

Introduction

This Summary Plan Description/Certificate of Coverage (also called your booklet) contains information that you need to know about your University of Maine System (University) HMO Choice Point of Service health care coverage insured and administered by Blue Cross and Blue Shield of Maine (Blue Cross). You are urged to read this Summary Plan Description carefully.

This Summary Plan Description explains how your HMO Choice Point of Service Plan works. It explains the terms, benefits, conditions, exclusions, and limitations of your coverage. It also includes information about eligibility requirements, enrollment for benefits, claim procedures and termination provisions. Key definitions appear in Section 1. Please read this important material carefully.

The benefits described in this Summary Plan Description are interpreted and administered according to the provisions and limitations herein. If there are coverage questions, the Insurer Administrator (Blue Cross) will base all decisions on the provisions in this Summary Plan Description.

The Summary Plan Description, any amendments or attached papers, the group application, the group account agreement, and your individual application make up your group contract and your complete coverage with Blue Cross for health care benefits. The benefits described in this Summary Plan Description are those in effect as of July 1, 1999. This Summary Plan Description (which is also the Plan Document) replaces any previous Summary Plan Descriptions you may have received regarding your point of service coverage.

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Table of Contents

Section 1 Definitions	1
Section 2 Who Is Eligible and How Do I Begin Coverage?	13
Beginning Coverage	13
How Do I Enroll in This Plan?	13
Who Is an Eligible Group Member?	13
Qualified Medical Child Support Order	15
Effective Date of Coverage for Newly Eligible Employees and Their Dependents.....	16
Your Share of the Cost of the Plan	16
Change in Family Status or Employment	16
Additional Special Enrollment Rights.....	17
Effect of Medicare on Eligibility	17
Plan Year.....	17
The Annual Enrollment Period	17
Section 3 How Can Coverage End?	19
Canceling the Group Contract	19
Canceling the Member=s Contract	19
Notice of Cancellation.....	20
Right to Reinstatement.....	20
Coverage Certification.....	21
Section 4 When Can I Continue Coverage?	23
COBRA - Group Continuation Coverage	23
Temporary Layoff and Temporary Leave of Absence	24
Long Term Disability.....	24
Group Coverage Ends - Disabled Members	24
Retirees Who are Under Age 65	25
Section 5 What Are My Benefit Levels, Deductibles, Copayments, Coinsurance, Out-of-pocket Limits, Annual Maximums, and Lifetime Maximums?	27
Benefit Levels	27
Deductible	27
Copayments and Coinsurance	28
Out-of-pocket Limits	28
Annual Maximum Benefits.....	28

Lifetime Maximum Benefits.....	28
Section 6 What Is a Primary Care Physician?	29
Choosing Your Primary Care Physician.....	29
Responsibilities of Your Primary Care Physician.....	29
Changing Your Primary Care Physician.....	29
Specialists and Referrals	30
Referral to Non-Participating Providers and Professionals	30
Self-Referral.....	30
Maintaining the Patient-Physician Relationship.....	31
Relationship of Network Physicians	31
Emergency Care In or Outside of the Service Area	31
Members at School Outside of Their Service Area.....	32
Section 7 What Is Utilization Management?	33
Inpatient Admission Review.....	33
Continued Inpatient Stay Review	34
Discharge Planning.....	34
Inpatient and Outpatient Mental Health/Substance Abuse Review.....	34
Individual Case Management.....	35
Members= Rights and Responsibilities	35
Procedure for Appeal of Medical Necessity.....	35
Section 8 What Is Covered?	37
Allergy Testing and Injections	37
Ambulance Service	37
Ambulatory Surgery Centers	37
Anesthesia Services	37
Asthma Education.....	37
Blood Transfusions.....	38
Chemotherapy Services.....	38
Chiropractic Care	38
Dental Care	38
Diabetic Services	38
Diagnostic Services.....	39
Durable Medical Equipment and Prostheses.....	39
Emergency Room Care.....	39
Eye Examinations	39
Foot Care.....	40
Freestanding Imaging Centers.....	40
Home Health Care	40

Home Infusion Therapy.....	40
Hospice Care.....	40
Hospice Respite Care	41
Inborn Errors of Metabolism.....	41
Independent Laboratories	41
Infertility Services.....	41
Inhalation Therapy.....	41
Inpatient Hospital Services	41
Laboratory and X-ray Services	42
Maternity.....	42
Medical Care.....	43
Medical Supplies.....	43
Mental Health Services and Substance Abuse Services - Professional	43
Mental Health and Substance Abuse Services - Provider	43
Morbid Obesity	44
Nutritional Counseling	44
Obstetrical Services and Newborn Care.....	44
Office Visits.....	44
Organ and Tissue Transplants.....	44
Orthotic Devices	45
Outpatient Private Duty Nursing	45
Outpatient Services	46
Parenteral and Enteral Therapy.....	46
Prescription Drugs.....	46
Radiation Therapy.....	47
Reconstructive Services.....	47
Routine Preventive Care.....	47
Skilled Nursing and Rehabilitation	48
Smoking Cessation.....	48
Speech, Physical and Occupational Therapy.....	48
Surgical Services.....	49
Section 9What Is Not Covered?.....	51
Section 10How Are Claims Filed and Who Do I Call with Claims Questions?.....	57
Filing a Claim.....	57
Time Limit for Filing Claims	57
Releasing Necessary Information.....	57
Non-compliance	57
Examination of Claimant	57
Questions About Claims?.....	57

Section 11	How Are Benefits Determined?	59
	Highest Benefit Level.....	59
	Self-referred Benefit Level.....	59
	Compliance with Laws.....	59
	Confidentiality.....	59
	Statements and Representations.....	60
	Severability	60
Section 12	How Are Claims Paid?	61
	Primary Care Physician Services.....	61
	Participating Providers and Professionals	61
	Self-referred Services.....	61
	Non-Participating Providers and Professionals	61
	Out-of-State Providers and Professionals - HMO Blue Card Disclosure	61
	Hospitals Outside of the United States.....	62
	Prescription Drug Claims.....	62
	Professional and Provider Payment Methods	63
Section 13	How Do I Complain Or Appeal?	65
	Complaints.....	65
	Reconsideration of Utilization Management Decisions	65
	Complaints Requiring Immediate Intervention.....	65
	Level One Appeal Process.....	65
	Level Two Appeal Process	66
	Legal Action Against Blue Cross	66
Section 14	What If I Have Other Coverage?	67
	Coordination of Benefits.....	67
	If You Qualify for Medicare	68
	Subrogation: Payments Resulting from Legal Actions	69
Section 15	How Does ERISA Affect This Plan?	71
Section 16	What Is Family and Medical Leave?	73
	Continuation of Health Coverage During Family and Medical Leave	73
	Reasons for Taking Leave	73
	Employee Eligibility	73
	Advance Notice and Medical Certification.....	73
	Continuation of Health Coverage, Job Benefits, and Protection.....	74
	Intermittent Leave	74

Substitution of Paid Leave	74
Spouses or Domestic Partners Who Work for the Same Employer.....	74
Reenrollment after a FMLA Leave	74
Section 17What Is the University=s Non-discrimination Policy?	75

Section 1

Definitions

This section explains the meaning of some of the words and phrases in this Summary Plan Description. Other words and phrases may be defined in the other sections.

Accident Care Treatment of a traumatic bodily injury resulting from an accident.

Affidavit of Domestic Partnership The University Affidavit of Domestic Partnership signed by the subscriber and domestic partner which attests to a domestic partner relationship including shared financial obligations, shared primary residence, and mutual responsibility for the welfare of the subscriber and domestic partner.

Ambulatory Surgery Facility A facility that meets both the following requirements:

- X Licensed as an ambulatory surgery center, or is Medicare certified; and
- X Meets Blue Cross=s participation standards.

Annual Enrollment A period of time during the year in which an eligible employee who had previously waived enrollment in the Plan may enroll or add dependents. Enrolled members may also terminate enrollment. Members may also make changes to benefit elections during annual enrollment. Historically, annual enrollment has been held during the month of November. Changes are effective on the following January 1.

Annual Out-of-pocket Limit For self-referred services, the limit on the deductible and coinsurance you pay each year. After you meet the annual out-of-pocket limit, you pay no further deductible or coinsurance for most services. Copayments still apply. Coinsurance you pay for non-listed mental health services and substance abuse services does not count toward your annual limit. Once your out-of-pocket limit is met, you continue to pay coinsurance for these services.

Annual Review Date The date set by Blue Cross and the University on which your group contract renews each year.

Appeal A request to Blue Cross from a member for a review of a decision on a registered complaint, or determination of medical necessity.

Assistant Surgeon A physician (Doctor of Medicine or Osteopathy) or dentist (Doctor of Dental Medicine or Dental Surgery) who actively assists the operating surgeon in performing a covered surgical service.

Benefits Payments Blue Cross makes on your behalf under this Plan.

Calendar Year The period starting on the effective date of your coverage and ending on December 31 of that year or the date your coverage ends, whichever occurs first. Each succeeding calendar year starts on January 1 and ends on December 31 of that year or the date your coverage ends, whichever occurs first.

Capitation A method of payment to professionals or providers for specific, agreed upon medical services based on a fixed dollar amount for each member on a monthly basis. The amount paid is based on the member=s gender and age rather than an amount per service or visit.

Certificate of Coverage This document that specifies the health care benefits available to members under the contract. This document is also called the Summary Plan Description and the Plan Document.

Chiropractor A person who is licensed or certified to perform chiropractic services, including manipulation of the spine, and who is practicing within the scope of his or her license or certification.

Coinsurance The percentage Blue Cross pays toward the cost of covered services and the percentage you pay toward the cost of covered services.

Community Mental Health Center An institution that meets both of the following requirements:

- X Licensed as a comprehensive level community mental health center; and
- X Meets Blue Cross=s participation standards.

Contract The Summary Plan Description/Certificate of Coverage, any endorsements, amendments, riders or attached papers, the group application, the group account agreement, and your individual application.

Contract Holder The employer, association, or trust that applies for and accepts coverage on behalf of its members. The University is the contract holder.

Copayment A fixed dollar amount you pay for certain services under this Plan. You pay the copayment to the health care provider at the time you receive care.

Cosmetic Services Procedures or services whose only goal is to improve appearance. Services to restore bodily function or to correct deformity resulting from disease, trauma or previous therapeutic process are not considered cosmetic services.

Covered Services Any services, supplies, room and board, or other items for which you receive benefits under this Plan.

Custodial Care Care that is designed chiefly to help a person with his or her activities of daily living. Such care does not require the continuing attention of trained medical or paramedical personnel. Custodial care differs from skilled nursing services. Examples of custodial care include but are not limited to: services that are personal care such as assisting walking or getting in and out of bed; aid in bathing, dressing, and feeding; preparing special diets; and supervising taking medication that can usually be self-administered.

Day Treatment Patient A patient receiving mental health or substance abuse care on an individual or group basis for more than two hours but less than 24 hours per day in either a hospital, rural mental health center, substance abuse treatment facility, or community health center. This type of care is also called partial hospitalization.

Deductible For self-referred services, the amount you must pay each calendar year toward the maximum allowance for certain covered services before the Plan provides benefits. Penalties for not obtaining preadmission approval do not count towards your deductible.

Dental Service Items and services provided in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth. Structures supporting the teeth mean the periodontium, which includes the gingiva, dentogingival junction, cementum (the outer surface of a tooth root), alveolar process (the lamina dura, or tooth socket and supporting bone) and the periodontal membrane (the connective tissue between the cementum and the alveolar process).

Dependent The eligible employee=s lawful spouse, domestic partner and any unmarried children of yours or your spouse who are under age 19, aged 19 to 23, and meet eligibility requirements listed in Section 2.

Diagnostic Service A service performed to diagnose specific signs or symptoms of an illness or injury, such as: X-ray exams (other than teeth), laboratory tests, cardiographic tests, pathology services, radioisotope scanning, ultrasonic scanning, and certain other methods of diagnosing medical problems.

Domestic Partnership A relationship between two people who are:
X At least 18 years old and mentally competent to contract,

- X Not legally married to another person,
- X Each other=s sole domestic partner,
- X Jointly responsible for each other=s welfare and who share financial obligations,
- X Living together for at least two years in a close, committed and exclusive personal relationship that is meant to be lasting,
- X Legally prohibited from marrying each other in the state of Maine, and
- X Not related by blood to a degree that would prohibit marriage in the state of Maine.

To apply for coverage, domestic partners must complete and sign a University Affidavit of Domestic Partnership. The employee and domestic partner may be required to provide satisfactory proof that the partnership meets the Plan definition. The employee must not have had a different domestic partner covered under this Plan during the prior consecutive 24 months.

Durable Medical Equipment Equipment that is prescribed by a physician, can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of sickness or injury, and is appropriate for use in the home. It does not include fixtures installed in your home or on your real estate.

Emergency Medical Condition A physical or mental condition, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- X Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- X Serious impairment to body functions;
- X Serious dysfunction of any body organ or part; or

With respect to a pregnant woman who is having contractions:

- X There is inadequate time to safely transfer to another hospital before delivery, or
- X Transfer may pose a threat to the health or safety of the woman or unborn child.

Emergency Service Health care services that are provided in an emergency facility or setting after the onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, that the absence of immediate medical attention could reasonably be expected by the prudent lay person, who possesses an average knowledge of health and medicine, to result in:

- X Placing the member=s physical and/or mental health in serious jeopardy;
- X Serious impairment to body functions; or
- X Serious dysfunction of any body organ or part.

Experimental/Investigational AExperimental≡ means a drug, medical/surgical device, health care technology, procedure, or service that is in the process of being tested for patient safety and

potential or actual efficacy under controlled conditions. An investigational means a drug, medical/surgical device, health care technology, procedure, or service that is in the process of being closely and systematically studied to determine its applicability to patient care and/or its short- or long-term efficacy. The investigational stage normally follows the experimental phase. Blue Cross reserves the right to determine whether a service is considered experimental/investigational. In making this determination, Blue Cross may rely on classification of these services by the Food and Drug Administration (FDA), the Blue Cross and Blue Shield Association, or medical literature, and/or may consult with medical specialists.

Family Medical Leave Leave granted a subscriber under the Family Medical Act of 1993. See Section 16.

Family Planning Agency An agency that meets both of the following requirements:

- X Is a delegated family planning agency under Title X of the Public Health Service Act and is in good standing with all applicable state and federal regulatory bodies; and
- X Meets Blue Cross's participation standards.

