

TABLE 1

COMPARISON OF BENCHMARK HEALTH PLANS

The chart below provides a **high-level comparison of major services** provided **for adults** by the Federal Employees Health Benefit plan, the Maine State Employee's Health Benefit plan (point of service option), the Anthem Blue Cross Blue Shield's HMO Maine plan (the largest HMO in Maine), and MaineCare. MaineCare is unique in serving exclusively low-income populations, particularly the elderly, people with disabilities and families with children. In addition, MaineCare plays a particularly unique and important role in providing long term care, so no attempt is made to compare long term care type services with the other plans, which by contrast cover people through their employment. Please note that this comparison focuses on adults and excludes additional services for children because of MaineCare's unique requirement that children receive any medically necessary care resulting from the Early Periodic Screening Diagnosis and Treatment (EPSDT) program. **This comparison is not intended to be a comprehensive analysis of all services covered under these plans.**

Plan Services and Costs	FEHB (Standard option) – fee-for-service, PPO	Maine State Employees (Point of Service Option) – “preferred referred,” “referred” and self-referred benefit levels	HMO Maine*	MaineCare – Primary Care Case Management with PCP referral to specialists required for most families and adults not also receiving Medicare
Ambulance	Covered. \$100/day copayment for ground transport; \$150/day for air or sea. No copayment for accidental injury.	Covered. No copayment. Referred level deductible applies.	Covered. \$50 copayment.	Covered. Copayment up to \$3/day, capped at \$30 per month.
Ambulatory Surgery Centers	Same as surgical services	Covered. \$50 copayment for referred (no deductible); 75% self-referred after deductible.	Covered. (Deductibles and coinsurance apply.)	Covered.
Chiropractic Care/manipulative therapy	\$20 copayment for preferred; 30% for non-preferred. Limited to 12	\$15 copayment for referred level; 25% coinsurance after deductible for self-	\$25 copayment. Manipulative therapy provided for treating acute	Rehabilitation potential required. Specific plan of care with justification for

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	manipulations per year, one initial office visit and one initial set of X-rays.	referred. Manipulative therapy provided for treating acute musculo-skeletal disorders. Not for maintenance treatment of chronic conditions.	musculo-skeletal disorders. Not for maintenance treatment of chronic conditions. Chiropractic limit of 36 self-referred visits per calendar year, PCP referral required thereafter.	treatment beyond 6 months required. Copayment of up to \$2, capped at \$20 per month.
Clinical trials	Not covered	Covered for those with life-threatening illness for which no standard treatment is effective.	Covered for those with life-threatening illness for which no standard treatment is effective.	Not covered.
Dental	Provides dental care necessary to promptly repair injury to sound natural teeth required as a result of an accidental injury. Other services covered up to a certain amount with patient billed for the balance.	Covers setting a jaw fracture; removing tumor; non-hospital removal of impacted or unerupted teeth; treatment within two years of accidental injury to repair or replace natural teeth or dental prostheses; emergency stabilization for accidental injury to natural teeth if within 72 hours of the injury; biopsy and excision of a lesion;	Covers setting jaw fracture, removing tumor, non-hospital removal of impacted or unerupted teeth; treatment within 6 months of accidental injury to repair or replace natural teeth or dental prostheses.	Covers selected procedures as necessary to relieve or eradicate acute pain, control bleeding, eliminate acute infection and prevent imminent tooth loss.

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		gingivectomy or gingoplasty; gingival flap procedure; osseous surgery or graft; pedicle soft tissue graft; free soft tissue graft.		
Durable Medical Equipment	Covered. 15% copayment for preferred, 30% non-preferred	For referred, fully covered after deductible; for self-referred, 25% coinsurance after deductible.	Covered. Least expensive option that meets medical needs covered. \$3,000 per member per year limit (not including prosthetics for limb replacement.)	Covered. Least expensive option and other various limits. Copayment up to \$3, capped at \$30/mo.
Family planning	Listed services covered. 15% copayment for preferred, 30% non-preferred	Covered.	Copayments for office visits: \$20 for PCP, \$25 for specialist. Full coverage for contraceptive devices.	Covers annual visit, prescriptions and related supplies. Co-payments for prescriptions.
Hearing services	Covers hearing tests related to illness or injury. 15% copayment for preferred; 30% for non-preferred. Does not cover routine hearing tests or hearing aids.	Covers hearing tests related to illness or injury. Does not cover routine hearing tests or hearing aids. For referred, \$15 copayment for audiology services, 25% after	Covers hearing tests related to illness or injury. Does not cover routine hearing tests or hearing aids.	Covers of hearing aids and audiological services only for residents of nursing facilities.

