENEFIT SUMMARY

### University of Maine System HMO Choice Point of Service Plan for Early Retirees Under Age 65 Benefit Summary - Effective January 1, 2008

	University of Maine System HMO Choice – Point of Service	
	Highest Level of Benefits	Self-referred Level of Benefits
<b>Important Information</b>	<p>Benefits are based on the maximum allowance for covered services. The maximum allowance is the most that will be paid for a particular service.</p> <p>Coverage described in this column applies when covered services are provided or authorized by your Primary Care Physician, unless otherwise stated.</p> <p>You are responsible for any copayments and coinsurance that apply.</p>	<p>Benefits are based on the maximum allowance for covered services. The maximum allowance is the most that will be paid for a service.</p> <p>Coverage described in this column applies when you self-refer to providers or professionals. (The Primary Care Physician does NOT provide or authorize services.)</p> <p>You may be responsible for filing claims and paying balance bills in addition to the deductible, copayments, and coinsurance. You may also need to pay the provider or professional up front.</p>
<b>Inpatient Admission Review</b>	<p>Scheduled inpatient admissions, except for planned deliveries, require preadmission authorization by the Primary Care Physician.</p> <p>For emergency admissions, you should call your Primary Care Physician within 48 hours after admission.</p>	<p>For scheduled inpatient admissions, except for planned deliveries, you or someone you designate must call 1-800-392-1016 for preadmission review. If you self-refer and do NOT call for review before admission, benefits can be reduced by up to \$500. The penalty does not apply to emergency admissions.</p> <p>For emergency admissions, you or someone you designate should call within 48 hours after admission. For maternity admissions, you or someone you designate must call if the hospital stay is longer than 48 hours for a normal vaginal delivery or longer than 96 hours for a cesarean section.</p>
<b>Calendar Year Deductible</b>	None	\$250 per person/ \$500 per family
<b>Coinsurance</b>	None (except for infertility treatment and non-listed mental health care)	Unless otherwise specified: The health plan pays 80% You pay 20 %
<b>Calendar Year Out-of-pocket Limit (Deductible + Coinsurance)</b>	None	\$2,500 per person \$5,000 per family
<b>Lifetime Maximum Benefits General</b>	None	\$1,000,000

	Highest Benefit Level	Self-referred Benefit Level
<b>Hospital Services (Inpatient &amp; Outpatient)</b>	100%	80%
<b>Emergency Room Care</b>	100% after a \$25 copayment for the emergency room visit.  All other services associated with the emergency room care are subject to the Primary Care Physician Level of Benefits deductible, then paid at 100% <b>For emergency services, you should seek immediate medical care. If you are admitted to the hospital from the emergency room, the copayment is waived.</b>	
<b>Professional Services Inpatient &amp; Outpatient</b>	100%	80%
<b>Physician Office Visits:</b>		
<b>Sick Care</b>	100% after a \$20 copayment	80%
<b>Routine/Preventive</b>	100% after a \$20 copayment	Not covered
<b>Well Baby/Child Care</b>	100% after a \$20 copayment	Not covered
<b>Maternity Care:</b>		
<b>Pre &amp; Postnatal</b>	100% after a \$20 copayment for first visit	80%
<b>Delivery</b>	100%	80%
<b>Routine Gynecological Exam One Exam and Pap Test per calendar year</b>	100% after a \$20 copayment (No PCP referral required)	100% after a \$20 copayment (Not covered if you self-refer to a non-participating professional.)
<b>Family Planning Services</b>		
<b>Physical Exam, Laboratory Tests, Information &amp; Counseling</b>	100% after a \$20 copayment	80%
<b>Insertion/Removal of IUD</b>	100% after a \$20 copayment	80%
<b>Insertion/Removal of Norplant</b>	100% after a \$20 copayment	80%
<b>Diaphragm</b>	100% after a \$20 copayment	80%
<b>Vasectomy</b>	100%	80%
<b>Elective Tubal Ligation</b>	100%	80%
<b>Reverse Sterilization</b>	100%	80%
<b>Abortion</b>	100%	80% (no PCP referral required)
<b>Infertility Services See Summary Plan Description for limitations</b>	50%	Not covered
<b>Diagnostic Services</b>	100%	80%
<b>High Tech Diagnostic Radiology</b> (including but not limited to, CT Scans, MRI/MRAs, Nuclear Cardiology, PET Scans. <b>These services require prior authorization</b> )	100%	80%
<b>Physical &amp; Occupational Therapy</b>	100% after a \$20 copayment <i>Combined limit of \$3,000 per calendar year for physical, occupational, and speech therapy</i>	80%
<b>Speech Therapy</b>	100% after a \$20 copayment <i>Combined limit of \$3,000 per calendar year for physical, occupational, and speech therapy</i>	80%
<b>Cardiac Therapy</b>	100% after a \$20 copayment <i>3 sessions per week, up to 24 sessions per calendar year</i>	80%