Freestanding Imaging Center An institution that meets both the following requirements:

- X Licensed (where available) as a freestanding imaging center, freestanding diagnostic center, or freestanding radiology center; and
- X Meets Blue Cross's participation standards.

Freestanding Surgical Facility An institution that meets the following requirements:

- X Has a medical staff of physicians, nurses and licensed anesthesiologists;
- X Maintains at least two operating rooms and one recovery room, as well as diagnostic laboratory and x-ray facilities;
- X Has equipment for emergency care;
- X Has a blood supply;
- X Maintains medical records;
- X Has agreements with hospitals for immediate acceptance of patients who need hospital confinement on an inpatient basis;
- X Is licensed in accordance with the laws of the appropriate legally authorized agency; and
- X Meets Blue Cross's participation standards.

Grace Period The 31 days that begin with and follow the due date of an unpaid subscription charge.

Group The employer, association, or trust that applies for and accepts coverage on behalf of its members. Your group is the University of Maine System who is also the Contract Holder/Plan Sponsor.

Home Health Agency An institution that meets both of the following requirements:

- X Licensed as a home health agency;
- X Meets Blue Cross=s standards for participation.

Hospice A facility that meets both of the following requirements:

- X Licensed as a hospice; and
- X Meets Blue Cross=s participation standards.

Hospice Care Services that furnish pain relief, symptom management, and support to terminally ill patients and their families.

Hospital An institution that is:

- X Duly licensed by the state of Maine as an acute care, rehabilitation, or psychiatric hospital; and
- X Certified to participate in the Medicare program under Title XVIII of the Social Security Act.

Inborn Errors of Metabolism A genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life.

Independent Laboratory An institution that meets both of the following requirements:

- X Licensed as an independent medical laboratory; and
- X Meets Blue Cross=s participation standards.

Infertility The inability to conceive a pregnancy after a year or more of regular sexual relations without contraception or the presence of a demonstrated condition recognized as a cause of infertility by the American College of Obstetrics and Gynecology, the American Urologic Association, or other appropriate independent professional association.

Inpatient A registered overnight patient who occupies a bed in a hospital, skilled nursing facility, or residential treatment facility.

Inpatient Stay One period of continuous inpatient confinement. An inpatient stay ends when you are discharged from the facility in which you were originally confined. A transfer from one acute care hospital to another acute care hospital as an inpatient when medically necessary is part of the same stay.

Insurer Administrator Blue Cross is the Insurer Administrator.

Late Enrollee A subscriber or a dependent family member who enrolls under the Plan more than 31 days after the date when the subscriber or dependent family member was first eligible for coverage; or a subscriber or dependent family member who enrolls after 31 days following any of the life events described in Section 2. A late enrollee may only submit an application during the annual enrollment period.

Maximum Allowance The highest dollar amount Blue Cross will pay for a covered service based on its contracts with providers and professionals. Payments to non-contracted providers and professionals are also based on Blue Cross's maximum allowance.

Medicaid A state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medical Necessity or Medically Necessary Blue Cross's determination that services, supplies, or levels of service are:

- X Medically appropriate for the symptoms, diagnosis, or treatment provided for your symptom, condition, illness, disease, or injury;
- X The most cost-effective means that can safely be provided to you;
- X Accepted medical practice and state-of-the-art; and
- X Not primarily for the convenience of the member, provider, or professional.

Blue Cross reserves the right to determine medical necessity. Benefits are not provided for any health care services that are not medically necessary except for preventive and routine services that are specifically listed as covered.

Medicare The program of medical benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Member The subscriber and all family members who are eligible for coverage and whom Blue Cross accepts for coverage under the Plan.

Member Effective Date The first day a member is eligible to receive benefits under the Plan.

Member Termination Date The last day a member is entitled to receive benefits under the Plan.

Mental Health Service A service to treat any disorder that affects the mind or behavior, whether of organic or functional origin.

Morbid Obesity A condition of persistent and uncontrollable weight gain that constitutes a present or potential threat to life. This is characterized by a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and sex in the most recently published Metropolitan Life Insurance table.

Network Providers and Professionals Health care providers and professionals that have a written agreement with Blue Cross to furnish health care services under this Plan. They are also referred to as participating providers and professionals.

Non-Network Providers or Professionals Providers or professionals that do not have a written agreement with Blue Cross to furnish health care services under the Plan.

Orthognathic Surgery A branch of oral surgery dealing with the cause and surgical treatment of malposition of the bones of the jaw and occasionally other facial bones.

Orthotic Device A device that restricts, eliminates, or redirects motion of a weak or diseased body part.

Outpatient A patient who receives services at a provider and who is not a registered inpatient or a day treatment patient.

Pharmacy Any retail establishment operating under a license and in which a registered pharmacist dispenses prescription drugs. Also, the mail order facility available under the Plan.

Pharmacy and Therapeutics Committee Blue Cross=s committee of Maine-based physicians and other experts in medicine and pharmacy.

Physician See definition of AProfessional≡.

Plan Your health coverage with Blue Cross as the Insurer Administrator and the University as the Contract Holder/Plan Sponsor.

Plan Anniversary Date The date occurring in each calendar year which is an anniversary of the effective date of the Plan. The Plan anniversary date is January 1.

Plan Sponsor The University of Maine System is the Plan Sponsor.

Prescription Drugs A narcotic or medicine approved by the Food and Drug Administration (FDA) for use outside a hospital dispensed under a physician's written order. Prescription drugs are required by state law to be dispensed only with a prescription; required by law to display the notice, A Caution: Federal law prohibits dispensing without a prescription; or any other drug Blue Cross approves through its drug approval process.

Primary Care Physician (PCP) A physician who participates in the Plan network whom the member has designated as his or her principal physician. Typically, this physician practices in the field of family or internal medicine, pediatrics or general practice. Some obstetrician/ gynecologists also participate as PCPs.

Professional An independently billing, licensed health care specialist acting within the scope of his/her license. Only the following professionals are eligible for payment under the contract:

Physicians:

- X Doctors of Medicine
- X Doctors of Osteopathy

Other Professionals:

- X Doctors of Optometry
- X Doctors of Chiropractic
- X Doctors of Podiatry
- X Doctors of Dentistry
- X Doctors of Psychology
- X Licensed Audiologists
- X Licensed Clinical Social Workers
- X Physical Therapists
- X Occupational Therapists
- X Speech Therapists
- X Registered Practical Nurses
- X Licensed Practical Nurses
- X Licensed Clinical Professional Counselors
- X Ambulance Services
- X Other professionals that have a written participating agreement with Blue Cross

Prostheses Prostheses are appliances that replace all or part of a body organ (including contiguous tissue) or replace all or a part of the function of a permanently inoperative, absent, or malfunctioning body part.

Provider A licensed health care institution, facility, or agency. Only the following providers are eligible for payment under the contract:

- X Acute-care Hospitals
- X Skilled Nursing Facilities
- X Rural Health Centers
- X Home Health Agencies
- X Ambulatory Surgery Centers
- X Hospices
- X Community Mental Health Centers
- X Substance Abuse Treatment Facilities
- X Licensed Pharmacies
- X Acute-care Psychiatric and Rehabilitation Hospitals
- X Independent Laboratories
- X Freestanding Imaging Centers
- X Family Planning Agencies
- X Durable Medical Equipment Providers
- X Home Infusion Providers
- X Other providers that have a written participating agreement with Blue Cross

Radiation Therapy The use of high energy penetrating rays to treat an illness or disease.

Reconstructive Procedures Procedures performed on structures of the body to improve or restore bodily function or to correct deformity resulting from disease, trauma, or previous therapeutic process.

Referral An authorization provided by a PCP for the member to receive care from another professional or provider in the Plan network. Referral to non-network professionals or providers requires approval by Blue Cross.

Rural Health Center An institution that meets both of the following requirements:

- X Certified by the Department of Human Services under the United States Rural Health Clinics Services Act; and
- X Meets Blue Cross=s participation standards.

Second Surgical Opinion A second or third opinion, which you may receive from a participating board certified surgeon when your physician recommends surgery.

Self-referral (or Self-referred) Your choice to receive services not authorized or provided by your PCP.

Service Area For primary care, the geographic area represented by 30 minutes travel time by automobile from your place of residence or employment. For specialty care and hospital services, the geographic area represented by 60 minutes travel time by automobile from your place of residence or employment.

Sitter/Companion A person who provides short-term supervision of hospice patients during the temporary absence of family members.

Skilled Nursing Facility (SNF) An institution that meets all the following requirements:

- X Licensed as a skilled nursing facility;
- X Accredited in whole or in a specific part as a skilled nursing facility for the treatment and care of inpatients;
- X Engaged mainly in providing skilled nursing care under the supervision of a physician in addition to providing room and board;
- X Provides 24-hour-a-day nursing care by or under the supervision of a Registered Nurse (RN);
- X Maintains a daily medical record for each patient;
- X Is a freestanding or a designated unit of another licensed health care facility; and
- X Meets Blue Cross=s participation standards.

Specialist Service A service by a professional practicing in specialty areas such as dermatology, neurology, surgery, and other specialties.

Subscriber The eligible employee or retiree who applied for coverage under the Plan and whose application and payment of required subscription charges Blue Cross has accepted.

Subscription Charge The rates established by Blue Cross as consideration for benefits offered under the Plan.

Substance Abuse The misuse, excessive use, or improper use of alcohol or drugs to the extent that such use contributes to physical, mental, or social dysfunction, regardless of origin.

Substance Abuse Treatment Facility A residential or nonresidential institution that meets all the following requirements:

- X Licensed or certified as a substance abuse treatment facility;
- X Provides care to one or more patients for alcoholism and/or drug dependency;
- X Is a freestanding unit or a designated unit of another licensed health care facility; and
- X Meets Blue Cross=s participation standards.

Summary Plan Description This booklet that describes the coverage available under the University HMO Choice Point of Service Plan insured and administered by Blue Cross. The Summary Plan Description is also the Certificate of Coverage and the Plan Document.

Surgical Service A service performed by a professional acting within the scope of his or her license that is:

- X A generally accepted operative and cutting procedure;
- X An endoscopic examination or other invasive procedure using specialized instruments; or
- X The correction of fractures and dislocations.

Terminal Illness A terminal illness exists if a person becomes ill with a prognosis of six months or less to live, as diagnosed by a physician.

Utilization Management The process Blue Cross uses to determine the appropriate level of health care services required by a patient to eliminate unnecessary services and procedures.

Waiting Period The period required by the University or Blue Cross before enrollment in your group program is allowed.

You or Your The employee or retiree and all family members Blue Cross accepts for coverage under the Plan.

Section 2

Who Is Eligible and How Do I Begin Coverage?

Beginning Coverage

Before your coverage begins Blue Cross must accept the University's group application, your application, and payment for your coverage. The University/contract holder acts as your remitting agent and is responsible for sending Blue Cross all applications and payments for coverage, as well as notifying the subscriber of any changes in payroll deductions for coverage and rate changes.

How Do I Enroll in This Plan?

When you become eligible for this Plan, you are required to complete an enrollment form to enroll yourself and your dependents. Enrollment forms are available at your University Human Resources or Campus Benefits Office.

Participation in this Plan is voluntary. Should you elect not to participate when you first become eligible, you must sign a waiver declining medical benefits.

It is important to note that if you decide to enroll at a later date, you may do so only during the Annual Enrollment Period unless you have a qualified change in employment or family status.

You may have a newly eligible dependent because of marriage, domestic partnership, birth, adoption or another reason. In order for coverage to be effective for a newly eligible dependent, you must complete a change form, which is available at your Human Resources or Campus Benefits Office.

Who Is an Eligible Group Member?

Subscribers

Except as provided for continuation members, only eligible employees, retirees or surviving spouses can apply to enroll in the Plan as subscribers.

The eligible subscriber is:

- X A full time regular employee (usually working 40 hours per week);
- X A part time regular employee working at least 75% of full time;
- X An eligible part time faculty member (see collective bargaining agreement for eligibility requirements);
- X A part time regular employee working 50-74% of full time who has two years of continuous service at the University;

- X A participant in the University Partial/Phased Retirement Program;
- X A part time regular employee with the equivalent of at least five years of full time continuous University service. For example, ten years of half time service equals five years of full time service;
- X A former covered employee who is eligible for long term disability benefits and is under age 65;
- X A foreign visiting faculty member in the University of Maine Exchange Program;
- X An eligible retiree who is under 65; or
- X If under age 65, a surviving spouse of a deceased subscriber.

Dependents

Except as provided for continuation members, only eligible dependents can be enrolled by the subscriber as covered dependents. Proof of dependency may be required.

The eligible dependent is:

- X The subscriber=s lawful spouse (provided you are not legally separated).
- X The subscriber=s domestic partner who meets the University=s criteria and files a University Affidavit of Domestic Partnership.
- X The subscriber=s unmarried children (biological, adopted or stepchildren) who are:
 - Under age 19 whom you are eligible to claim as a federal income tax exemption;
 - 19 years old but less than 23 years old and 50% or more dependent on you for financial support; or
 - Under age 23, living with the subscriber=s former spouse and who was enrolled as a dependent in the Plan before the divorce.
- X A visiting foreign student who is under age 23, living with the subscriber in a parent-child relationship and 50% or more dependent on the subscriber for financial support.
- X A child for whom the subscriber has been appointed legal guardian, living with the subscriber in a parent-child relationship, and 50% or more dependent on the subscriber for financial support.
- X A subscriber=s grandchild under age 23, living with the subscriber in a parent-child relationship and 50% or more dependent on the subscriber for financial support. The subscriber cannot enroll a child and grandchild at the same time under the same certificate/policy number. The eligible child or grandchild can be covered under a separate University HMO Choice Point of Service certificate/policy number.
- X A child for whom the subscriber has received a qualified court order to provide coverage; or
- X A child 19 years of age or older and primarily supported by you who is incapable of self-sustaining employment because of physical or mental handicap. The disability must have begun before the child=s 23rd birthday and the child must have been covered under the Plan continuously since his or her 23rd birthday. You must submit proof of the child=s condition within 31 days of his or her 23rd birthday. Blue Cross reserves the right to require ongoing proof of the mental or physical incapacity.
- X A surviving dependent of a deceased employee if the surviving dependent was enrolled in the Plan at the time of the employee=s death.