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		deductible for self-referred.		
Hospital - Inpatient	<p>Co-payment: \$200 per admission preferred or \$300 per admission, non-preferred. (No deductible for surgery).</p> <p>Precertification for inpatient stay required, except for normal delivery. For inpatient, operating, recovery, maternity and other treatment rooms, prescribed drugs, diagnostic tests, pathology, MRIs, machine diagnostic tests, and X-rays; blood or blood plasma, dressings, splints, casts,; internal prosthetic devices, other medical supplies and equipment, including oxygen, anesthetics and anesthesia services, take-home items, nutritional counseling, pre-admission testing</p>	<p>For preferred referred, no copayment/deductible applies. For referred, \$100/day copayment up to a maximum of \$300 per year (no deductible). For self-referred, 25% coinsurance after deductible. Pre-admission review required except for emergency and maternity. Covers room and board, semi-private or private room if medically necessary; intensive care or coronary care unit; diagnostic services; medical, surgical and central supplies; treatment services; ancillary services, including operating room, anesthesia, lab, x-ray, inpatient OT, PT,</p>	<p>Pre-admission review required except for emergency and maternity. Covers room and board, semi-private or private room if medically necessary; intensive care or coronary care unit; diagnostic services; medical, surgical and central supplies; treatment services; ancillary services, including operating room, anesthesia, lab, x-ray, inpatient OT, PT, inhalation therapy, and radiotherapy; Phase I Cardiac rehabilitation; Medication; blood and blood derivatives; prosthetics or orthotic devices; newborn care,</p>	<p>Precertification required in advance of admission unless condition is acute and faster admission is medically necessary. Semi-private accommodations unless patient has infectious disease; intensive care or coronary care unit; supplies, appliances and equipment if surgically implanted or if it would be contraindicated to limit use to hospital stay. Temporary or disposable items needed to facilitate discharge are limited to a 10 day supply, otherwise limited per outpatient services. Ancillary, diagnostic and therapeutic services subject to restrictions. OT, PT & speech limited as per non-hospital services. DME,</p>

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	recognized as part of admission process, acute inpatient rehabilitation. Admission to noncovered facilities such as nursing homes, extended care facilities, residential treatment centers not covered.	inhalation therapy, and radiotherapy; Phase I Cardiac rehabilitation; Medication; blood and blood derivatives; prosthetics or orthotic devices; newborn care, including routine well-baby care.	including routine well-baby care. (Deductibles and coinsurance apply as indicated above.)	including prosthetics, for use outside the hospital subject to prior authorization (PA). Restricted physician services are also restricted in the hospital. Observation and testing limited to 48 hours. Adults, 20-64, without minor children, limited to two inpatient visits per year. Copayment of up to \$3/day, capped at \$30/month.
Hospital outpatient	Copayment of 15% for preferred; 30% for non-preferred (no deductible for surgery). No copayment for accidental injury within 72 hours of accident. Regular benefit for other emergency hospital and physician care.	For preferred referred, no copayment/deductible applies. For referred, \$50 copayment (no deductible). For self-referred, 25% coinsurance after deductible. \$50 copayment for high tech imaging diagnostics. Covers emergency care; removal of sutures;	Covers emergency care (\$100 copayment, waived if admitted to hospital), removal of sutures, application or removal of cast, diagnostic services, surgical services, removal of impacted teeth, endoscopic procedures, blood administration, radiation therapy,	Emergency care, outpatient diabetes and asthma education covered. Adults, 20-64, without minor children limited to 5 visits per year, except regarding laboratory, x-ray services, prenatal care, and mental health diagnoses. Copayment of up to \$3/day, capped at \$30/mo