	Highest Benefit Level	Self-referred Benefit Level
<b>Chiropractic Care</b>	100% after a \$20 copayment No referral required for up to 36 visits in a calendar year to a network professional	100% after a \$20 copayment for the first 36 visits in a calendar year to a network chiropractor. 80% for visits to a non-network professional or over 36 visits in a calendar year
<b>Routine Eye Exam</b> <i>One routine eye exam every calendar year up to age 19. One routine eye exam every two calendar years thereafter.</i>	100% after a \$20 copayment	100% after a \$20 copayment (no PCP referral required) Not covered if you self-refer to a non-participating professional
<b>Private Duty Nursing</b> <i>Preapproval required</i>	100%	80% <i>Up to \$ 2,500 per calendar year</i>
<b>Skilled Nursing Facility</b>	100%	80%
<b>Home Health Care</b> <i>Preapproval required</i>	100%	80%
<b>Hospice</b>	100%	80%
<b>Durable Medical Equipment</b> <i>(Prosthetics to replace limbs are not subject to the limit or deductible)</i>	100%	80%
<b>Smoking Cessation</b>		
<b>Smoking Cessation Program</b> <i>Up to \$35 per program; \$70 per lifetime</i>	100%	80%
<b>Medications prescribed by a physician</b>	Prescription drug copayment applies	Prescription drug copayment applies
<b>Physician Follow-up Visits/Counseling</b>	100% after a \$20 copayment	80%
	<b>Highest Benefit Level</b>	<b>Lower Benefit Level</b>
<b>Mental Health and Substance Abuse</b> Managed by Anthem Behavioral Health (ABH) - all non-emergency services require preauthorization. Failure to comply with the requirements outlined in your Summary Plan Description/ Certificate of Coverage may result in a penalty up to \$500.	This coverage level applies when you obtain preauthorization from ABH (1-800-755-0851) for non-emergency inpatient and outpatient mental health and substance abuse services, <b>AND</b> receive those services from the authorized provider.	This coverage level applies when you do <b>NOT</b> contact ABH (1-800-755-0851) for preauthorization of non-emergency mental health and substance abuse services <b>OR</b> choose to receive services from a non-authorized provider. (You may have to pay balance bills in addition to deductible and coinsurance amounts.)
<b>*Listed Mental Illnesses: Benefits are provided at the same benefit level provided for medical treatment for the following listed mental illnesses: Psychotic disorders, including schizophrenia; dissociative disorders; mood disorders; anxiety disorders; personality disorders; paraphilias; attention deficit and disruptive behavior disorders; pervasive developmental disorders; tic disorders; eating disorders, including bulimia and anorexia; and substance abuse-related disorders.</b>		

	Highest Benefit Level	Lower Benefit Level
<b>Mental Health Services</b>		
<b><u>*Listed mental illnesses including substance abuse services:</u></b>		
Inpatient	100%	80% after deductible
Day Treatment	100%	80% after deductible
Outpatient	100%	80% after deductible
Hospital Emergency Room	\$25 copayment, then 100%	\$25 copayment, then 100%
Office Visits	\$20 copayment, then 100%	80% after deductible
Home Health Care Services	100%	80% after deductible
<b><u>Non listed mental illnesses:</u></b>		
Inpatient	80%	60% after deductible
<i>Up to a combined limit of 60 days per person per calendar year</i>	<i>Two days of day treatment equal one day of inpatient services.</i>	<i>Two days of day treatment equal one day of inpatient services.</i>
Outpatient	50%	30% after deductible
<i>Up to a combined limit of 40 visits per person per calendar year.</i>		
Home Health Care Services	100%	80% after deductible

**Prescription Drug Coverage (3 Tier Benefit)**

**Note: Primary Care Physician authorization is not required.**

**Retail Pharmacy**

**Tier 1 Drugs:**

You pay a:  
 \$10 copayment for up to a 30-day supply,  
 \$20 copayment for up to a 60-day supply,  
 \$30 copayment for up to a 90-day supply.

