



**University of Maine System
 COMP-CARE Comprehensive Group Health Plan/HMO Choice Point of Service Plan
 Benefit Comparison - Renewal Effective July 1, 2002**

Represented Professional (UMPSA); Police; Clerical, Office, Lab & Technical (COLT); Service & Maintenance; and COBRA Beneficiaries of these units

	COMP-CARE Comprehensive Group Health Plan	HMO Choice - Point of Service Coverage	
		Highest Level of Benefits	Self-referred Level of Benefits
Important Information	<p>Benefits are based on our maximum allowance for covered services. Our maximum allowance is the most we will pay for a particular service.</p> <p>When covered services are received from a participating provider:</p> <ul style="list-style-type: none"> • Claims are filed by the provider in most instances. • You are only responsible for the deductible and coinsurance. • Participating providers cannot bill you for balances that exceed Anthem Blue Cross and Blue Shield's maximum allowance. 	<p>Benefits are based on our maximum allowance for covered services. Our maximum allowance is the most we will pay for a particular service.</p> <p>Coverage described in this column applies when covered services are provided or authorized by your Primary Care Physician, unless otherwise stated.</p> <p>You are responsible for any copayments and coinsurance that apply.</p>	<p>Benefits are based on our maximum allowance for covered services. Our maximum allowance is the most we will pay for a particular service.</p> <p>Coverage described in this column applies when you self-refer to providers or professionals. (The Primary Care Physician does NOT provide or authorize services.)</p> <p>You may be responsible for filing claims and paying balance bills in addition to the deductible, copayments, and coinsurance. You may also need to pay the provider or professional up front.</p>

	COMP-CARE Comprehensive Group Health Plan	HMO Choice - Point of Service Coverage	
		Highest Level of Benefits	Self-referred Level of Benefits
Inpatient Admission Review	<p>For scheduled inpatient admissions, except for planned cesarean sections, you or someone you designate must call 1-800-392-1016 for a preadmission review. If you do NOT call for review before admission, benefits can be reduced by 50% up to \$500.</p> <p>For emergency admissions, you or someone you designate should call within 48 hours after admission.</p> <p>For maternity admissions, you or someone you designate must call if the hospital stay is longer than 48 hours for a normal vaginal delivery or longer than 96 hours for a cesarean section.</p>	<p>Scheduled inpatient admissions, except for planned cesarean sections, require preadmission authorization by the Primary Care Physician.</p> <p>For emergency admissions, you should call your Primary Care Physician within 48 hours after admission.</p>	<p>For scheduled inpatient admissions, except for planned cesarean sections, you or someone you designate must call 1-800-392-1016 for preadmission review. If you self-refer and do NOT call for review before admission, benefits can be reduced by up to \$500. The \$500 penalty does not apply to emergency admissions.</p> <p>For emergency admissions, you or someone you designate should call within 48 hours after admission.</p> <p>For maternity admissions, you or someone you designate must call if the hospital stay is longer than 48 hours for a normal vaginal delivery or longer than 96 hours for a cesarean section.</p>
Calendar Year Deductible Non-listed Mental Health/Substance Abuse Deductible	<p>\$150 per member/\$300 per family</p> <p>\$100 per member</p>	<p>None</p> <p>None</p>	<p>\$250 per member/\$500 per family</p> <p>General deductible applies</p>
Coinsurance	<p>Unless otherwise specified:</p> <p>Anthem Blue Cross and Blue Shield pays 80%</p> <p>You pay 20%</p>	<p>None</p>	<p>Unless otherwise specified:</p> <p>Anthem Blue Cross and Blue Shield pays 80%</p> <p>You pay 20%</p>

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Calendar Year Out-of-pocket Limit (Deductible + Coinsurance) A separate out-of-pocket limit applies to prescription drugs.	\$750 per member \$1,500 per family	None	\$2,500 per member \$5,000 per family
Lifetime Maximum Benefits			
General	\$1,000,000	None	\$1,000,000
Substance Abuse	\$50,000	\$50,000	
Hospital Services (Inpatient & Outpatient)	80%	100%	80%
Preadmission Testing	100% (deductible does not apply)	100%	80%
Second Surgical Opinion	100% (deductible does not apply)	100%	80%
Emergency Room Care	80%	<p>100% after a \$25 copayment</p> <p>For emergency services, you should seek immediate medical care.</p> <p>If you are admitted to the hospital from the emergency room, the copayment is waived.</p>	