The term child includes:

- X A biological child;
- X A legally adopted child from the date of placement in the home or from birth, provided that a written agreement to adopt the child has been entered into prior to the child=s birth. If a child placed for adoption is not adopted, all health care coverage will cease when placement ends. No continuation provisions will apply;
- X A child for whom you are the court-appointed legal guardian; and
- X A stepchild who lives with you.

Anyone who is covered under the Plan as an employee may not be a covered dependent of another employee. Your dependent child who is eligible for employee health coverage under this Plan or another group health plan is not eligible for coverage as your dependent under this Plan. If you or your spouse or domestic partner are each eligible for benefits as employees under a University health plan, only one of you can cover your dependent children.

When a covered child reaches age 19, Blue Cross will send you an application to continue the child=s coverage. You must return the completed application to Blue Cross if you want the child=s coverage to continue.

The eligible subscriber and dependents is not required to live or work in the service area.

Qualified Medical Child Support Order

If a qualified medical child support order is issued for your child, that child will be eligible for medical coverage as stated in the order. A qualified medical child support order is a judgment, decree or order issued by a court of law which:

- X Specifies your name and last known address;
- X Specifies the child=s name and last known address;
- X Provides a description of the coverage to be provided or the manner in which the type of coverage is to be determined;
- X States the period of time to which it applies; and
- X Specifies each plan to which it applies.

A Qualified Medical Child Support Order may not require health care coverage that is not already included under the Plan.

Effective Date of Coverage for Newly Eligible Employees and Their Dependents

Your coverage is effective on the first day you become eligible, as long as Blue Cross receives your enrollment application within 31 days of that date. Benefits for eligible dependents you enroll at the same time are effective on the same day employee benefits are effective. If you do not enroll when you are first eligible, you may enroll at a later date under the conditions described in the provisions titled **AChange in Family Status or Employment**, **AAdditional Special Enrollment Rights**, and **AAnnual Enrollment Period** in this section.

Your Share of the Cost of the Plan

To be covered under the University HMO Choice Point of Service Plan, you must make contributions toward the cost of coverage.

Change in Family Status or Employment

Your elected benefits will be in effect for the entire plan year if you continue to be eligible. However, in accordance with Internal Revenue Service rules, you may elect to make a change in coverage if you have a change in your family status. The change you make in your benefit elections must be consistent with the change in family status.

The following are considered qualified family status changes:

- X Marriage or divorce;
- X Formalization or dissolution of domestic partner relationship;
- X Birth or adoption of a child (A newborn child will be covered for the first 31 days of life even if you fail to enroll the child. An adopted child will be effective on the date placed for adoption);
- X Death of your spouse, domestic partner or a dependent child;
- X A court orders you to provide coverage for a spouse or child;
- X Employment status changes for you or your spouse/domestic partner (termination, layoff, reduction in hours, etc.);
- X One or more of your dependents become ineligible for coverage;
- X Exhaustion of COBRA benefits; and
- X Termination of the group contract or policy under which you were covered, without replacement.

For coverage to begin, you must complete and submit an enrollment form which is available from your University Human Resources or Campus Benefits Office. If you are adding a family member to your coverage, unless otherwise noted above, coverage will be effective on the first day of the month following the occurrence provided Blue Cross receives an enrollment form within 31 days of eligibility and any applicable subscription charge is paid.

Additional Special Enrollment Rights

In addition to the exceptions for qualifying life events listed above, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. If you are eligible for coverage but do not enroll, your dependent cannot enroll.

Effect of Medicare on Eligibility

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) requires employers to offer currently employed workers and their spouses or domestic partners who are age 65 and older the same health care coverage offered to younger workers. If you are a person affected by TEFRA, you must elect whether or not you want to be covered under the University HMO Choice Point of Service Plan. If you elect this Plan, this Plan will provide benefits before Medicare provides benefits.

If you elect to be covered under the HMO Choice Point of Service Plan, you and your lawful spouse or domestic partner age 65 or older will be eligible for all of the coverage under this Plan. If you and your lawful spouse or domestic partner are enrolled in Medicare, Medicare will pay certain benefits in addition to your group health benefits.

Even though benefit payments will be made to you under the Plan before it is determined whether any payments are to be made under Medicare, it may be to your advantage to enroll yourself and your lawful spouse or domestic partner in both Medicare Parts A and B when first becoming eligible for Medicare. Under Medicare, premium payments may be increased for late enrollees and the date of coverage could be delayed.

Eligibility for benefits as described above is in effect from the first day of the calendar month in which you attain age 65 but only while you remain employed by the University.

Plan Year

Your benefits are in effect for a one-year period as long as you remain eligible and enrolled. This is often referred to as the plan year. The plan year begins on January 1 and ends on December 31.

The Annual Enrollment Period

Each year there will be an enrollment period. During this time you will be asked to review your benefit needs, add or delete covered dependents, and elect your benefits for the upcoming plan year. If you choose to make any benefit changes, they will become effective on January 1 of the upcoming year. If you choose to cover your eligible dependents, they will be covered under the same health plan you elect for yourself.

If you decline benefits for yourself and/or your dependents, you will not be able to elect coverage again until the next annual enrollment period unless you have a qualified change in your family status or in employment.

Section 3

How Can Coverage End?

The subscriber, the University, or Blue Cross can cause your coverage to end. If your coverage ends for any reason, except misrepresentation or fraud, it will stop on the last day for which Blue Cross has accepted full payment. If termination is requested before the completion of the period for which Blue Cross has accepted payment, payment may not be refunded, and coverage may continue until the end of that period.

Canceling the Group Contract

By Notice The University may cancel the contract by giving Blue Cross written notice as described in the group contract. It is the responsibility of the University to notify the subscriber of any change in insurance carriers. All rights to benefits under the contract end on the effective date of cancellation.

For Non-Payment If your group does not pay the subscription charge when due, Blue Cross may cancel the contract. If the group contract is canceled for non-payment, Blue Cross will notify the subscriber of the cancellation prior to the termination date of the contract. Blue Cross will not notify the subscriber of cancellation if the group provides notice to Blue Cross that coverage has been replaced.

Non-Renewal The University may cancel the contract by not renewing the group contract with Blue Cross. Blue Cross may cancel the contract by not renewing the group contract as described in the group contract.

Other Cancellation Events Other cancellation events are listed in the group contract.

Canceling the Member=s Contract

Ending Employment If the subscriber ends employment with or membership in the group, your contract will be canceled. Your coverage will end on the last day of the month that follows the month when your employment ended.

Deletion from Membership If the University notifies Blue Cross that you have been deleted from membership, your contract will be canceled. The subscriber must delete a member from coverage if the member is no longer eligible for reasons such as a child=s marriage, the subscriber=s divorce or legal separation, termination of domestic partnership, or a member=s death. The subscriber must notify the University of these events and complete a form to remove a member. If you do not promptly disenroll your dependents when they are no longer eligible, you will be fully responsible for all claims they incurred and this Plan paid after they were no longer eligible.

Covered Children Your coverage will be canceled if you are a covered child and:

X You marry. Coverage will end on the first day of the month that occurs immediately on or after your date of marriage.

- X You reach age 19 and Blue Cross has not received and accepted an application for continued coverage under the subscriber's contract. Coverage will end on the first day of the month that occurs immediately on or after your 19th birthday.
- X Blue Cross has accepted your application for coverage after age 19 and you then reach age 23. Coverage will end on the first day of the month that occurs immediately on or after your 23rd birthday, unless you are an eligible disabled dependent, as defined in Section 2.

Coverage Under Two or More Contracts If you enroll under another University health plan, your coverage under the HMO Choice Point of Service Plan will end when the alternate plan coverage begins.

Medicare is the Primary Payor If Medicare is the primary payor for any member covered under your contract, you are no longer eligible for the HMO Choice Point of Service Plan. You can enroll in the University COMP-CARE comprehensive group health plan.

Misrepresentation or Fraud If you make any misrepresentation or use fraudulent means in applying for coverage or filing for benefits, your contract will be canceled. In such cases the contract will be null and void.

Notice of Cancellation

If your coverage is canceled for non-payment of subscription charges or other lapse or default, Blue Cross will send you a notice of cancellation. Blue Cross will offer you the opportunity to reinstate your coverage. You have the right to designate another person to receive notice of cancellation of the contract for non-payment of charges or other lapse or default. Blue Cross will send the notice to you and the person you designate at the last address you provided to Blue Cross. You also have the right to change the person you designate if you wish. Your coverage will continue in force for a grace period of 31 days from the date group payment is due for the subscription charge if payment is made during the 31 day grace period. The charges will be the same amount they would have been if the contract had remained in force.

In order to designate a person to receive this notice or to change a designation, you must fill out a Third Party Notice Request Form. You can obtain this form by contacting Blue Cross.

Right to Reinstatement

You may be eligible to reinstate the contract within 90 days after the date of cancellation if non-payment of charges or other lapse or default took place because you suffered from organic brain disease at the time of cancellation. For the purposes of this provision, organic brain disease means a mental or nervous disorder of demonstrable origin that causes significant cognitive impairment.

If you request reinstatement, Blue Cross may require a physician examination at your own expense or request medical records that confirm you suffered from organic brain disease at the time of cancellation.

If Blue Cross accepts the proof, it will reinstate your coverage without a break in coverage. Blue Cross will reinstate the same coverage you had before cancellation or the coverage you would have been entitled to if Blue Cross had not canceled the contract, subject to the same terms, conditions,

exclusions, and limitations. Before Blue Cross can reinstate your contract, you must pay the amount due from the date of cancellation through the month in which Blue Cross bills you. The charges will be the same amount they would have been if the contract had remained in force.

If Blue Cross denies your request for reinstatement, it will send you a Notice of Denial. You have the right to request a hearing before the Superintendent of Insurance within 30 days after the date you receive the Notice of Denial from Blue Cross.

Coverage Certification

When your medical coverage ends, Blue Cross will give you a written record of the coverage you received under the Plan, under COBRA, if applicable, and the waiting period, if any. You will receive a coverage certification when your group coverage ends, when COBRA continuation coverage terminates and upon your request (if the request is made within 24 months following either termination of coverage). If you obtain future employment, you may need to submit the coverage certification to that employer and it may reduce the duration of your subsequent employer's pre-existing condition limit, if there is one, by one day for each day of prior coverage (subject to certain requirements). If you are purchasing individual (non-group) coverage you may need to present the coverage certification at that time as well.

Section 4

When Can I Continue Coverage?

If your group health coverage ends, you may be eligible for group continuation coverage or continued coverage if you are disabled.

COBRA - Group Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that most employers sponsoring group health plans offer employees and their families a temporary extension of health care benefits (called continuation coverage) at the employee=s (or dependent=s) expense in instances when coverage would otherwise end because of the occurrence of certain qualifying events.

Coverage may be continued for up to 36 months for:

- X Surviving lawful spouses or domestic partners and/or children of deceased employees;
- X Legally separated or divorced lawful spouses of current employees, including children if their coverage is dropped at this time;
- X Domestic partners whose domestic partnership with the employee has terminated; or
- X Children of current employees who would lose coverage because they are no longer dependents as defined in this Plan.

Coverage may be continued for up to 18 months for employees, lawful spouses, domestic partners, and eligible children in case of loss of coverage through the employee=s:

- X Reduction in work hours;
- X Voluntary termination of employment or retirement;
- X Layoff for economic reasons; or
- X Discharge (other than for gross misconduct).

Continuation of coverage may be extended from a limit of 18 months up to a maximum of 29 months for an employee, spouse, domestic partner or dependent who is disabled, as defined by the Social Security Administration, at the time of termination of employment or who is disabled at the time a reduction in hours of employment occurs, provided the COBRA beneficiary has provided written notice of the disability before the end of the first 18 months of continuation coverage.

Coverage may be terminated before the COBRA eligibility period ends under the following circumstances:

- X Termination of all health plans provided to any employee;
- X The covered person fails to pay the required contribution by the payment due date;

- X The covered person obtains coverage under another group health plan upon employment or remarriage after having elected COBRA continuation coverage, unless the new coverage contains a pre-existing condition clause which would affect the COBRA beneficiary; or
- X The covered person becomes entitled to Medicare benefits after having elected COBRA continuation coverage.

Written notice will be sent to any covered person who becomes eligible for continuation coverage. The written notice will include an application to continue coverage. However, if you become eligible for continuation coverage because of divorce, separation, dissolution of domestic partnership, or because a dependent child ceases to be an eligible dependent under the Plan, you must notify the University in writing within 60 days. Then you will receive an application to continue coverage. If you want to continue coverage, you submit your completed, signed application within 60 days of the date of notice of your right to continue coverage.

By electing to continue coverage, a covered person becomes a COBRA beneficiary under the Plan. COBRA beneficiaries pay the full cost of their premiums under this Plan plus a 2% administrative fee.

Temporary Layoff and Temporary Leave of Absence

If the subscriber is on approved temporary layoff, coverage may continue under the group plan for up to 12 months, at the subscriber=s expense. If the subscriber is on approved temporary leave of absence, coverage may continue for up to four years, at the subscriber=s expense.

Long Term Disability

If you apply and are approved for long term disability benefits, you may continue coverage under the group plan for the duration of the disability or until you reach age 65, whichever comes first. You are responsible for paying applicable premium.

Group Coverage Ends - Disabled Members

If the University=s group coverage with Blue Cross ends while you are totally disabled, benefits for covered services directly relating to the condition causing total disability remain available to you for six months from the date of termination of your group contract, until you reach the contract maximums, until you are no longer disabled, or you obtain replacement health coverage, whichever comes first. If you have replacement coverage, that coverage will pay primary benefits, and Blue Cross will pay secondary benefits for covered expenses directly related to the totally disabling condition. Disabled means:

- X If you were employed, you are unable to work in your regular and customary occupation because of illness or injury.
- X If you were not gainfully employed, you are unable to engage in most normal activities of a person of like age in good health.

Blue Cross=s coverage of losses during your total disability has the same limits that apply to employees and members who are not disabled.

Retirees Who are Under Age 65

If you retire from the University before you reach age 65, you may continue in the Plan up to the age of 65 by paying the applicable premium.

Section 5

What Are My Benefit Levels, Deductibles, Copayments, Coinsurance, Out-of-pocket Limits, Annual Maximums, and Lifetime Maximums?

The level of benefits paid for covered services as well as the deductible, copayments, coinsurance, and out-of-pocket limits depend on whether services are received from or coordinated by your PCP or you self-refer for services. These amounts are shown in your Benefit Overview.