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	(deductible applies) Covers emergency care, outpatient hospital and ambulatory surgical services include special treatment rooms, diagnostic tests, including lab and pathology, MRIs, machine diagnostic tests, and x-rays. Chemo and radiation therapy, IV infusion therapy, cardiac rehabilitation, pulmonary rehabilitation, physical, occupational and speech therapy, (per outpatient limits), renal dialysis, outpatient visits for non-emergency care, blood, blood plasma and other biologicals., Dressings, splints, casts, other medical supplies, including oxygen.	application or removal of a cast; diagnostic services; surgical services; removal of impacted or unerupted teeth; endoscopic procedures; blood administration; radiation therapy; chemotherapy; outpatient rehabilitation programs including covered Phase II and Phase III cardiac rehabilitation, physical rehabilitation, head injury rehabilitation, pulmonary rehabilitation, and dialysis training; asthma education and diabetes education.	outpatient rehabilitation programs including Phase II cardiac rehabilitation, physical rehabilitation, head injury rehabilitation, pulmonary rehabilitation and dialysis training; diabetes and asthma education.	(in combination with inpatient copayments).
Hospice	Provided upon certification of life expectancy of six	Provided upon certification of life expectancy of	Provided upon certification of life expectancy of	Provided upon certification of life expectancy of six

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	<p>months or less. PA required of treatment plan. Includes physicians’ visits, nursing care, medical social services, PT, home health aids, DME rental, supplies, prescription drugs. Up to five days inpatient services, must be separated by 21 days. \$200 per admit for preferred.</p>	<p>twelve months or less. If provided by home health agency according to written plan. Prior approval required for more than eight hours per day. Includes physician services, nursing care, respite care, medical and social work services, counseling services, nutritional counseling, pain and symptom management, medical supplies and durable medical equipment, occupational, physical or speech therapies, home health care services, bereavement services and volunteer services. Includes up to 48 hours for respite care. Inpatient hospice services also covered.</p>	<p>twelve months or less. If provided by home health agency according to written plan. Prior approval required for more than eight hours per day. Includes physician services, nursing care, respite care, medical and social work services, counseling services, nutritional counseling, pain and symptom management, medical supplies and durable medical equipment, occupational, physical or speech therapies, home health care services, bereavement services and volunteer services. Includes up to 48 hours for respite care. Inpatient hospice services also covered.</p>	<p>months or less. Inpatient care capped at 20% of aggregate hospice care days. Inpatient and in-home respite care provided subject to limitations. Includes physician services, nursing services, medical social worker, home health aides, supplies, drugs and biologicals, OT, PT, and speech language for symptom control or to assist with activities of daily living.</p>

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Infertility services	Not covered	Covered. Limited to in vitro fertilization, artificial insemination, and gamete intrafallopian transfer (GIFT).	Not covered	Not covered
Laboratory and imaging services	Covered. 15% copayment for preferred; 30% for non-preferred.	Fully covered after referred level deductible, except \$50 copayment for high tech diagnostics (SPECT, Nuclear cardiology, MRI, CT Scan, and PET scan.)	Covered. (Coinsurance applies to high tech diagnostics, as indicated above.)	Covered. For lab, copayments of up to \$1, capped at \$10 per month.
Mental Health and Substance Abuse – inpatient	Covered. Requires precertification.	For preferred referred, no copayment/deductible applies. For referred, \$100/day copayment up to a maximum of \$300 per year (no deductible). For self-referred, 25% coinsurance after deductible. Prior approval required. Covers listed illnesses/inpatient services, non-listed illnesses up to 31 days/calendar year.	Prior approval required. Covers listed illnesses covered as per inpatient services, non-listed illnesses up to 31 days per calendar year. (80% coverage).	Inpatient coverage in psychiatric hospital not covered for adults 21-64. (Community hospitalization covered). For others, determination of medical eligibility required. Subject to UR and regularly reviewed plan of care. Partial hospitalization (2-12 hrs/day care) covered for all ages.