**Tier 2 Drugs:\***

You pay a:  
 \$25 copayment for up to a 30-day supply,  
 \$50 copayment for up to a 60-day supply,  
 \$75 copayment for up to a 90-day supply.

**Tier 3 Drugs: \***

You pay a:  
 \$40 copayment for up to a 30-day supply,  
 \$80 copayment for up to a 60-day supply,  
 \$120 copayment for up to a 90-day supply.

**Mail Service Pharmacy**

**Tier 1 Drugs:** You pay a \$20 copayment for up to a 90-day supply.

**Tier 2 Drugs\*:** You pay a \$50 copayment for up to a 90-day supply.

**Tier 3 Drugs\*:** You pay a \$80 copayment for up to a 90-day supply.

Certain Maine retail pharmacies can fill your prescription at the same copayments that apply to the mail service pharmacy level of benefits. Please ask your pharmacy if they offer this special arrangement or call the Anthem Customer Service Department at the phone number on your ID card for a list of retail pharmacies that offer the mail service pharmacy level of benefits.

Any amendments that apply to your coverage are listed below:

## PLAN INFORMATION

**Plan Name:** The University of Maine System Group Health Plan

**Type of Plan:** Self-funded Group Health Plan, medical benefits including prescription drug benefits

**Employer/Plan Sponsor Name, Address and Phone Number:** University of Maine System  
16 Central Street  
Bangor, Maine 04401

**Plan Year:** January 1 though December 31, 2008

**Plan Administrator:** University of Maine System  
16 Central Street  
Bangor, Maine 04401

The Plan Administrator has authority to control and manage the operation and administration of the Plan, subject to the terms of the contracts.

**Agent for Service of Legal Process:** University of Maine System  
16 Central Street  
Bangor, Maine 04401

**Type of Plan Administration** Contract Administration

**Claims Administrator  
Fiduciary for Appeals Only** Anthem Blue Cross and Blue Shield  
2 Gannett Drive  
South Portland, ME 04106

**Plan Changes or Termination:** The Plan Administrator may amend the Plan in whole or in part at any time. The Plan Sponsor reserves the right to terminate the Plan at any time, by action of the University of Maine System or its delegate.

**Accompanying Documents:** The term “Summary Plan Description/Certificates of Coverage” refers to the documentation provided by the Contract Administrator, which describes in detail certain benefits provided through the health plan. If you do not have a copy of a Certificate of Coverage, you may obtain one from the Plan Administrator.

**Amendment to the University of Maine System HMO Choice Summary Plan  
Description/Certificate of Coverage for Early Retirees Under Age 65 (Form #6321ME),  
Hereinafter Referred to as the Benefit Booklet**

**Introduction**

The “Introduction” is deleted and replaced with the following:

This Document is your Benefit Booklet and describes the benefits available to participants under the self-funded University of Maine System HMO Choice Plan for early retirees who are under age 65.

The benefits described in this Document are those in effect as of January 1, 2008. The Plan is subject to the terms, provisions and limitations stated herein. Every attempt has been made to be informative about benefits available under the Plan and those areas where a benefit may be lost or denied.

In the event where a question arises as to a claim for benefits or denial of a claim for benefits, the Employer, Plan Administrator, Contract Administrator, and such other individuals as may be party to or associated with the Plan shall be guided solely by this Document.

The Plan Administrator shall have authority, subject to applicable law, to interpret this Plan, its provisions and regulations with regard to eligibility, coverage, benefit entitlement, benefit determination and general administrative matters. The Plan Administrator’s decisions will be binding on all Participants and conclusive on all questions of coverage under this Plan, subject to the Participant’s appeal rights described later in the Document.

The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator reserves the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

**Funding**

All references to Anthem as the insurer or insurer administrator of the Plan are deleted. Anthem is the Contract Administrator and receives payment from the University of Maine System to administer the University of Maine System HMO Choice Plan for Early Retirees Under Age 65. All references to premium payments or subscription charges paid to Anthem are deleted.