Benefit Levels

There are two levels of benefits under the Plan:

- X **Services authorized or provided by your PCP** These services are reimbursed at the highest level.
- X **Self-referred services** In most cases, these services are reimbursed at the lowest level and deductibles and coinsurance apply.

If you self-refer for services, a benefit payment is made for covered services, but at a lower level. In most cases, your obligation will be greater when you do not obtain authorization or receive services from your PCP.

Deductible

Under this Plan, most self-referred covered services are subject to a deductible. A deductible is the amount you must pay toward the cost of covered services before the contract provides benefits. Check your Benefit Overview for the amount of the deductible under your Plan.

How Your Deductible Works Each calendar year before benefits can be paid for self-referred covered services, you must pay your deductible.

Under family coverage, if the total family expenses for self-referred covered services exceed two times the individual deductible, then your family deductible under the contract has been met for the calendar year. In this case, all family members will be eligible for self-referred benefits for the rest of the calendar year without meeting further deductibles.

One Deductible For a Common Accident Under family coverage, if two or more family members are injured in the same accident, only one deductible will apply for all covered services resulting from that accident during a calendar year.

Copayments and Coinsurance

For services provided or authorized by your PCP, copayments may apply. For self-referred services, copayments or coinsurance apply after you have satisfied your deductible. Please see your Benefit Overview for copayment amounts and coinsurance amounts and limits.

Copayments For some services, your share of the cost is a fixed dollar amount. Copayment amounts do not count toward any coinsurance or out-of-pocket limits under the Plan. If you have a separate out-of-pocket limit that applies to prescription drugs, it is indicated on your Benefit Overview.

Coinsurance For some services, your share of the cost is a percentage which is limited to an annual dollar amount. This is the coinsurance amount. Coinsurance amounts you pay toward non-listed mental health and substance abuse benefits do not count toward your coinsurance limit. Under family coverage, if the total family coinsurance expenses exceed two times the individual coinsurance limit, your family coinsurance limit under the contract has been met for the calendar year. In this case, all family members will be eligible for benefits for the rest of the calendar year without paying further coinsurance.

Out-of-pocket Limits

For self-referred services, your out-of-pocket expenses for your deductible and coinsurance are limited. Please refer to your Benefit Overview for out-of-pocket limits that apply. Once you reach the annual out-of-pocket limit, no further deductibles or coinsurance apply for the remainder of the calendar year, excluding non-listed mental health and substance abuse services. Copayment amounts continue to apply after the out-of-pocket limits are met. If you have a separate out-of-pocket limit that applies to prescription drugs, it is indicated on your Benefit Overview.

Annual Maximum Benefits

There is no general annual limit on services you receive under the HMO Choice Plan. Certain services, such as non-listed mental health care and durable medical equipment and prostheses, are subject to annual limit. Please refer to your Benefit Overview for services that have annual limits.

Lifetime Maximum Benefits

There is no general lifetime maximum on benefits for services provided or authorized by your PCP. If you self-refer for care, there is a limit to the benefits each member can receive in a lifetime. Refer to the Benefit Overview for specific lifetime limits that apply.

Section 6

What Is a Primary Care Physician?

When you enroll in the HMO Choice Point of Service Plan, you and each of your family members select a Primary Care Physician (PCP) who will coordinate and oversee your health care. Most services received from or authorized by your PCP are covered in full after a small copayment has been paid. If you choose to self-refer, covered services will be reimbursed at a lower level shown on your Benefit Overview. Whether or not you choose to use your PCP, you must choose a PCP at the time of enrollment.

Choosing Your Primary Care Physician

When you enroll in the HMO Choice Point of Service Plan, you and each eligible family member must choose a PCP from the HMO Choice Directory of Primary Care Physicians. The Directory is available on Blue Cross=s website at www.mainebluecross.com or by calling Blue Cross at **1-800-527-7706**. Members should select a PCP within a 30-mile radius of their residence or employment. You may select a pediatrician to coordinate the care of infants and young children, a family practitioner to coordinate the care of people of all ages or an internist to oversee the health of adult family members. It is important for you to consider the specialty and location of the PCP when choosing.

Responsibilities of Your Primary Care Physician

Your PCP provides and coordinates your overall health care. When you need medical services, contact your PCP. He or she will usually provide the care, such as routine physical examinations, treatment of sickness or injury and administration of medically necessary injections and immunizations. When your PCP determines that you need specialized care, he or she will refer you to a network specialist or coordinate any hospital care you may need.

You should telephone your PCP=s office to schedule an appointment before you visit the office. If your physician is not available and you require urgent medical treatment, the on-call physician will help you.

Changing Your Primary Care Physician

If you or a dependent wishes to change PCPs, you may call Blue Cross to obtain a change form. You may also change your PCP over the telephone by calling a Customer Service Representative at **1-800-527-7706**.

When you change PCPs, the change is effective on the first day of the month after your change form is received and accepted, or after you call to request the change.

If your PCP=s participation in the HMO Choice Point of Service network ends, Blue Cross will notify you and furnish you with a list of PCPs so you can select a new one. If you do not select a new PCP, Blue Cross will assign a PCP closest to your home or place of employment. If, for some reason, your PCP unexpectedly withdraws from the network, you will be assigned a temporary PCP until you can choose a new one.

Specialists and Referrals

Your PCP may refer you to a specialist. Specialists are professionals who practice in special areas such as dermatology, neurology, surgery, and others. With the prior authorization of your PCP, you can obtain care from any of the approved specialists listed in the Directory and receive the highest level of benefits.

If your PCP authorizes a referral to a professional or provider for you, make sure you understand:

- X The name of the professional or provider to whom you are being referred;
- X The period of time, the number of visits and services for which care is authorized; and
- X Who is to make the appointment(s) with that professional or provider: you or your PCP=s office staff.

The time period, number of visits and services your doctor authorizes are specified on the referral confirmation you will receive from Blue Cross. You will need to discuss additional care recommended by the referring professional or provider with your PCP, if the care exceeds the initial referral for services.

If your referred professional or provider recommends you to another professional or provider, you must contact your PCP prior to any treatment so he or she can determine if that care will be authorized. Only your PCP can authorize care with another professional or provider.

Note: A referral from your PCP is not a guarantee of coverage for those services.

Referral to Non-Participating Providers and Professionals

If your PCP determines that you need special care and a specialist is not available within the HMO Choice network, your PCP will make a referral to a non-network provider for these services. In those instances, you will be covered for receiving care from a non-network provider if approval is obtained from Blue Cross prior to receiving services.

Self-Referral

The amount of your benefits is determined each time you seek health care services. To receive the highest level of benefits provided by this health care plan, your PCP must either provide or arrange for your necessary health care services. However, you do have the choice to self-refer for covered health

care services or supplies whenever you feel it is necessary. When you self-refer for covered health care services or supplies, your benefits will be provided at a lower level of coverage, in most cases. This level of benefits is referred to as your Self-Referred Level of Benefits on your Benefit Overview.

Maintaining the Patient-Physician Relationship

Members enroll in this Plan with the understanding that the PCP is responsible for determining appropriate treatment for the member. For personal or religious reasons, some members may disagree with the treatment recommended by the PCP. They may demand treatment that the PCP or Blue Cross judge to be incompatible with proper medical care. In the event of such disagreement, members have the right to refuse the recommendation of the PCP. Members who do not adhere to recommended treatment or who use non-recognized sources of care because of such disagreement, do so with the full understanding that Blue Cross has no obligation for the costs of such non-authorized care.

Relationship of Network Physicians

Blue Cross contracts with a select group, or network, of physicians to provide you with health care services. These physicians are not Blue Cross employees. In their agreements with Blue Cross, network physicians agree to be responsible for the health care services provided to members according to quality assurance and utilization management standards. Under both the terms and conditions of this contract, and agreements with network physicians, Blue Cross pays for covered services determined to be appropriate by its utilization management standards.

Emergency Care In or Outside of the Service Area

This Plan provides benefits for health care services received in an emergency care facility or setting. To receive benefits for emergency care services, you must have symptoms of sufficient severity that a prudent lay person would reasonably expect that the absence of immediate medical attention could result in serious physical and/or mental jeopardy; serious impairment to body functions; or serious dysfunction to any body organ or part.

In emergency situations, you should seek immediate medical attention. Blue Cross covers emergency services necessary to screen and stabilize, without prior authorization from your PCP, only if a prudent lay person acting reasonably would have believed that an emergency medical condition existed. You should contact your PCP within 48 hours of receiving emergency services, or as soon as possible after emergency screening and stabilization have taken place, to receive the highest level of benefits and arrange for follow up care if needed. Benefits for emergency care may be denied if your PCP, applying the prudent lay person guideline, determines that your symptoms and discharge diagnosis did not indicate that emergency services were necessary. If you disagree with the medical judgement of your PCP, and feel that your emergency services should be authorized, you have the right to appeal that decision, as outlined in Section 13.

If you are traveling outside of Maine and you need urgent care, you can call your PCP or you can call **1-800-4HMO-USA (1-800-446-6872)** for direction. You will be responsible for copayments, just as

you would if you received care within the network. Any follow up care should be coordinated with your PCP once you return home.

Members at School Outside of Their Service Area

If you require emergency services while you are outside your service area enrolled as a full time student at a school or college, Blue Cross will provide benefits for covered services in a physician's office, clinic, or hospital. You should seek emergency care services just as you would at home or inside your service area.

For non-emergency care, you should seek care and send the itemized bill with a short letter of explanation to Blue Cross's Customer Service Department. The letter must indicate that services were for a student away at school. Follow-up visits and elective and routine procedures are not covered unless performed by or authorized in advance by your PCP.

Section 7

What Is Utilization Management?

All services you receive are subject to the provisions in this section, whether they are received through your Primary Care Physician (PCP) or you self-refer. Failure to comply with any or all of the requirements listed below will result in a penalty, or in denial or reduction of your benefits.

If you have a health concern, please contact your PCP. Only services that have been provided, arranged, or authorized by your PCP and approved by Blue Cross are eligible for the highest level of benefits shown on your Benefit Overview.

Utilization review and management decisions regarding appropriateness of care, length of stay or treatment setting may at times differ from the decisions of your physician(s). This difference of opinion may occur as the treatment plan is compared to national medical guidelines, taking into consideration your individual medical circumstances. These national medical guidelines are based on the actual practices of clinical physicians nationwide. This review is to determine financial reimbursement for services. The ultimate decision for treatment is between the patient and physician, regardless of the decision made regarding reimbursement.

The purpose of the utilization management program is to ensure that you receive high quality health care services in the most appropriate setting. The utilization management program consists of the following.

Inpatient Admission Review

Preadmission Review All inpatient admissions for non-emergency services require preadmission review. Non-scheduled maternity services do not require preadmission review. Your PCP must call for review before you are admitted. If you self-refer, it is your responsibility to make sure the call is made. We will notify you and your physician of the results of the readmission review within 2 working days of our obtaining all necessary information regarding the proposed admission. If you self-refer and do not receive a preadmission review before you are admitted for non-emergency/non-maternity services, Blue Cross will reduce benefits for the admission by up to \$500.

For inpatient non-emergency and non-maternity admissions, call toll-free **1-800-392-1016**. For special rules that apply to maternity admissions, see the Continued Inpatient Stay Review provision in this section.

Postadmission Review All inpatient admissions for emergency services, including non-scheduled maternity services, are subject to postadmission review. For postadmission review to occur, you, a family member, or the provider should call within 48 hours after you are admitted. We will notify you

and your physician of the results of the postadmission review within 2 working days of receiving all necessary information. For inpatient emergency admissions, call toll-free **1-800-392-1016**. For special rules that apply to maternity admissions, see the Continued Inpatient Stay Review provision in this section.

Continued Inpatient Stay Review

During your stay as an inpatient, your attending physician and the utilization management team will monitor your progress to determine how long you should remain in the hospital. When they determine that it is time for your release, you will be notified that benefits will no longer be available (if you are potentially liable for the entire cost of continued care).

If you elect to continue your hospital stay after you have been notified that no further inpatient days are approved, benefits will be denied for that part of your stay that has not been approved.

Note: The Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother=s or newborn=s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under federal law, require that a provider obtain authorization from the Plan or Blue Cross for prescribing a length of stay that does not exceed 48 hours (or 96 hours). Additionally, following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer, or any maternity admission, the inpatient length of stay will be determined by the attending physician in consultation with the patient as outlined in the Inpatient Hospital Services provision in Section 7.

Discharge Planning

You may be ready to be discharged from a provider even though you still need medical care. In that case, Blue Cross will work with you and your physician to make arrangements for treatment even after you are released from the provider.

Inpatient and Outpatient Mental Health/Substance Abuse Review

Primary Care Physician authorization is not required for mental health or substance abuse services. Unless you have an emergency medical condition, you must call Green Spring at **1-800-755-0851** for approval of all inpatient and outpatient mental health and substance abuse services before you receive the services, in order to receive the highest level of reimbursement. It is your responsibility to make sure you receive prior approval for all inpatient and outpatient mental health and substance abuse services, in order to receive the highest level of reimbursement. If you do not call for inpatient listed mental health services before you receive the services, your benefits may be reduced by up to \$500. The \$500 penalty does not apply to emergency admissions.

For outpatient services, you can self-refer and choose to receive care from either a participating or non-participating provider.

Individual Case Management

The purpose of the individual case management program is to have registered nurse care managers coordinate cost-effective options for catastrophically ill or injured patients by working with patients and their families, physicians, providers and employers to access the most appropriate medical care. In certain extraordinary circumstances involving intensive case management, benefits may be provided for alternate care that is not listed as a covered service in this Plan. Covered services may also be extended beyond the normal benefit limits of this Plan. Decisions will be made case-by-case based upon a determination of medical necessity and the cost-effectiveness of the alternate treatment or extended benefits. A decision to provide extended benefits or alternate care in one case is not an obligation to provide the same benefits again to you or any other member covered under the HMO Choice Point of Service Plan. The Plan reserves the right, at any time, to cease providing extended benefits or benefits for alternate care.

Members= Rights and Responsibilities

You have the right to:

- X Request in writing a copy of Blue Cross=s clinical review criteria used in arriving at any denial or reduction of benefits.
- X Appeal any adverse determinations based on medical necessity.
- X Refuse treatment for any condition, illness, or disease without jeopardizing future treatment.