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		(80% coverage).		
Mental Health and Substance Abuse - outpatient	<p>Maximum of 25 visits per year for office visits, partial hospitalization, intensive outpatient treatment, and other hospital outpatient treatment (limit may be waived for preferred providers).</p> <p>Approved treatment plan required after ninth visit with preferred provider.</p> <p>Covers office and home visit professional services, hospital outpatient, medication management, intensive outpatient treatment, partial hospitalization (PA required), and diagnostic tests.</p>	<p>No deductible for day treatment for preferred referred hospital. Full coverage after deductible for referred level, 25% coinsurance after deductible for self-referred.</p> <p>\$20 hospital emergency room copayment.</p> <p>\$15 copayment for specialist office visits for referred; 25% coinsurance after deductible for self-referred. Prior approval required except for self-referred. Covers individual, group and family counseling, psychological testing, diagnostic and evaluation services, intervention and assessment, facility-based professional and ancillary</p>	<p>Prior approval required. Covers individual, group and family counseling, psychological testing, diagnostic and evaluation services, intervention and assessment, facility-based professional and ancillary services, and day treatment. \$25 copayment for listed illnesses. For non-listed illnesses 50% coinsurance and benefit subject to \$1,500 annual limit.</p>	<p>Services subject to approved individual treatment plan within 30 days commencing service. Individual/family therapy limited to two hours/week. Substance abuse therapy limited to 3 hours/week for 30 weeks in a 40 week period. Group therapy limited to 90 minutes/week with exceptions. Intensive outpatient covered, but reviewed every 30 days. Psych testing limited to 4 hours, with some exceptions. Medication management sessions limited to 30 minutes; one hour for assessment. Psychological services limited to 16 one-hour visits per year, with possible increase to 24. Copayment of up to</p>

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		services, and day treatment. Non-listed illnesses subject to 40 visit annual cap.		\$2/day, capped at \$20 per month.
Obesity	Covers gastric restrictive procedures, malabsorptive procedures or combination to treat morbid obesity (BMI of 40 or more, or BMI of 35 or more with comorbidities who has failed conservative treatment.)	Coverage for morbid obesity lasting 5 or more consecutive years; intestinal bypass, gastric bypass, or gastroplasty. PA required.	Coverage for morbid obesity lasting 5 or more consecutive years; intestinal bypass, gastric bypass, or gastroplasty. PA required.	Coverage for gastric bypass or gastroplasty; must be 2 times normal weight or 100 pounds overweight and have been unable lose weight with medical supervision nonsurgically. Surgery must be needed to correct another related condition such as diabetes or hypertension. PA required. Removal of excess skin and subcutaneous tissue of the abdomen (panniculectomy), with PA, only after 1 year since bariatric surgery or 100 pounds of weight loss and photo documents that pannus hangs at least to the

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				pubis.
Obstetrical services and newborn care	Covered, including circumcision.	Covered. Does not cover routine circumcision.	Covered. Does not cover routine circumcision.	Covered. Does not cover routine circumcision.
Occupational therapy, physical therapy, speech therapy.	PT, OT, Speech or a combination of all three limited to 75 visits/yr. \$20 copayment for preferred; 30% for non-preferred.	\$15 copayment for specialist visits for referred; 25% coinsurance after deductible for self-referred. Covered for short term OT and PT, speech therapy on an outpatient basis for conditions subject to significant improvement. Speech therapy not for deficiencies resulting from mental retardation or conditions that are self-correcting such as some language deficiencies in young children.	\$25 copayment. Covered for short term OT and PT, speech therapy on an outpatient basis for conditions subject to significant improvement. \$3,000 combined calendar limit (per particular contract). Speech therapy not for deficiencies resulting from mental retardation or conditions that are self-correcting such as some language deficiencies in young children.	OT & PT requires documented rehabilitation potential; limited to physical function; only one visit per year for design of treatment plan needed to prevent deterioration of function; after acute hospital stay, surgery or extreme limitation in ADLs additional permitted if PA. For speech therapy, person must have an initial evaluation by a physician or PCP documenting a significant decline in ability to communicate orally, safely swallow or masticate, and an expectation of significant