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Professional Services			
Inpatient & Outpatient	80%	100%	80%
Physician Office Visits: Sick Care Adult Routine/Preventive	80% 100% (deductible does not apply) Includes: Up to one exam per calendar year ages 18+ Screening mammograms Screening Prostate Specific Antigen test and rectal exam	100% after a \$10 copayment 100% after a \$10 copayment	80% Not covered
Well Baby Care	100% (deductible does not apply) (6 exams age 0 through age 1, 2 exams age 1 through age 2)	100% after a \$10 copayment	Not covered
Well Child Care	100% (deductible does not apply) (1 exam per calendar year age 3 through 17)	100% after a \$10 copayment	Not covered
Maternity Care: Pre & Postnatal	80%	100% after a \$10 copayment for first visit	80%
Delivery	80%	100%	80%
Routine Gynecological Exam <i>One Exam and Pap Test per calendar year</i>	100% (deductible does not apply)	100% after a \$10 copayment (No PCP referral required)	100% after a \$10 copayment Not covered if you self-refer to a non- participating professional.
Family Planning Services			
Physical Exam, Laboratory Tests, Information & Counseling	80%	100% after a \$10 copayment	80%
Insertion/Removal of IUD			
Insertion/Removal of Norplant	80%	100% after a \$10 copayment	80%
Diaphragm	80%	100% after a \$10 copayment	80%
Vasectomy	80%	100% after a \$10 copayment	80%
Elective Tubal Ligation	80%	100%	80%
Reverse Sterilization	80%	100%	80%
Abortion	80%	100%	80%
			100% (no PCP referral required)

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Infertility Services	Not covered	50% <i>See Summary Plan Description for limitations</i>	Not covered
Diagnostic Services	80%	100%	80%
Physical & Occupational Therapy	80%	100% after a \$10 copayment <i>Combined limit of \$3,000 per calendar year for physical, occupational, and speech therapy</i>	80%
Speech Therapy	80% <i>Up to 35 visits per person per calendar year</i>	100% after a \$10 copayment <i>Combined limit of \$3,000 per calendar year for physical, occupational, and speech therapy</i>	80%
Cardiac Therapy	80%	100% after a \$10 copayment <i>3 sessions per week, up to 24 sessions per calendar year</i>	80%
Chiropractic Care	80%	100% after a \$10 copayment No referral required for up to 36 visits in a calendar year to a network professional	100% after a \$10 copayment for first 36 visits in a calendar year to a network professional 80% for visits to a non-network professional or over 36 visits in a calendar year No referral required for up to 36 visits in a calendar year to a network professional
Routine Eye Exam One routine eye exam every calendar year up to age 18. One routine eye exam every 2 calendar years thereafter	Not covered	100% after a \$10 copayment	100% after a \$10 copayment (no PCP referral required) Not covered if you self-refer to a non-participating professional
Allergy Testing/Injections	80%	100% after a \$25 copayment per testing visit 100% after a \$10 copayment per injection	80%
Private Duty Nursing	80%	100% <i>Preapproval required</i>	80% <i>Preapproval required</i> <i>Up to \$2,500 per calendar year</i>

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Skilled Nursing Facility	80% <i>Up to 730 days when transferred from hospital; up to 100 days otherwise</i>	100% <i>100 days per calendar year</i>	80%
Home Health Care	80% (<i>Up to 100 visits per calendar year</i>)	100% <i>Preapproval required</i>	80% <i>Preapproval required</i>
Hospice	100% (<i>Deductible does not apply</i>)	100%	80%
Christian Science Sanatorium	80%	Not covered	Not covered
Jaw Joint Disorder Services (TMJ)	80%	Not covered	Not covered
Durable Medical Equipment	80%	100% <i>\$3,000 annual maximum for both benefit levels combined</i>	80%
Smoking Cessation Smoking Cessation Program	80%	100% <i>Up to \$35 per program; \$70 per lifetime</i>	80%
Medications prescribed by a physician	Prescription drug copayment applies	Prescription drug copayment applies	Prescription drug copayment applies
Physician Follow-up Visits/Counseling	80%	100% after a \$10 copayment	80%