Procedure for Appeal of Medical Necessity

If you disagree with Blue Cross=s determination of medical necessity, you have the right to appeal.

Expedited For urgent situations requiring a review of a decision within 24 hours, you or your physician may request an expedited review.

Standard When a service or a referral is not approved based on medical necessity, you or your physician can request a review of the determination. Blue Cross will notify both you and your physician, in writing, of the decision within 21 working days.

Level Two Appeal If you disagree with Blue Cross=s decision in the standard review, you may appeal further under Blue Cross=s Level Two appeal provisions outlined in Section 13.

Section 8

What Is Covered?

This section includes the types of health care services that are covered under the University HMO Choice Point of Service Plan. All of the benefits and services are subject to the exclusions, limitations and conditions of this Plan. Refer to your Benefit Overview for deductibles, copayments, coinsurance, maximums, and limitations that apply. Benefits are provided for medically necessary services and for routine/preventive services listed in this Summary Plan Description.

Please see the Utilization Management section for conditions that apply to all inpatient admissions and outpatient mental health and substance abuse services.

Only medically necessary care is covered. Although Blue Cross does not provide benefits for covered services that do not meet its definition of medical necessity, you and your physician must decide what care is appropriate. If you choose to receive care that does not meet Blue Cross's definition of medical necessity, Blue Cross will not provide benefits for it.

Allergy Testing and Injections Benefits are provided for allergy testing and injections.

Ambulance Service Transportation to or from a local hospital in a licensed vehicle for the sick or injured is covered when other transportation would endanger your health. If the local hospital cannot adequately provide the care you need, ambulance transportation to the nearest facility outside your area will be provided. If you are transported to a facility that is not the nearest facility that can meet your needs, benefits will be based on transportation to the nearest facility that can meet your needs.

Ambulatory Surgery Centers Benefits are provided for covered services provided by ambulatory surgery centers. Covered services vary according to the scope of an individual facility's licensure.

Anesthesia Services Benefits are provided for anesthesia only if administered while a covered service is being provided. Benefits are not provided for local or topical anesthesia unless it is part of a regional nerve block.

Asthma Education Benefits are provided for approved asthma education programs for members with asthma. Benefits are provided for up to a calendar year maximum of \$200 per patient when the program is received from an approved network provider or professional. Please call Blue Cross for a listing of approved providers and professionals.

Blood Transfusions Benefits are provided for blood transfusions including the cost of blood, blood plasma, blood plasma expanders and administrative costs of autologous blood pre-donations.

Chemotherapy Services Blue Cross provides benefits for antineoplastic drugs and antibiotics and their administration when they are administered by parenteral means such as intravenous, intramuscular, or intrathecal means. This does not include the use of drugs for purposes not specified on their labels, except for the diagnoses of cancer, HIV, or AIDS, unless approved by Blue Cross for medically accepted indications or as required by law. Any FDA Treatment Investigational New Drugs are not covered unless approved by Blue Cross for medically accepted indications or as required by law.

Chiropractic Care Benefits are provided for chiropractic care. You can self-refer to a licensed participating chiropractor and receive the highest level of benefits; benefits are available for up to 36 visits in a 12-month period. A lower level of benefits is available if you self-refer to a non-network chiropractor. No benefits are available beyond the 36 visit limit without a referral from your PCP.

Dental Care Benefits are provided for only the following teeth and jaw services:

- X Setting a jaw fracture;
- X Removing a tumor or cyst (but not a root cyst);
- X Removing impacted or unerupted teeth in a non-hospital or non-rural health center setting;
- X Removing seven or more permanent teeth;
- X Gingivectomies;
- X Osseous surgery;
- X Dental services needed as a result of chemotherapy;
- X Repairing or replacing dental prostheses damaged by an accidental bodily injury;
- X Treating accidental bodily injury to natural teeth.

In order to determine possible coverage of other dental procedures that are related to medical conditions not listed in this provision, have your dentist submit a proposed treatment plan to Blue Cross.

Diabetic Services Benefits are provided for diabetes medication and supplies which are medically appropriate and necessary. Medications include insulin, insulin pumps and oral hypoglycemic agents. Covered supplies and equipment are limited to glucose monitors, test strips, syringes and lancets. Covered benefits also include outpatient self-management and educational services used to treat diabetes if services are provided through Ambulatory Diabetes Education Facilities authorized by the State=s Diabetes Control Project.

Diagnostic Services Benefits are provided for diagnostic services when they are ordered by your PCP as a preventive or well-care service or when they are ordered by a professional to diagnose specific signs or symptoms of an illness or injury.

Durable Medical Equipment and Prostheses The Plan provides benefits for renting or purchasing durable medical equipment. Whether you rent or buy the equipment, benefits are provided for the least expensive equipment necessary to meet your medical needs. If you rent the equipment, Blue Cross will make monthly payments only until the Plan's share of the reasonable purchase price of the least expensive equipment is paid or until the equipment is no longer necessary, whichever comes first. Benefits for replacement or repair of purchased durable medical equipment are subject to Blue Cross approval. Benefits are not provided for the repair or replacement of rented equipment. Supplies are covered if they are necessary for the proper functioning of the durable medical equipment. Once the reasonable purchase price of the equipment has been paid, benefits for supplies are no longer provided.

The Plan provides benefits for prostheses. Prostheses are appliances that replace all or part of a bodily organ (including contiguous tissue) or replace all or a part of the function of a permanently inoperative, absent or malfunctioning body part. Prostheses include artificial limbs and prosthetic appliances.

If more than one treatment, prosthetic device, or piece of durable medical equipment may be provided for your disease or injury, benefits will be based on the least expensive method of treatment, device, or equipment that can meet your needs. Benefits for durable medical equipment and external prosthetics are limited to the amount listed on your Benefit Overview.

Emergency Room Care Emergency room treatment received for medical care emergencies is covered once you pay the copayment or coinsurance listed on your Benefit Overview. To receive the highest level of benefits, you or a designated person must contact your PCP within 48 hours from the time you receive care.

If you are admitted to the hospital from the emergency room, the copayment is waived. To receive the highest level of benefits, you or a designated person must contact your PCP within 48 hours from the time you are admitted. If you do not contact your PCP, you or someone you designate should call Blue Cross Care Management at **1-800-392-1016** within 48 hours of admission.

Eye Examinations Routine eye examinations (one every 12 months if you are under age 18, and one every 24 months if you are age 18 or older) for vision correction are covered. A PCP referral is not required for routine eye examinations. If it is necessary to have an eye examination in order to diagnose a medical condition, these exams are covered as often as required regardless of age but require a referral from your PCP.

Foot Care Benefits are provided for cutting, removal or treatment of corns, calluses, or toenails only if medically necessary because of diabetes or other similar disease. Open cutting, operations of metatarsalgia or bunion, or complete removal of nail roots are covered.

Freestanding Imaging Centers Benefits are provided for diagnostic services performed at freestanding imaging centers. All services must be ordered by a professional.

Home Health Care Benefits are provided for home health care. A home health agency must provide and coordinate the services as approved by Blue Cross. Approved home health care services listed below are covered.

- X Physician home and office visits;
- X Registered Nurse (RN) or Licensed Practical Nurse (LPN) visits;
- X Services of home health aides when supervised by an RN;
- X Paramedical services, including physical, occupational, inhalation and speech therapy; and nutritional counseling by a qualified professional;
- X Supportive services, including prescription drugs, medical and surgical supplies, ambulance, oxygen, laboratory tests, durable medical equipment and rental of medical equipment.
- X Benefits for rented medical equipment will be provided only until the Plan=s share of the reasonable purchase price is reached or until the equipment is no longer medically necessary, whichever occurs first.

Home Infusion Therapy Benefits are provided for home infusion therapy. Supplies and equipment needed to appropriately administer home infusion therapy are covered.

Hospice Care Hospice care is designed to provide care in a supportive setting for the patient, as well as to help the patient=s family during the final stages of a terminal illness. To be eligible for hospice care benefits the patient=s physician must certify that the patient has a life expectancy of six months or less.

Benefits are provided for hospice care when services are furnished in the home by a home health agency and may include services of a Registered Nurse (RN), Licensed Practical Nurse (LPN), or a home health aide or sitter/companion. The patient need not be homebound nor receiving skilled nursing services in order to be eligible for hospice care. Benefits are available for up to 24 hours of care a day by a home health agency. Prior approval is required when care exceeds eight hours a day. In this case, the agency must submit a plan of care to receive approval. Thereafter, care plans must be submitted every 14 days.

Benefits are available for inpatient hospice care at a hospital, skilled nursing facility or hospice. The patient=s physician must certify that the patient cannot be cared for at home.

Hospice Respite Care Hospice respite care is designed to allow the person who regularly assists the patient at home, either a family member or other nonprofessional, to have personal time solely

for relaxation. The patient may then need a temporary replacement to provide hospice care. Benefits will be provided for up to a 48-hour period for respite care.

A home health agency must submit a plan of care for approval before the patient receives respite care. It is also necessary to receive prior approval when respite care is provided by an inpatient hospice.

Inborn Errors of Metabolism The Plan provides benefits for metabolic formula and up to \$3,000 per member per calendar year for special modified low-protein food products for patients with diseases caused by inborn errors of metabolism. To be covered, these products must be specifically manufactured for patients with diseases caused by inborn errors of metabolism.

Independent Laboratories Benefits are provided for diagnostic services performed by independent laboratories. All services must be ordered by a professional.

Infertility Services Benefits are provided for procedures, treatment, and services related to treat infertility if provided or authorized by your PCP. See your Benefit Overview for coinsurance that applies. Artificial insemination with your spouse's sperm is covered. No benefits are available for self-referred services. See Section 9 for infertility services that are not covered.

Inhalation Therapy Benefits are provided for inhalation therapy by a licensed therapist for the administration of medications, gases (such as oxygen, carbon dioxide or helium), water vapor or anesthetics.

Inpatient Hospital Services The Plan provides benefits for inpatient hospital care. The Plan covers the cost of a semi-private room while you are confined in the hospital. Charges for a private room are covered if medically necessary. Charges that exceed this rate are not covered by the Plan.

The Plan provides benefits for the following hospital inpatient services:

- X Room and board, including general nursing care, special duty nursing, and special diets;
- X Use of intensive care or coronary care unit;
- X Diagnostic services;
- X Medical, surgical, and central supplies;
- X Treatment services;
- X Hospital ancillary services including but not limited to use of operating room, anesthesia, laboratory;
- X X-ray; and inpatient occupational therapy, physical therapy, inhalation therapy, and radiotherapy services;
- X Medication used when you are an inpatient, such as drugs, biologicals, and vaccines. This does not include the use of drugs for purposes not specified on their labels, except for the diagnoses of cancer, HIV, or AIDS, unless approved by Blue Cross for medically accepted indications, or as

required by law. Any FDA Treatment Investigational New Drugs are not covered unless approved by Blue Cross for medically accepted indications or as required by law;

- X Blood derivatives (but not whole blood or plasma);
- X Prostheses or orthotic devices; and
- X Newborn care including routine well-baby care.

To obtain the highest level of benefits, for all scheduled inpatient admissions, preadmission authorization and approval must be received by the PCP. For emergency admissions, to obtain the highest level of benefits, the member or designated person must call the PCP within 48 hours after admission. The PCP will be responsible for monitoring or recommending ongoing care.

If your care is not provided or coordinated by your PCP, for all scheduled inpatient admissions, you or a designated person must call for preauthorization. For emergency admissions, you or a designated person should call **1-800-392-1016** for review within 48 hours of admission.

Following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer, or any maternity admission, the inpatient length of stay will be determined by the attending physician in consultation with the patient.

Benefits for an inpatient stay in a hospital will end for any of the following reasons:

- X Your inpatient stay ends;
- X Your attending physician or Blue Cross notifies you that inpatient care is no longer medically necessary;
- X The hospital's utilization review committee notifies you in writing that further inpatient care is not medically necessary. Coverage will end within 72 hours after you receive this notice.

The utilization review committee is a group of physicians and other hospital professionals responsible for reviewing the quality of care and the need for continued care in that hospital.

Laboratory and X-ray Services Diagnostic laboratory tests and x-rays are covered.

Maternity Benefits are provided for prenatal and postnatal care, delivery of a newborn, care of a newborn and complications of pregnancy. Routine circumcisions are covered while the newborn is still in the hospital, or later if medically necessary.

To receive the highest level of benefits, for planned cesarean sections, preadmission authorization and approval must be received by the PCP. For other maternity admissions, to receive the highest level of benefits, the member or designated person must call the PCP within 48 hours after admission. The PCP will be responsible for monitoring or recommending ongoing care.

If your care is not provided or coordinated by your PCP, you or a designated person should call **1-800-392-1016** within 48 hours of admission.

Medical Care Benefits are provided for medical care and services including office visits and consultations, hospital and skilled nursing facility visits, and pediatric services.

Medical Supplies Syringes which are medically necessary for injecting insulin or a prescription drug are covered under your prescription drug program. Syringes must be purchased from an authorized seller of syringes.

Mental Health Services and Substance Abuse Services - Professional For mental health, benefits are provided only for the following mental health services when they are for the active treatment of mental disorders:

- X Individual and group counseling;
- X Family counseling;
- X Diagnostic and evaluation services;
- X Emergency treatment for the sudden onset of a mental health condition requiring an immediate and acute need for treatment;
- X Intervention and assessment.

These services must be part of an established plan of treatment and must be performed and independently billed by a professional acting within the scope of his or her license.

For substance abuse, benefits are provided only for services that are for the active treatment of substance abuse. For care that is independently billed by a professional, the services must be part of an established plan of treatment and performed by a medical doctor or psychologist acting within the scope of his or her license.

Section 7 contains additional information about seeking mental health services.

Mental Health and Substance Abuse Services - Provider Benefits are provided for inpatient, outpatient, and day treatment services for mental health and substance abuse when you receive them from a provider.

If you receive provider services from a community mental health center or substance abuse treatment facility, services must be:

- X Supervised by a licensed physician, clinical psychologist, or licensed clinical social worker; and
- X Part of a plan of treatment for furnishing such services established by the appropriate staff member.