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				improvement in a reasonable, predictable period of time as a result of treatment plan. Reevaluation required after six months. Up to \$2 copayment for each service, with \$20 cap per month on any one service.
Organ and tissue transplants	Copayment is 15% preferred; 30% for non-preferred. PA usually required. Coverage includes cornea, heart, heart-lung, pancreas-kidney, liver-kidney, islet tissue for chronic pancreatitis, small intestine, combined small intestine with other organ(s), single, double or lobar lung, double-lung only for end-stage cystic fibrosis, allogenic or autologous blood or marrow stem cell transplants for	PA required. Covers heart, heart/lung, lung, islet tissue, liver, adrenal gland, bone, cartilage, muscle, skin, tendon, heart valve, blood vessel, parathyroid, kidney, cornea, allogeneic bone marrow, pancreas, and autologous bone marrow.	PA required. Covers heart, heart/lung, islet tissue, liver, adrenal gland, bone, cartilage, muscle, skin, tendon, heart valve, blood vessel, parathyroid, kidney, cornea, allogeneic bone marrow, pancreas and autologous bone marrow.	PA usually required. Covers heart, heart-lung, bone marrow (autologous and allogeneic bone marrow or stem cell transplants), kidney, corneal, liver, lung, small intestine, combined liver-small intestine, and pancreas transplants.

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	specified diagnoses.			
Orthotic devices	15% copayment for preferred, 30% for non-preferred. Covers functional foot orthotics when prescribed by a physician, rigid devices attached to the foot or a brace or placed in a shoe, replacement, repair and adjustment of covered devices.	20% coinsurance for referred level and 50% coinsurance for self-referred level (after deductible) for custom-molded shoe inserts for those with diabetes. Covers devices such as orthopedic braces, back or surgical corsets, and splints. Certain stockings are covered only when provided for post-surgical use or when prescribed for circulatory diseases. Does not cover arch supports, shoe inserts, other foot support devices, orthopedic shoes (unless attached to a brace), support hose, and garter belts.	Covers devices such as orthopedic braces, back or surgical corsets, and splints. Does not cover arch supports, shoe inserts, orthopedic shoes (unless attached to a brace), support hose and garter belts. Note cap on durable medical equipment.	Covered. Custom-molded requires PA. Inserts lifts and supports are limited to a total of one (1) per foot per year. Orthopedic shoes of all types are one (1) shoe per foot per year. Various other limits apply. Copayment up to \$3, capped at \$30/mo.
Physician visits	Covered. \$20 copayment for preferred office visit,	Covered. No copayment for preferred referred PCP;	Covered. \$20 PCP copayment; \$25 specialist	Covered.

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	30% for non-preferred (no deductible). Copayment for inpatient professional services: 15% for preferred; 30% non-preferred	\$10 PCP copayment or \$15 specialist copayment for referred office visits; 25% coinsurance after deductible for self-referred.	copayment.	
Podiatry	\$20 copayment for visit (preferred), 15% for other services. 30% copayment for non-preferred. Covers routine foot care when under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	Cost-sharing is the same as physician specialists. Covered, including for systemic circulatory disease. Routine foot care not covered.	Covered, not including routine foot care. \$25 specialist copayment.	Only for conditions where treatment is needed to prevent loss of function or potential loss of limb. PA required. Copayment of \$2 up to a \$20 per month cap.
Prescription drugs	Open formulary; three tiers of pricing (generic, formulary brand name and non-formulary). Some PA required. Co-payments for preferred retail pharmacy 20% for generic, 30% for brand name; for non-	Open formulary. Two tiers of copayment \$10 and \$30 for 59 day supply at retail pharmacy or for 90 day supply for mail service pharmacy. Some PA required; some required step therapy; vacation	Open formulary; three tiers of co-payments: \$10, \$30, and \$50 for 30 days supply at a pharmacy or \$20, \$60, \$100 for a 90 day supply by mail. Some PA required; some required step therapy; vacation	Open formulary; PA required for drugs not preferred drug list; some required step therapy. Copayments of \$3 up to a cap of \$30 per month. No copayments for mail-order