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Mental Health and Substance Abuse Benefits <i>*Listed Mental Illness: Benefits are paid at the same benefit level provided for medical treatment for the following listed mental illnesses: schizophrenia, bipolar disorder, pervasive developmental disorder (autism), paranoia, panic disorder, obsessive-compulsive disorder, and major depressive disorder</i>	<p>For scheduled inpatient mental health and substance abuse services, you or someone you designate must call Green Spring at 1-800-755-0851 for preauthorization of services. For listed mental illnesses, if you do not call for preauthorization, benefits can be reduced by 50% up to \$500.</p> <p>For emergency admissions, you or someone you designate should call Green Spring within 48 hours of admission.</p> <p>For outpatient mental health and substance abuse services, you are encouraged to call Green Spring at 1-800-755-0851 for preauthorization and to be directed to an appropriate provider.</p>	<p>Primary Care Physician authorization is not required. Limits and maximums apply to services received at the highest and self-referred levels of benefits combined.</p> <p>The highest coverage level applies when the member calls Green Spring at 1-800-755-0851 for preauthorization of mental health and substance abuse services and receives those services from the Green Spring assigned provider.</p> <p>For inpatient services you must call Green Spring at 1-800-755-0851 for preauthorization of all scheduled inpatient admissions. For emergency admissions, you or someone you designate should call Green Spring within 48 hours of admission.</p> <p>For outpatient services you must call Green Spring at 1-800-755-0851 for pre-authorization of mental health and substance abuse services and to be directed to an appropriate provider.</p>	<p>The self-referred level applies when the member does NOT call Green Spring for preauthorization of mental health or substance abuse services OR chooses to use other than the Green Spring assigned provider.</p> <p>For scheduled inpatient services, you or someone you designate must call Green Spring at 1-800-755-0851 for preauthorization of services. For listed mental illnesses, if you do not call for preauthorization, benefits can be reduced by up to \$500.</p> <p>For emergency admissions, you or someone you designate should call Green Spring within 48 hours of admission.</p>
Mental Health - Non-listed Illnesses			
Inpatient	80% <i>Up to 31 days per member per calendar year. 2 days of day treatment count as 1 inpatient day</i>	100% <i>Up to 60 days per member per calendar year. Two days of day treatment count as one inpatient day.</i>	80%
Outpatient <i>Up to 40 visits per member per calendar year for non-listed illnesses</i>	50%	100% after a \$10 copayment	50%
Substance Abuse - Inpatient	90% <i>Up to 31 days per member per calendar year. 2 days of day treatment count as 1 inpatient day</i>	100% <i>Detoxification: up to 30 days per member per calendar year. Two days of day treatment count as one inpatient day</i> <i>Rehabilitation: up to 60 days per member per calendar year. Two days of day treatment count as one inpatient day.</i>	80%
Substance Abuse - Outpatient	80% <i>Up to \$1,500 per member per calendar year</i>	\$10 copayment visits 1-10 \$20 copayment visits 11-20	80% up to 20 visits or \$1,500 whichever comes first

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Prescription Drug Coverage			
Note: Primary Care Physician authorization is not required.			
Represented Professional (UMPSA); Service & Maintenance; Police; Clerical, Office, Lab & Technical (COLT);	Generic: Member pays a \$5 maximum copayment per 30-day supply. Brand Name: Member pays a \$15 maximum copayment per 30-day supply. Out of Pocket Maximum: Once the member or family has paid \$600 in copayments during the calendar year, prescriptions are covered at 100% for the rest of the calendar year. Mail Order is Available		

This Benefit Comparison is not a contract; it is an outline of your coverage. Your Summary Plan Description/Certificate of Coverage and Benefit Overview fully describe the benefits and exclusions. In the event of a conflict, the terms of the Summary Plan Description/Certificate of Coverage and Benefit Overview prevail. You may contact us to obtain a copy of the Summary Plan Description/Certificate of Coverage and Benefit Overview.