We provide benefits for only the following mental health and/or substance abuse treatment services:

- X Room and board, including general nursing;
- X Prescription drugs, biologicals, and solutions administered to inpatients;
- X Supplies and use of equipment required for detoxification and rehabilitation;
- X Diagnostic exams and evaluation;
- X Intervention and assessment;
- X Facility-based professional and ancillary services;
- X Individual and group counseling;
- X Family counseling;
- X Psychological testing;
- X Emergency treatment for the sudden onset of a mental health or substance abuse condition requiring immediate and acute treatment.

You are not required to contact your PCP for mental health or substance abuse services. To receive the highest level of benefits, you must call **1-800-755-0851** to receive either inpatient or outpatient services. A coordinator will assist in identifying the appropriate course of treatment. Section 7 contains additional information about seeking mental health and substance abuse care.

Morbid Obesity Benefits are available for surgery for an intestinal bypass, gastric bypass, or gastroplasty to treat morbid obesity if you are diagnosed as morbidly obese for a minimum of five consecutive years.

Nutritional Counseling Nutritional counseling is a covered benefit when required for a medical condition. This benefit is limited to three visits per condition, but may be extended if authorized by your PCP.

Obstetrical Services and Newborn Care Blue Cross provides benefits for prenatal and postnatal care, delivery of a newborn, care of a newborn, and complications of pregnancy.

Office Visits Benefits are provided for office visits.

Organ and Tissue Transplants You must obtain approval from Blue Cross prior to being admitted to receive an organ transplant in order to be eligible for benefits. Only the following organ and tissue transplants are covered under the Plan:

- X Heart
- X Heart/lung
- X Lung
- X Islet tissue
- X Liver
- X Adrenal gland
- X Bone

- X Cartilage
- X Muscle
- X Skin
- X Tendon
- X Heart valve
- X Blood vessel
- X Parathyroid, and
- X Kidney

For certain conditions, the following transplants are covered under the Plan:

- X Cornea
- X Allogeneic bone marrow
- X Pancreas, and
- X Autologous bone marrow

For information about coverage for these transplants, call Blue Cross Customer Service at **1-800-527-7706** or **822-8282** from Greater Portland.

All other organ and tissue transplants are not covered. No benefits for any services related to a transplant will be covered if the transplant is not covered.

The Plan provides benefits as follows:

- X If both the donor and recipient are covered members of a Blue Cross health plan, benefits will be provided to both patients;
- X If the recipient is a member under a Blue Cross plan but the donor is not, benefits will be provided to both the recipient and donor as long as benefits are not available to the donor from other sources;
- X If the recipient is not a member under a Blue Cross plan but the donor is a member, neither the donor nor the recipient will receive benefits.

Orthotic Devices Benefits are provided for orthotic devices, such as orthopedic braces, back or surgical corsets, splints, orthopedic shoes and other supportive devices. Benefits are not provided for arch supports, shoe inserts, other foot support devices, support hose, garter belts, and other devices available over-the-counter.

Outpatient Private Duty Nursing Private duty nursing care provided outside of the hospital is covered. Care must be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) and ordered by a physician. You or your physician must call Blue Cross Care Management at **1-800-392-1016** for prior approval.

Outpatient Services Benefits are provided for the following hospital outpatient and rural health center services:

- X Removal of sutures;
- X Application or removal of a cast;
- X Diagnostic services;
- X Surgical services;
- X Removal of impacted or unerupted teeth;
- X Endoscopic procedures;
- X Blood administration;
- X Radiation therapy;
- X Chemotherapy.

Outpatient rehabilitation and education programs are also covered. These services are limited to covered Phase II cardiac, physical, head injury and pulmonary rehabilitation; diabetic education; asthma education; and dialysis training. Benefits for these services have special requirements. Please contact Blue Cross to see if you are eligible for benefits.

Parenteral and Enteral Therapy Benefits are provided for parenteral and enteral therapy. Supplies and equipment needed to appropriately administer parenteral and enteral therapy are covered. Nutritional supplements for the sole purpose of enhancing dietary intake are not covered unless they are given in conjunction with enteral therapy.

Prescription Drugs Benefits are provided under your prescription drug program for FDA approved prescription drugs and medicines bought for use outside a hospital. This includes coverage of necessary supplies and equipment needed to appropriately administer medications, including clinically approved hyperalimentation supplies. Blue Cross may determine, after consideration of recommendations from its Pharmacy & Therapeutics (P & T) Committee, dispensing limitations and/or prior approval requirements for certain prescription drugs. For more information about limitations or prior approval requirements, call Blue Cross at **1-800-527-7706** or **822-8282** from Greater Portland.

When your prescription is filled at the pharmacy or through the mail order program, you pay the pharmacy the copayment amount shown on your Benefit Overview.

Changes in Your Prescription Your pharmacist may check your prescription to determine if there may be harmful interactions between the prescription you are filling and any other prescription you may be taking. The pharmacist may contact your physician to discuss possible changes to your prescription.

Refills on Prescriptions Your physician will indicate the number of refills for your prescription. Refills for your prescription are covered when you have taken 75% of the medication or within 10 days of the refill date, whichever is greater. Benefits are not provided for refills that are filled sooner.

Maintenance Prescription Supplies Benefits are provided for up to a 90 day supply if prescribed by your physician as medically appropriate. Please refer to your Benefit Overview for copayment amounts that apply to you.

Vacation Supplies If you are going out of the area for an extended period of time and your supply of medication is not sufficient for this period, you may contact your pharmacy or the prescribing physician prior to leaving the area to receive an early refill or an extended day supply of medications while you are away from home.

Prescription Drugs by Mail You can obtain prescription drugs by mail. To obtain benefits for prescription drugs by mail, complete a mail order pharmacy form, available from Blue Cross=s Customer Service Department, and mail it with your prescription. You must pay the applicable copayment indicated on your Benefit Overview.

Radiation Therapy Benefits are provided for radiation therapy.

Reconstructive Services Benefits are provided for reconstructive services to improve or restore bodily function or to correct deformity resulting from disease, trauma or previous therapeutic process only when there is functional impairment. Procedures to correct congenital or developmental anomalies are considered reconstructive only when the anomaly results in functional impairment. Benefits will be provided for reconstruction of a breast on which mastectomy surgery has been performed and for surgery and reconstruction of the other breast to produce a symmetrical appearance.

Routine Preventive Care You and your enrolled family members are covered for routine preventive care. To be covered, most care must be provided by your PCP. See your Benefit Overview for details. The following are covered services:

- X Periodic routine physical examinations;
- X Well-baby care;
- X Well-child care;
- X Routine ear examinations to determine the need for hearing correction, up to the end of the calendar year in which you reach age 19. Hearing exams to diagnose a medical condition are covered regardless of age;
- X Routine pediatric and adult immunizations;
- X Counseling for family planning, insertion and fitting of contraceptive devices, voluntary sterilization and reverse sterilization. Benefits are not provided for over-the-counter contraceptive devices.
- X One annual prostate specific antigen test and digital rectal examination for men aged 50 to 72, if recommended by your physician.

The following preventive services do not require authorization by your PCP:

- X Routine eye examinations for vision correction. Routine eye exams will be covered once every 12 months if you are under age 18, and once every 24 months if you are age 18 or older.
- X One routine gynecological examination every 12 months, which includes breast and pelvic examination, and a Pap smear. These services must be received from a HMO Choice Point of Service network professional.
- X One screening mammogram performed once a year for women 40 years of age and over. One screening mammogram for women age 35-39 who have a family history of breast cancer.

Skilled Nursing and Rehabilitation The Plan covers skilled nursing facility care and rehabilitative therapy. Benefits are limited to 100 consecutive days per illness.

Smoking Cessation Benefits are provided for nicotine replacement therapy (NRT) products. You may obtain medications by using your prescription drug card. To be eligible for benefits, these products must be prescribed by your physician (including medications available over-the-counter). NRT products can include but are not limited to nicotine patches, gum or nasal spray. Benefits will be provided for physician office visits for follow up education and counseling. Copayments will apply. Participation in an approved smoking cessation class is also covered.

Speech, Physical and Occupational Therapy Benefits are provided for short-term speech, physical and occupational therapy on an outpatient basis for conditions that are subject to significant improvement within 60 days. Benefits are limited to a period of up to 60 consecutive days per calendar year per medical/surgical condition from the date on which services begin. Visits to more than one therapist for the same condition are counted toward the same 60-day limit. Chronic or recurring conditions such as back strains or sprains are considered to be the same condition and are limited to one 60-day treatment period. A copayment applies to these services.

Physical and occupational therapy services must be provided by a licensed physical therapist or registered occupational therapist. No benefits are provided for:

- X Massage therapy; and
- X Treatments such as paraffin baths, hot packs, whirlpools or moist/dry heat applications unless in conjunction with an active course of treatment.

Speech therapy must be provided by a licensed speech pathologist acting within the scope of his or her license. No benefits are provided for:

- X Deficiencies resulting from mental retardation; and
- X Dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors.

Surgical Services Benefits are provided for covered surgical procedures, including services of a surgeon, specialist, anesthetist or anesthesiologist, and for preoperative and postoperative care. Benefits for an assistant surgeon are provided when the complexity of the surgery warrants an assistant.

Blue Cross reserves the right to determine when assistant surgeon services will be covered.

Section 9

What Is Not Covered?

This section includes some, but not all, of the services which are excluded or limited under the University HMO Choice Point of Service Plan. If you receive care, services or supplies described in this section, you will be responsible for paying these expenses with no reimbursement from the Plan.

Acupuncture Benefits are not provided for acupuncture treatments.

Benefits Available From Other Sources Benefits are not provided for any services to the extent that there is no charge to you or to the extent that you can recover expenses through a federal, state, county or municipal law. This is the case even if you waive or fail to assert your rights under these laws; however, this exclusion does not apply to Medicaid.

Biofeedback Benefits are not provided for biofeedback treatments.

Blood Benefits are not provided for any blood, blood donors or packed red blood cells when participation in a volunteer blood program is available.

Conditions Resulting From War Benefits are not provided for any disease or injury that is a result of war, declared or undeclared, or any act of war.

Cosmetic Services Benefits will not be provided for cosmetic services intended solely to improve appearance. Cosmetic services include services to treat emotional, psychiatric or psychological conditions.

Custodial Care Services for custodial, convalescent or sanitarium rest cures, whether or not they are recommended by a professional, are not covered.

Dental Services Services for orthognathic surgery, dental surgery, dentistry or dental implants, unless specifically listed as covered in the Dental Care provision in Section 8 are not covered.

Department of Veterans Affairs Benefits are not provided for any treatment, services or supplies provided to veterans by The Department of Veterans Affairs, its hospitals or facilities if the treatment is related to your service connected disability.

Experimental/Investigational Services Benefits are not provided for any drugs, supplies, providers, professionals or medical or health care services that are experimental/investigational. This exclusion includes the cost of all services from a provider or professional including the cost of all services while you are an inpatient receiving an experimental/investigational service or surgery. Drugs classified as Treatment Investigational New Drugs (IND) by the FDA and devices with the FDA Investigational Device Exemption (IDE), any device to which the FDA has limited access or otherwise limited approval, and any services involved in clinical trials are considered experimental/investigational.

Facilities of the Uniformed Services Benefits are not provided for any treatments, services or supplies provided to you by or through any health care facility of the Uniformed Services. This exclusion does not apply to benefits if you are a military dependent or retiree.

Family Planning Services Benefits are not provided for birth control preparations (such as foams or jellies); over-the-counter contraceptive devices; and costs associated with achieving pregnancy through surrogacy.

Genetic Testing Genetic testing services are not covered under this Plan. Genetic testing performed on a previously diagnosed patient is covered only if the genetic testing is required to plan treatment of the diagnosed condition.

Government Institutions Services provided to you by any institution that is owned or operated by the United States or a state, county or municipal government are not covered.

Hearing Care Benefits are not provided for hearing examinations except for screening members under the age of 19 years or when related to injury or disease. Benefits are not provided for the prescription, fitting or purchase of hearing aids including audiant bone conductors.

Leased Services and Facilities Benefits are not provided for any health care services or facilities that are not regularly available by the provider you go to or that the provider must rent or make special arrangements to provide, and that are billed independently.

Major Disaster or Epidemic In the event of a major disaster, epidemic or other circumstances beyond the Blue Cross=s control, a good faith effort to provide or arrange for covered services will be made. Blue Cross is not responsible for any delay or failure in providing services due to lack of available facilities or personnel.

Medical Supplies Medical supplies, including bandages and other disposable items, which may be purchased without a prescription, are not covered. This exclusion does not apply to syringes used for injecting insulin or a drug prescribed by a physician.

Medically Unnecessary Services and Excess Charges Benefits are not provided for any charge for treatment, services or supplies that are medically unnecessary, unreasonably priced or unusual for the treatment of the illness or injury.

Medicare Benefits are not provided in situations where Medicare would have primary liability for health care costs under federal Medicare Secondary Payor regulations. If you are enrolled in Medicare Part A and/or Part B, and Medicare is the primary payor, you are no longer eligible for HMO Choice Point of Service coverage. You can enroll in the University's COMP-CARE comprehensive group health plan. If you are eligible for premium-free Medicare Part A, and Medicare would be the primary payor, the Plan may pay benefits as if Medicare had made their primary payments for Medicare Part A and/or B, even if you fail to exercise your right to premium-free Medicare Part A coverage.

Mental Health, Substance Abuse Treatment and Lifestyle Counseling The following services or any services related to those listed below are not covered:

- X Weight reduction and nutritional counseling, except as indicated in Section 8;
- X Nicotine addiction and smoking clinics, except as indicated in Section 8;
- X Sensitivity training;
- X Encounter groups;
- X Educational programs, except as indicated in the Section 8;
- X Marriage, guidance and career counseling;
- X Pain control;
- X Co-dependency;
- X Adult Children of Alcoholics (ACOA) programs;
- X Activities whose primary purpose is recreation and socialization;
- X Services for mental disorders that do not respond favorably to treatment according to generally accepted professional standards; and
- X Services by an independently billing professional other than a medical doctor or psychologist for the treatment of substance abuse.

Methods of Impregnation Benefits are not provided for any treatment, services or drugs to enhance fertility. Artificial insemination with other than a spouse's sperm, in-vitro fertilization, and intravaginal conception are also not covered.

Miscellaneous Expenses Benefits are not provided for a professional's or member's expenses for traveling or a provider's or professional's charge to provide required information to process a claim or application for coverage.

Missed Appointments Benefits are not provided for missed appointments. Physicians and other providers may charge you for failing to keep scheduled appointments without giving reasonable

notice to the office. Benefits are not available for these charges. Missed appointments are not counted against benefit limitations.

