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**University of Maine System
 COMP-CARE Comprehensive Group Health Plan/HMO Choice Point of Service Plan
 Benefit Comparison – Effective January 1, 2008**

	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>	
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>	
Calendar Year Deductible	\$300 per member/\$600 per family		None	
Non-listed Mental Health	\$100 per member		None	
Coinsurance	<p>Unless otherwise specified: Anthem Blue Cross and Blue Shield pays 80%</p> <p>You pay 20%</p>		None	
Calendar Year Out-of-pocket Limit (Deductible + Coinsurance) <i>A separate out-of-pocket limit applies to prescription drugs.</i>	<p>\$1,100 per member \$2,200 per family</p>		None	
Lifetime Maximum Benefits				
General	\$1,000,000		None	

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		Highest Level of Benefits	Self-referred Level of Benefits
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%	100% after a \$25 copayment For emergency services, you should seek immediate medical care. If you are admitted to the hospital from the emergency room, the copayment is waived.	
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 \$20 copayment 100% after a \$20 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 3)	100% after a \$20 copayment	Not covered
Well Child Care	100% (deductible does not apply) (1 exam per calendar year age 3 through 19)	100% after a \$20 copayment	Not covered
Maternity Care: Pre & Postnatal	80%	100% after a \$20 copayment for the 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 \$20 copayment (No PCP referral required)	100% after a \$20 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 \$20 copayment	80%
Insertion/Removal of IUD	80%	100% after a \$20 copayment	80%
Insertion/Removal of Norplant	80%	100% after a \$20 copayment	80%
Diaphragm	80%	100% after a \$20 copayment	80%
Vasectomy	80%	100%	80%
Elective Tubal Ligation	80%	100%	80%
Reverse Sterilization	80%	100%	80%
Abortion	80%	100%	100% (no PCP referral required)
Infertility Services	Not Covered	50% See Summary Plan Description for limitations	Not covered
Diagnostic Services	80%	100%	80%
High Tech Diagnostic Radiology (including but not limited to, CT Scans, MRI/MRAs, Nuclear Cardiology, PET Scans. These services require prior authorization)	80%	100%	80%
Physical & Occupational Therapy	80%	100% after a \$20 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 \$20 copayment <i>Combined limit of \$3,000 per calendar year for physical, occupational, and speech therapy</i>	80%

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Cardiac Therapy	80%	100% after a \$20 copayment <i>3 sessions per week, up to 24 sessions per calendar year</i>	80%
Chiropractic Care	80%	100% after a \$20 copayment No referral required for up to 36 visits in a calendar year to a network professional	100% after a \$20 copayment for 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	Not covered	100% after a \$20 copayment One routine eye exam every calendar year up to age 18. One routine eye exam every 2 calendar years thereafter.	100% after a \$20 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 <i>100% after a \$20 copayment per injection</i>	80%
Private Duty Nursing	80%	100% Preapproval required	80% Preapproval required <i>Up to \$2,500 per calendar year</i>
Skilled Nursing Facility	80% Up to 730 days when transferred from hospital; up to 100 days otherwise.	100% <i>100 days per calendar year</i>	80%
Home Health Care	80% (Up to 100 visits per calendar year)	100% Preapproval required	80% Preapproval required
Hospice	100% (deductible does not apply)	100%	80%
Christian Science Sanatorium	80%	Not covered	Not covered
Jaw Joint Disorder Services (TMJ)	80%	Not covered	Not covered
Durable Medical Equipment <i>(Prosthetics to replace limbs are Not subject to the limit or deductible)</i>	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 \$20 copayment	80%

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Managed by Anthem Behavioral Health and all services require preauthorization. Failure to comply with the requirements outlined in your Certificate of Coverage may result in a penalty up to \$500.	For inpatient services you must call Anthem Behavioral Health (1-800-755-0851) for preauthorization of all scheduled inpatient admissions. For emergency admissions, you or someone you designate should call within 48 hours of admission. For outpatient services you must call Anthem Behavioral Health (1-800-755-0851) for preauthorization of mental health and substance abuse services to be directed to an appropriate provider.		Primary Care Physician authorization is not required. Limits and maximums apply to services received at the highest and self-referred levels of benefits combined. This coverage level applies when the member obtains preauthorization from Anthem Behavioral Health (1-800-755-0851) for all inpatient and outpatient mental health and substance abuse services, and receives those services from the provider that the mental health care manager indicates.	This coverage level applies when the member does not contact Anthem Behavioral Health (1-800-755-0851) for preauthorization of mental health and substance abuse services or chooses to receive services from a provider other than the provider the mental health care manager indicates. (The member may have to pay balance bills in addition to deductible and coinsurance amounts.)
*Listed Mental Illnesses: State of Maine Statute requires that benefits be provided at the same benefit level provided for medical treatment for the following listed mental illnesses: Psychotic disorders, including schizophrenia; dissociative disorders; mood disorders; anxiety disorders; personality disorders; paraphilias; attention deficit and disruptive behavior disorders; pervasive developmental disorders; tic disorders; eating disorders, including bulimia and anorexia; and substance abuse-related disorders.				
Mental Health Services *Listed mental illnesses including substance abuse services:				
Inpatient	80%		100%	80% after deductible
Day Treatment	80%		100%	80% after deductible
Outpatient	80%		100%	80% after deductible
Hospital Emergency Room	80%		\$25 copayment, then 100%	\$25 copayment, then 100%
Office Visits	80%		\$20 copayment, then 100%	80% after deductible
Home Health Care Services	80%		100%	80% after deductible
Non listed mental illnesses:				
Inpatient <i>Up to a combined limit of 60 days per member per calendar year</i>	80%	<i>Two days of day treatment equal one day of inpatient services</i>	80%	60% after deductible
Outpatient <i>Up to a combined limit of 40 visits per member per calendar year.</i>	50%		50%	30% after deductible
Home Health Care Services	80%		100%	80% after deductible

Prescription Drug Coverage (3 Tier Benefit)

Retail Pharmacy

<p>Prescription Drug Coverage</p> <p>Note: Primary Care Physician authorization is not required.</p> <p>All eligible University of Maine System Employees; Retirees; Former Employees on Long Term Disability; and COBRA beneficiaries</p>	<p>Generic Drugs: You pay a: \$10 copayment for up to a 30-day supply, \$20 copayment for up to a 60-day supply, \$30 copayment for up to a 90-day supply.</p>	<p>Brand Name Drugs:* You pay a: \$25 copayment for up to a 30-day supply, \$50 copayment for up to a 60-day supply, \$75 copayment for up to a 90-day supply.</p>	<p>Optional Brand Name Drugs: * You pay a: \$40 copayment for up to a 30-day supply, \$80 copayment for up to a 60-day supply, \$120 copayment for up to a 90-day supply.</p>
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Mail Service Pharmacy

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

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

Optional Brand Name Drugs*: You pay a \$80 copayment for up to a 90-day supply.

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

Out of Pocket Maximum: Once the member has paid \$1,300 in copayments during the calendar year, prescriptions are covered at 100% for the rest of the calendar year for that member. Once the family has paid \$1,950 in copayments during the calendar year, prescriptions are paid at 100% for the rest of the calendar year for the whole family.

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 your Campus Benefits Office to obtain a copy of the Summary Plan Description/Certificate of Coverage and Benefit Overview.