You may be required to share in the cost for Health Plan coverage on a contributory basis. The University of Maine System shall from time to time evaluate the cost of the Plan and determine the premium to be paid for Plan benefits. The University of Maine System pays claims otherwise allowable under the terms of the Plan.

All references to the “Group Agreement” are deleted and replaced with the “Administrative Services Agreement”.

All references to “member” are deleted and replaced with “participant”. The following is added to the Definitions section.

**Participant** The subscriber and all family members who are eligible for properly enrolled under the Plan.

### **Benefit Booklet**

All references to the “Summary Plan Description/Certificate of Coverage” are deleted and replaced with “Benefit Booklet”.

The following is added to the Definitions section:

**Benefit Booklet** A description of the portion of the health care benefits provided under the Plan that is administered by Anthem.

### **Eligibility for Dependents Losing Coverage**

The following is added to the “Qualifying Life Events” subsection of the “Eligibility, Termination and Continuation of Coverage” section:

- A dependent with other coverage losing that coverage
- Reaching a lifetime limit on all benefits under other coverage

The following is added to “Conditions required for enrollment” in the “Special Enrollment” subsection of the “Eligibility, Termination and Continuation of Coverage” section:

- h. a dependent who has other coverage loses eligibility under that coverage

### **Pharmacy**

The “Covered Services” section is changed by adding the following to the “Prescription Drugs” provision:

**Specialty Pharmacy Network** You or your physician can order specialty drugs directly from any network, specialty network or non-network pharmacy. If you or your physician orders your specialty drugs from a specialty participating pharmacy, you will be assigned a patient care coordinator who will work with you and your physician to obtain prior authorization and to coordinate any shipping of your specialty drugs directly to you or your physician’s office. Your patient care coordinator will also contact you directly when it is time to refill your specialty drug prescription.

Specialty pharmacies may fill retail and mail service specialty drug prescription orders, subject to a 30-90 day supply. The amount of benefits paid is based upon whether you receive the covered services from a network pharmacy, including a network specialty pharmacy, a non-network pharmacy, or a mail order vendor. You may obtain a list of specialty drugs available through the specialty pharmacy network and a list of participating specialty pharmacies by contacting the Anthem Customer Service number on the back of your ID card, or by visiting the website [www.anthem.com](http://www.anthem.com).

The “Definitions” section is changed by adding the following:

**Network Specialty Pharmacy** Any appropriately licensed pharmacy located within the United States which has entered into a contractual agreement with Anthem, or its pharmacy benefits manager designee, to render specialty drug services and certain administrative functions.

**Specialty Drug** Prescription legend drugs which:

- are approved to treat limited patient populations, indications or conditions;
- are normally injected, infused or require close monitoring by a physician or clinically trained individual; or

- have limited availability, special dispensing and delivery requirements, and/or require additional patient support- any or all of which make the drug difficult to obtain through traditional pharmacies.

### **Hearing Care**

The Covered Services Section is changed by adding the following:

**Hearing Care** Benefits are provided for wearable hearing aids for covered participants up to age 18. Coverage is limited to \$1,400 per hearing aid for each hearing-impaired ear every 36 months. Related items such as batteries, cords, and other assistive listening devices, including but not limited to, frequency modulation systems, are not covered. A hearing aid is defined as a wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing.

The “Exclusions” section is changed by deleting the “Hearing Care” exclusion and replacing it with the following:

**Hearing Care** Benefits are not provided for hearing examinations except for screening participants under the age of 19 years or when related to injury or disease. Please see “Hearing Care” in the “Covered Services” section for benefits for hearing aids.

### **Claims Payment**

The “Benefit Determinations, Payments and Appeals” section is changed as follows:

The “Claims Payment” section is changed by deleting the “Professional and Provider Payment”, “Primary Care Physician Services”, “Network Providers and Professionals”, and “Non-Network Providers and Professionals” subsections and replacing them with the following:

#### **Professional and Provider Payment**

When a network professional renders a covered service, the payment for the service is based on a maximum allowance agreed to by him or her. In addition to the maximum allowance, an eligible network professional can receive additional payments if he or she has met certain quality standards.