Orthognathic Surgery Benefits are not provided for orthognathic surgery.

Orthotic Devices Orthotic devices, other than those listed in Section 8, are not covered.

Personal Comfort Items Personal comfort items, such as television, newspaper, telephone and guest meals are not covered.

Physical and Occupational Therapy Benefits are not provided for massage therapy, treatment such as paraffin baths, hot packs, whirlpools or moist/dry heat applications unless in conjunction with an active course of treatment.

Prescription Drugs Blue Cross does not provide for the following:

- X Any refill in excess of the number specified by the physician or for refills dispensed after one year from the date of original prescription order;
- X Vitamins, except prenatal vitamins, prescription vitamins, cosmetics, dietary supplements, health or beauty aids, dermatologicals used for cosmetic purposes, or topical dental fluorides;
- X Prescription drugs for the treatment of weight reduction;
- X Contraceptives, except oral contraceptives and diaphragms;
- X Fertility drugs;
- X Medication that is taken by or administered to an inpatient;
- X Experimental or investigational drugs or any FDA Treatment Investigational New Drugs (IND);
- X Disposable supplies such as alcohol, cotton balls, or bandages used to administer medications;
- X Prescription drugs dispensed by a physician;
- X Prescription drugs approved by the FDA used for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS, unless approved by Blue Cross for medicinally accepted indications or as required by law;
- X Drugs that are the subject of new FDA approvals, after you receive this provision, unless Blue Cross determines the drug to be covered.

Preventive Care Benefits are not provided for preventive care and well-care services unless they are received from or authorized by your PCP, with the exception of routine eye exams and annual gynecological exams.

Refractive Eye Surgery Benefits are not available for refractive eye surgery, including radial keratotomy, for conditions that can be corrected by means other than surgery.

Routine Foot Care Benefits are not provided for any services rendered as routine foot care. Foot care listed in Section 8 is covered.

Services After Your Coverage Ends Benefits are not provided for any services that are provided after your coverage ends unless:

- X You are an inpatient at the time; or
- X You are totally disabled on the cancellation date (See Section 4).

All benefits stop when your inpatient stay ends or when you reach any of the Plan maximums shown on your Benefit Overview, whichever comes first.

Services Before the Effective Date Benefits are not provided for any admissions, treatment, services, supplies, medical equipment or prostheses rendered to you or received before your individual effective date of coverage. Any services you receive during a hospital stay that started before you enrolled in this HMO Choice Point of Service Plan are not covered.

Services by Ineligible Providers or Professionals Services provided by any provider or professional not listed as an eligible provider or professional in this Summary Plan Description are not covered.

Services by Relatives or Volunteers Benefits are not provided for any services provided in any capacity by immediate family members or step-family members, spouse, domestic partner, father, mother, brother, sister, son or daughter, or services by volunteers.

Services Not Listed as Covered Any service, procedure, or supply not listed as a covered service in this Summary Plan Description is not covered.

Services Related to Non-covered Services Benefits are not provided for services related to any non-covered service and any complications and conditions resulting from any non-covered service.

Sex Changes Benefits are not provided for any services related to any transsexual operation.

Speech Therapy Benefits are not provided for deficiencies resulting from mental retardation or dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors.

Temporomandibular Joint (TMJ) Syndrome Services Benefits are not provided for any temporomandibular joint syndrome services. This exclusion does not apply to oral surgical services listed as covered in the Dental Care provision in Section 8.

Travel Expenses Any travel expenses, whether or not a professional recommends the travel, are not covered.

Vision Care Benefits are not provided for vision therapy, including treatment such as vision training, orthoptics, eye training or eye exercises. Benefits are not provided for the prescription, fitting or purchase of glasses or contact lenses.

Weight Reduction Benefits are not provided for weight reduction services other than those described in Section 8.

Workers= Compensation Benefits are not provided for any condition, ailment or injury that arises out of and in the course of employment or any disability that results from an occupational disease. Benefits are not provided for services or supplies that are obtained or obtainable completely or partially under any Workers= Compensation Act or similar law. This is the case even if you waive or fail to assert your rights under these laws, unless you waive them before the condition, ailment or injury occurs as provided by the Workers= Compensation Act.

Benefits will be paid on a provisional basis for treatment of a contested work-related condition, ailment or injury only if all the following conditions are met:

1. You are making a claim under the Workers= Compensation Act;
2. Your health care coverage is provided through your employer;
3. Your employer or your employer's workers= compensation administrator or insurer has filed a notice of controversy stating that your claim is being denied for work-relatedness;
4. The Workers= Compensation Board has not made a determination on your claim;
5. Your employer has made no payment on or settlement of your claim.

Section 10

How Are Claims Filed and Who Do I Call with Claims Questions?

Filing a Claim

In most cases, there will be no need to file a claim form. The HMO Choice Point of Service providers and professionals are responsible for filing the claims for you. However, if you receive care from providers or professionals outside of the HMO Choice Point of Service network, you may need to submit a claim form.

Claim forms are available from your Human Resources or Campus Benefits Office or by calling Blue Cross's Customer Service Department. All claim forms include instructions for completing the form and the address where you should send the completed form(s). Be sure to attach original bills when submitting your claims.

Time Limit for Filing Claims

Claims must be submitted to Blue Cross within 180 days after the service is received. If Blue Cross receives proof as soon as is reasonably possible, however, it will not consider a claim invalid or reduce benefits. Blue Cross has the right to investigate why filing a claim was delayed.

Releasing Necessary Information

Providers and professionals often have information needed to determine your coverage. As a condition for receiving benefits, you or your representative must provide all of the medical information needed to determine your eligibility for coverage or to process your claim.

Non-compliance

If Blue Cross does not enforce compliance of any provision of this Plan, it is not required to allow non-compliance of that provision or any other provision at any time, in any case.

Examination of Claimant

To ensure that all claims are valid, Blue Cross may require a person submitting a claim to have a physical examination at Blue Cross's expense.

Questions About Claims?

Please contact a Customer Service Representative toll free at: **1-800-527-7706**. You may also call from the Greater Portland area at **207-822-8282**. Customer Service Representatives are available from 8:00 a.m. to 5:00 p.m. Monday through Friday.

Blue Cross has offices at these locations:

South Portland (Main Office)
2 Gannett Drive
South Portland, Maine 04106-6911
Telephone: **1-800-527-7706** or **207-822-8282**

Bangor
1 Merchants Plaza
Bangor, Maine 04401
Telephone: **207-561-2262**

Augusta
168 Capital Street
Augusta, Maine 04330
Telephone: **207-629-2238**

Presque Isle
55 North Street, Suite A
Presque Isle, Maine 04769
Telephone: **207-764-8124**

You may also contact Blue Cross by e-mail at:

customerservice@bcbsme.com

You can also call Blue Cross to leave a voice-mail message 24 hours a day at:

1-800-243-3988 or **207-822-8270**.

Section 11

How Are Benefits Determined?

Blue Cross has the sole power and authority to administer, construe, and interpret the contract and all of its terms whenever necessary to carry out its intent and purpose including making benefit determinations.

You may have some responsibility for the cost of health services under your Plan. Your responsibility may take the form of a deductible, coinsurance percentage, or a copayment amount. Please see your Benefit Overview for the deductible, coinsurance, and copayment amounts that apply to your coverage.

If you have some responsibility for the cost of health care services you receive, you will pay your coinsurance, deductible, or copayment amount directly to the professional, hospital, or other provider of care.

If you have coinsurance responsibility that is based on a percentage, you will pay your coinsurance percentage based on the hospital's or provider's discounted charge or negotiated amount, or Blue Cross's maximum allowance for professionals. Blue Cross's payment to professionals will consist of its percentage of the maximum allowance after any deductibles coinsurance, and copayments have been applied.

Highest Benefit Level

Blue Cross determines benefits at the highest level for services when they are provided or authorized by your PCP. For most covered services, no deductible or coinsurance applies and you pay nothing or only a small copayment. See your Benefit Overview for details.

Self-referred Benefit Level

When you self-refer for care, for most services, Blue Cross determines benefits at the lower level and a deductible and coinsurance apply. See your Benefit Overview for details.

Compliance with Laws

If federal laws or the laws of the state of Maine change, the provisions of the contract will automatically change to comply with those laws on the required dates. Any provision that does not conform with applicable federal law or the laws of the state of Maine will be construed and applied as if it were in full compliance.

Confidentiality

Any information pertaining to your diagnosis, treatment or health obtained from either your physician, provider, or Blue Cross will be held in confidence. Blue Cross may reveal this information only to the extent required by law.

Statements and Representations

The statements you make on your application for coverage with Blue Cross are representations and not warranties.

Severability

If any term or provision in this Summary Plan Description is deemed invalid or unenforceable, this does not affect the validity or enforceability of any other term or provision.

Section 12

How Are Claims Paid?

This section explains how the Plan pays benefits for covered services. Benefits paid will never exceed the actual charges. Blue Cross reserves the right to pay benefits to another person if so ordered by a court of competent jurisdiction.

Primary Care Physician Services

If your claim from a PCP is approved, benefits will be paid directly to your PCP. Except for copayments, in most cases, you are not required to pay any balances to your PCP for covered services. PCPs rendering a covered service with a benefit based on a maximum allowance agree to limit their charges to the maximum allowance.

Participating Providers and Professionals

If your PCP has authorized services from a participating provider or professional, benefits will be paid directly to them. Except for copayments, you are not required to pay any balances to the participating provider or professional until after Blue Cross determines the benefits it will pay. Participating providers and professionals rendering a covered service with a benefit based on a maximum allowance agree to limit their charges to the maximum allowance.

Self-referred Services

If your claim for self-referred services is approved, benefits will be paid directly to you, unless you assign benefits to the provider of care or Blue Cross has a participating agreement with that provider or professional, in which case, payment will be made directly to the provider or professional.

Non-Participating Providers and Professionals

If your PCP refers you to a non-participating provider or professional, Blue Cross will decide if it pays benefits. Blue Cross will base this decision on factors such as the provider or professional's ability to meet certain standards of participation, such as license to perform a covered service. If Blue Cross does approve your claim, the highest level of benefits will apply.

If you self-refer to a non-participating provider, the self-referred benefits level will apply. Blue Cross will pay claims directly to you or the provider.

Out-of-State Providers and Professionals - HMO Blue Card Disclosure

If your PCP refers you to an out-of-state provider or professional with Blue Cross's prior approval, Blue Cross will provide benefits at the PCP benefit level. If you self-refer to an out-of-state provider or professional, Blue Cross will provide benefits at the self-referred level.

When you obtain health care services through the BlueCard program outside of Maine, the amount you pay for covered services is usually calculated on the lower of:

- X The actual billed charges for your covered services, or
- X The negotiated price that the on-site Blue Cross and/or Blue Shield Plan passes on to Blue Cross.

The negotiated price could consist of any or all of the following:

- X A simple discount.
- X An estimated final price that factors in expected settlements, or other non-claims transactions, with your health care providers or with a specified group of providers.
- X A discount from billed charges that reflects average expected savings.

The estimated or average price may be adjusted in the future to correct over- or underestimation of past prices.

Also, laws in a small number of states require Blue Cross and/or Blue Shield Plans to use a basis for calculating your payment for covered services that does not reflect the entire savings realized or expected to be realized on a certain claim. When you receive covered health care services in those states, your required payment for these services will be calculated using their statutory methods.

Hospitals Outside of the United States

Blue Cross provides benefits for inpatient and outpatient services in a foreign hospital. If you obtain covered services outside of the United States, in most cases you will have to pay your bill when you leave the hospital.

When you return to Maine, send Blue Cross the following:

- X A statement of the nature of the illness or injury;
- X An itemized statement translated into English (accompanied by the original statement) showing the services received and the date(s) of service;
- X Your contract number; and
- X The dollar rate of exchange at the time you received the service, if possible.

When you receive this information, Blue Cross will reimburse you for covered services according to the terms of the contract.

Prescription Drug Claims

Prescriptions Ordered at a Retail Pharmacy To obtain benefits for prescription drugs at a retail pharmacy, present your identification card to any pharmacy that has an agreement with Blue Cross's

pharmacy benefit manager (PBM) in this or any other state. Blue Cross's PBM is the company that administers its prescription drug program. You must pay the applicable copayment, or coinsurance amounts shown on your Benefit Overview for generic and brand name prescription drugs. The participating pharmacy will submit the claim for you and Blue Cross's PBM will directly pay the pharmacy the balance due.

If you use a pharmacy that does not have an agreement with Blue Cross's PBM or if you do not use your identification card, you must pay the pharmacy the entire cost for the prescription and submit a claim form to the PBM for reimbursement. Claim forms are available from your Human Resources or Campus Benefits Office or by contacting a Customer Service Representative at Blue Cross. If you receive prescription drugs from a non-participating pharmacy or if you do not use your identification card, you may receive a reduced benefit. Blue Cross will reimburse you based on the amount it would have paid a participating pharmacy less your share of the cost, indicated on your Benefit Overview.

Prescriptions Ordered Through the Mail Order Program To obtain benefits for prescription drugs ordered through the mail order program; complete an order form, enclose the prescription and your copayment and mail it to the address preprinted on the mail order program envelope. The applicable copayment amount is shown on your Benefit Overview. The mail order pharmacy will submit the claim for you and Blue Cross's PBM will directly pay the pharmacy the balance due.

Professional and Provider Payment Methods

Blue Cross generally pays PCPs and some specialists, on a capitated basis for benefits delivered to members. Capitation means that the professional is paid a fixed dollar amount each month based on the member's gender and age for agreed upon medical services.

When a physician renders a covered service that is not capitated care, the payment for the service is based on a maximum allowance agreed to by him or her. In addition to capitation, a PCP can receive additional payments at the end of the year if he or she has met certain quality standards.

Blue Cross generally pays specialists and professionals for each service they provide, based on a maximum allowance. The maximum allowance for a service is determined based upon the resources needed to provide a given service. The resources taken into account are a physician's total work, practice costs and malpractice costs. These costs are added and multiplied by a factor to establish the maximum allowance.

Blue Cross generally pays providers in several different ways. These ways may include discounts from regular charges and fixed fees.

Section 13

How Do I Complain Or Appeal?

Complaints

Blue Cross=s Customer Service Representatives are available to assist members in the resolution of complaints concerning claims administration, benefit determination, eligibility or medical care provided to you. A Customer Service Representative may need to forward your complaint to the appropriate internal department for response. The internal staff receiving the member complaint will conduct an investigation and promptly issue a decision to the member on the complaint, either in writing or by telephone. You will receive a response within twenty working days of Blue Cross=s receipt of your complaint. If your complaint is not satisfactorily resolved, you may seek help through the appeal process outlined below.

Reconsideration of Utilization Management Decisions

Blue Cross may determine there is no medical necessity in a case involving preadmission or continued inpatient stay review. If your physician does not agree with the Blue Cross decision, he or she can request a reconsideration of this adverse determination. If the reconsideration does not resolve the difference of opinion, you or your physician may appeal.

Complaints Requiring Immediate Intervention

If a member is dissatisfied with a decision regarding an urgent care situation, Blue Cross will immediately work with the health care professional or provider involved to respond quickly to the concern. This will occur before the need for services, whenever possible. If services are already in progress, Blue Cross will promptly notify the member, so he or she may decide whether to receive services for which he or she may be financially responsible and which may not be covered by the Plan.

Level One Appeal Process

A member who is dissatisfied with the decision on a registered complaint may appeal the decision to the Blue Cross Customer Service Appeals Coordinator. An appeal may be submitted orally or in writing and must include specific reasons why the member does not agree with the issued decision. Appeal of a decision must be filed within 90 calendar days of the date the decision was issued, unless there are extenuating circumstances. Blue Cross reserves the right to investigate the reason for the delay and determine whether the circumstances warrant acceptance of the Level One Appeal beyond the required 90 day time frame.

On 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 a prior decision. Additional

information may be submitted by or on behalf of the member, Blue Cross or any treating professional. A decision will be issued to the member within 20 working days of receipt of the member's request for an appeal. If additional information is needed, a final decision will be issued within an additional 20 working days.

Once a decision is issued, the member may take a second level appeal to Blue Cross, or contact the Bureau of Insurance. The Superintendent of Insurance may be contacted at **1-800-300-5000**.

Level Two Appeal Process

A member who is dissatisfied with the outcome of the Level One Appeal may appeal the decision to the Blue Cross Special Inquiry Administrator. An appeal must be in writing and include specific reasons why the member does not agree with the issued decision, and must be filed within 90 calendar days of the date the Level One Appeal decision was issued.

On a Level Two Appeal, the entire record will be reviewed. This review will not be done by the same individuals who were involved in a prior decision on this issue. 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 member, Blue Cross or any treating professional. The member may appear before the review panel. The review will be conducted within 45 calendar days of the receipt of the member's Level Two Appeal. A written decision will be issued to the member within 5 working days of completing the review. Once a final decision has been issued, the member may take no further appeal to Blue Cross. Members may, however, file a complaint with the Bureau of Insurance and/or bring legal action against Blue Cross. The Superintendent of Insurance may be contacted at **1-800-300-5000**.

Legal Action Against Blue Cross

No legal action may be brought against Blue Cross until after the member has exhausted the complaint and appeals process outlined above. You have one year from the date of the final decision in which to file a legal claim; after that, no legal action regarding that final decision may be brought against Blue Cross.

Section 14

What If I Have Other Coverage?

Coordination of Benefits

All benefits of the contract are subject to coordination of benefits (COB). COB is a formula that determines how benefits are paid to members covered by more than one contract. It helps keep down the cost of health coverage by ensuring that the total benefits you receive from all contracts do not exceed the cost of covered services.

COB sets the payment responsibilities for any contract that covers you, such as:

- X Group, group conversion, individual (also known as non-group), self-insured plans, franchise, or blanket insurance, including coverage through a school or other educational institution but excluding school accident type coverage;
- X Group practice, individual practice, and other prepaid group coverage, labor-management trustee plan, union welfare plan, employer organization plan, or employee benefit organization plan; or
- X Other insurance that provides medical benefits.

The contract with primary responsibility provides full benefits for covered services as if there were no other coverage. The contract with secondary responsibility may provide benefits for covered services in addition to those of the primary contract. When there are more than two contracts covering the person, the contract may be primary to one or more contracts, and may be secondary to another contract or contracts. All benefits are limited to the contract maximums or to the maximum allowance for the services you receive.

When you have duplicate coverage, Blue Cross will determine benefits by using the first of the following rules that applies:

- X If the other contract does not contain a COB clause or does not allow coordination of benefits with this Plan, the benefits of that contract will be primary.
- X If both contracts contain a COB clause allowing the coordination of benefits with this Plan, Blue Cross will determine benefit payments by using the first of the following rules that applies:
 1. **Non-Dependent/Dependent** The benefits of the contract that covers you as an employee or subscriber will be determined before the benefits of the contract that covers you as a dependent are determined.
 2. **Dependent Children (Parents Not Separated or Divorced)** For claims on covered dependent children, the contract of the parent whose birthday occurs first in the year will be primary. If both parents have the same birthday, the contract that has covered one parent longer will be primary over the contract that has covered the other parent for a shorter

period. If the other contract does not include the rule described immediately above, but instead has a rule based on the gender of the parent, and as a result the contracts do not agree on the order of benefits, the rule in this Summary Plan Description will determine the order of benefits.

3. **Dependent Children (Parents Separated or Divorced)** In the case of legal separation or divorce, the coverage of the parent with custody will be primary. If the parent with custody has remarried, coverage of the parent's spouse will be secondary, and the coverage of the parent without custody will be last. Whenever a court decree specifies the parent who is financially responsible for the dependent's health care expenses, the coverage of that parent's contract will be primary. If a court decree states that the parents have joint custody, without stating that one or the other parent is responsible for the health care expenses of the child, the order of benefits is determined by following rule two.
4. **Active/Inactive Employee** The benefits of a contract that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a contract that covers the person as a laid-off or retired employee (or as that employee's dependent). If the other coverage does not include this provision, and as a result, the contracts do not agree on the order of benefits, rule six applies.
5. **Continuation of Coverage** If a person whose coverage is provided under the right of continuation pursuant to a federal or state law is also covered by another contract, the benefits of the contract covering the person as an employee or subscriber, or as the dependent of an employee or subscriber, will be primary. The benefits of the continuation coverage will be secondary. If the other coverage does not include this provision regarding continuation coverage, rule six applies.
6. **Longer/Shorter Length of Coverage** If none of the rules above determines the order of benefits, the benefits of the contract that has covered the employee or subscriber longer will be determined before those of the contract that has covered the person for a shorter period.

Blue Cross reserves the right to:

- X Take any action needed to carry out the terms of this section;
- X Exchange information with an insurance company or other party;
- X Recover its excess payment from another party or reimburse another party for its excess payment; and
- X Take these actions when Blue Cross decides they are necessary without notifying the covered persons.

If You Qualify for Medicare

If you or your eligible dependent becomes eligible for Medicare while you are still actively at work, your medical benefits will be provided primarily by the University Plan. Medicare will be a secondary benefits payor.

Medicare may supplement the payments you receive from this Plan. However, these supplementary Medicare payments will be limited so that the combined benefits paid will not be more than the expenses you or your dependent have incurred. You must notify Blue Cross if you become eligible for premium-free Medicare Part A. Failure to notify Blue Cross could result in cancellation of your coverage.

You may choose to continue your coverage once you are eligible for premium-free Medicare Part A. However, your HMO Choice Point of Service Plan will not provide benefits that duplicate any benefits payable under Medicare Part A or B. This is true even if you fail to exercise your rights to premium-free Medicare Part A coverage.

For you and your dependents who are eligible for Medicare because of renal failure, this Plan is considered the primary payor for the first 18 months after your Medicare effective date. After the 18-month period, Medicare becomes the primary payor, and you are no longer eligible for coverage under the HMO Choice Point of Service Plan. You can enroll in the University's COMP-CARE comprehensive group health plan.

Subrogation: Payments Resulting from Legal Actions

When another party has caused or is responsible for your injury or illness, you may be entitled to payment from a claim or legal action against that party. When Blue Cross provides health care benefits for treatment of your injury or illness, it has the right to recover up to the total benefit it paid from any payment you receive from the responsible party. The process of recovering these expenses is called subrogation.

Blue Cross also has subrogation rights against your own insurance; including medical payments, uninsured, and underinsured motorist provisions in your auto insurance policy.

Subrogation applies whether any of the payment or settlement is allocated for medical expenses.

If the services related to your illness or injury are covered by a capitation fee, Blue Cross is entitled to the reasonable cash value of the services.

By accepting the contract you agree:

- X You authorize Blue Cross's right of subrogation, or your signed application for coverage is your authorization;
- X To notify Blue Cross of any event which could result in legal action, a claim against a third party, or a claim against your own insurance;
- X To notify Blue Cross of any payments you receive as a result of legal action, a claim against a third party, or a claim against your own insurance;
- X To cooperate with Blue Cross in exercising its right of subrogation by providing all information it requests;

- X To sign documents Blue Cross deems necessary to protect its rights; and
- X To do nothing to interfere with Blue Cross's subrogation rights.

If you do not comply with the above, you may be responsible for expenses Blue Cross incurs in enforcing its subrogation rights.

Section 15

How Does ERISA Affect This Plan?

The University of Maine system has established this Plan for the benefit of its employees. The provisions of the Employee Retirement Income Security Act of 1974 (ERISA) do not apply to this Plan. However, the University of Maine System voluntarily complies with most ERISA provisions.

ERISA provides that the people administering your Plan are to do so prudently and in your best interests and not discriminate against you to prevent you from obtaining a welfare benefit.

Plan participants are entitled to:

- X Examine all Plan documents; and
- X Obtain copies of all Plan documents (for a reasonable charge).

The University of Maine System anticipates that this Plan is established as a permanent health and welfare benefit plan. The University of Maine System, however, reserves the right to amend, modify, or terminate the Plan, or any part of the Plan, by written instrument executed by the University of Maine System. Upon execution, such instrument will become effective in accordance with its terms to all Plan participants and all persons having or claiming any interest hereunder.

Section 16

What Is Family and Medical Leave?

Continuation of Health Coverage During Family and Medical Leave

The Family and Medical Leave Act of 1993 (FMLA) requires employers to provide up to 12 weeks of unpaid, job-protected leave during any 12 month period to eligible employees for certain family and medical reasons. This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. See your employer to find out details about how this continuation applies to you.

Reasons for Taking Leave

FMLA leave will be granted for any of the following reasons:

- X Care of your child after birth;
- X Placement of a child with you for adoption or foster care;
- X Care of your spouse, child or parent who has a serious health condition; or
- X A serious health condition that makes you unable to work.

Employee Eligibility

To be eligible for FMLA benefits, an employee must:

- X Work for a covered employer;
- X Have worked for the employer for at least 12 months;
- X Have worked at least 1,250 hours over the previous 12 months; and,
- X Work at a location where at least 50 employees are employed by the employer within 75 miles.

Advance Notice and Medical Certification

The employee must provide advance notice and medical certification. Taking of leave may be denied if requirements are not met.

The employee ordinarily must provide 30 days advance notice when the leave is foreseeable. If the need for the leave is unforeseen, notice must be given as soon as practicable. An employer may require medical certification to support a request for leave because of a serious health condition, and may require a second or third opinion (at the employer=s expense) and a fitness for duty report to return to work.

Continuation of Health Coverage, Job Benefits, and Protection

For the duration of FMLA leave, the employer must maintain your health coverage. You may continue the health plan for you and your dependents on the same terms as if you had continued to work. You must pay the same contributions toward the cost of the coverage that you made while working.

If you fail to make the payments on a timely basis, the employer can end the coverage during the leave if your payment is more than 30 days late. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms. The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Intermittent Leave

Under some circumstances, you may take FMLA leave intermittently which means taking leave in blocks of time, or by reducing your normal weekly or daily work schedule. Where FMLA leave is for birth or placement for adoption or foster care, use of intermittent leave is subject to the employer's approval. FMLA leave may be taken intermittently whenever it is medically necessary to care for a seriously ill family member, or because you are seriously ill and unable to work.

Substitution of Paid Leave

Subject to certain conditions, employees or employers may choose to use accrued paid leave (such as sick or vacation leave) to cover some or all of the FMLA leave. The employer is responsible for designating if paid leave used by you counts as FMLA leave, based on information provided you. In no case can your paid leave be credited as FMLA leave after the leave has been completed.

Spouses or Domestic Partners Who Work for the Same Employer

Spouses or domestic partners employed by the same employer are each entitled to 10 work weeks of family leave for the birth or placement of a child for adoption or foster care, and to care for a child or parent (but not a parent *in law*) who has a serious health condition.

Reenrollment after a FMLA Leave

If any or all of your coverages stop while you are on a FMLA leave, when you return from leave, you are entitled to be reinstated on the same terms as prior to taking the leave, without any qualifying period, physical examination, or exclusion of pre-existing conditions.

See your employer for details about continuing group coverage other than the health coverage.

Section 17

What Is the University's Non-discrimination Policy?

In complying with the letter and spirit of applicable laws and in pursuing its own goal of diversity, the University of Maine System shall not discriminate on the grounds of race, color, religion, sex, sexual orientation, national origin or citizenship status, age, disability, or veteran status in employment, education, and all other areas of the University. Upon request, the University provides reasonable accommodations to qualified individuals with disabilities.

Questions and complaints about discrimination in any area of the University should be directed to the appropriate University Equal Opportunity Director or to Sally Dobres, Equal Opportunity Coordinator for the University of Maine System, 107 Maine Avenue, Bangor, Maine 04401, **(207) 621-3199** (voice) or **(207) 973-3300** (TTY/TDD).

Inquiries or complaints about discrimination in employment or education may also be referred to the Maine Human Rights Commission. Inquiries or complaints about discrimination in employment may be referred to the U.S. Equal Employment Opportunity Commission.

If you have inquires about the University's compliance with the following:

- X Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, and national origin;
- X Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act of 1990, which prohibit discrimination on the basis of disability;
- X Title IX of the Education Amendments of 1972, which prohibits discrimination on the basis of sex; and
- X The Age Discrimination Act of 1975, which prohibits discrimination on the basis of age.

Direct them to:

The U.S. Department of Education
Office for Civil Rights (OCR)
Boston, Massachusetts 02109-4557
Telephone: **(617)223-9662** (voice) or **(617)223-9695** (TTY/TDD)

Generally, an individual may also file a complaint with OCR within 180 days of the alleged discrimination.