Payment will be based on the most cost effective means that can safely be administered. You can contact Anthem to find out the maximum allowance for a service by calling the telephone number on your ID card; the maximum allowance is calculated by various methodologies.

Network providers are paid in several different ways, including but not limited to discounts from regular charges and fixed fees agreed to by them.

#### **Primary Care Physician Services**

If your claim from a network professional PCP is approved, Benefits will be paid directly to your PCP. Payment will be based on the most cost effective means that can safely be administered. Except for copayments, in most cases, you are not required to pay any balances to your PCP for covered services. If more than a copayment applies, you are not required to pay any balances to your PCP until after Anthem determines the benefits that will be paid. Network professional PCPs rendering a covered service agree to limit their charges to the maximum allowance.

#### **Network Providers and Professionals**

If your PCP has authorized services from a network provider or professional, benefits will be paid directly to that provider or professional. Payment will be based on the most cost effective means that

can safely be administered. Except for copayments, you are not required to pay any balances to the network provider or professional until after Anthem determines the benefits that will be paid. Network providers and professionals rendering a covered service agree to limit their charges to the maximum allowance.

Your network professional's agreement for providing covered services may include financial incentives or risk sharing relationships related to provision of services or referrals to other professionals, including network professionals and non-network professionals and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your professional or Anthem.

Note: When services are rendered at a network provider by a non-network professional, you will be responsible for amounts over and above the maximum allowance paid to the non-network professional.

### **Non-Network Providers and Professionals**

Your PCP may refer you to a provider or professional that does not have a written agreement with Anthem. Benefits will be provided for covered services rendered by non-network providers or professionals only if such services are not available from a network provider or professional and/or prior approval has been granted by Anthem. Anthem will base this decision on factors such as the non-network provider's or professional's ability to meet certain standards for licensure and expertise to meet the needs of the participant.

Payment will be based on the most cost effective means that can be safely administered. If you self-refer to a provider or professional that does not have a written agreement with Anthem, the self-referred level of benefits will apply and you may be responsible for any remaining balance. Anthem will pay claims directly to you or the non-network provider or professional. Anthem will not provide benefits for services which were referred to non-network providers or professionals if the referral was not pre-approved by us.

The "Definitions" section is changed by deleting the definition of "Capitation" in its entirety.

The "Definitions" section is further changed by deleting the definition of "Maximum Allowance" and replacing it with the following:

**Maximum Allowance** The highest dollar amount that will be paid by the participant and the Plan for a covered service based on agreements with network providers and professionals. Payment will be based on the most cost effective means that can be safely administered.

For covered services provided by non-network providers and professionals, the participant's portion of the payment will include charges over and above what would have been paid to a network provider or professional.

### **Appeals and Legal Action**

The "Complaints and Appeals" section is changed by deleting the second paragraph of the "Level Two Appeal Process (Voluntary)" subsection and replacing it with the following:

On a Level Two Appeal, the entire record will be reviewed. Appeals of a clinical nature will be reviewed by an appropriate clinical peer or peers who have not been involved with the prior decision. Additional information may be submitted by or on behalf of the participant, any treating professional, or Anthem. You or your authorized representative may appear before the review panel. If you do not

request the opportunity to appear in person, the decision for second level grievance reviews will be issued within 30 calendar days. If you do request the opportunity to appear in person, the review will be conducted within forty-five (45) working days of receipt of the participant's Level Two Appeal. A written decision will be issued to the participant within five (5) working days of completing the review. Once a final decision has been issued by the Second Level Appeal panel, the participant may request an external review, file a complaint with the Bureau of Insurance and/or bring legal action against the Plan. The Superintendent of Insurance may be contacted toll-free at 1-800-300-5000.

In any appeal under the grievance procedure in which a professional medical opinion regarding a health condition is a material issue in the dispute, you may be entitled to an independent second opinion, of a provider of the same specialty, paid for by the Plan.

The "Legal Action Against Anthem" section is deleted and replaced with the following:

No legal action may be brought against the Plan until the participant or the participant's authorized representative has exhausted the complaint and appeals process outlined above. Any action must be initiated within three (3) years from the earlier of:

- The date of issuance of the external review decision; or
- The date of issuance of the underlying adverse Level One Appeal decision or the Level One grievance determination