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	preferred retail pharmacy the copayment is 45% AWP. For mail service program, the copayment is \$10 for generic, \$65 for brand name. All copayments apply to up to a 90-day supply	supplies.	supplies	pharmacy.
Preventative and well-care	<p>\$20 copayment for visit to preferred provider; no copayment for related tests. No coverage for non-preferred provider.</p> <p>No copayment for well-child exams.</p> <p>Home and office visits for physical examination (but office visits for other preventative services and routine immunizations not covered.) Tests and screening for colorectal</p>	<p>No copayment for preferred referred PCP; for referred, \$10 PCP copayment or \$15 specialist copayment; immunizations, colonoscopies, mammograms and related tests fully covered. For self-referred, no preventative coverage except well-woman care with \$15 copayment. Routine physical examinations, immunizations, one annual</p>	<p>\$20 PCP copayment; \$25 specialist copayment. Periodic routine physical examinations, routine immunizations, one annual prostate specific antigen test and digital rectal examination for men, one routine gynecological exam per year, screening mammograms, routine eye exams.</p>	<p>Routine physical examination once per year. Must use vaccines and immunizations provided by Maine Center for Disease Control if available.</p>

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	cancer, prostate cancer, cervical cancer, breast cancer (mammograms), ultra sound for aortic abdominal aneurysm, routine immunizations	prostate specific antigen test and digital rectal examination for men, routine gynecological exams, screening mammography, routine eye exams.		
Prostheses	15% copayment for preferred, 30% for non-preferred. Covered.	For referred, no copayment, but deductible applies, for self-referred with limb replacement, 20% coinsurance (deductible does not apply); for self-referred and other prosthetics, coinsurance of 25% after deductible. Covered, except dental, those exclusively for athletic purposes and those with a microprocessor	Covered, except dental, those exclusively for athletic purposes and those with a microprocessor. Note cap on durable medical equipment (does not apply to limb prostheses).	PA required for costs of \$500 or above and any custom molded device. Copayment up to \$3, capped at \$30/mo.
Reconstructive services	Covered to correct a functional impairment, a significant congenital	Covered to restore bodily function, to correct deformity, or for	Covered to restore bodily function, to correct deformity, or for	Breast reconstruction only with PA and only after cancer surgery or trauma.

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	abnormality, restore mouth to a pre-cancer state, and reconstruct the breast after mastectomy. 15% for preferred; 30% non-preferred.	congenital or developmental anomalies. Benefits are provided only when there is a functional impairment. Breast reconstruction after mastectomy is covered.	congenital or developmental anomalies. Benefits are provided only when there is a functional impairment. Breast reconstruction after mastectomy is covered.	Correction of deformities possible with prior authorization.
Smoking cessation	Covers psychotherapy for smoking cessation; drugs to aid cessation. 20% copayment for preferred office visit; 15% for other services; 30% copayment for non-preferred.	For referred, no copayment, but deductible applies. For self referred, 25% coinsurance after deductible. Covers nicotine replacement therapy (NRT) products and prescribed drugs for smoking cessation, up to two physician office visits cessation education and counseling, completion of approved smoking cessation program.	Two visits per year for education and counseling, prescribed medications capped at \$200/yr, \$400 per lifetime. Cessation program up to \$35 per program; \$70 per lifetime.	Three visits per year for education and counseling. Medication covered.
Surgical services	Covered. Copayment is 15% for preferred; 30% for non-preferred.	For preferred referred, no copayment or deductible applies. For referred, \$50 copayment with no	Covered. Coinsurance and deductible applies.	Covered. The following limits apply. PA with particular criteria is required for bunion

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		deductible. For self-referred, 25% coinsurance after deductible.		surgery, cochlear implants, orthognathic surgery; penile implants permitted only after surgery for cancer, trauma or birth defect if pharmacological treatment has failed; rhinoplasty only after more conservative treatment for obstructions or infections has failed; skin tag removal requires PA; vagus nerve stimulation for partial onset seizures only when resistant to treatment by medication.
Temporomandibular Joint Syndrome	Covers oral surgery for reduction of dislocations and excisions of temporomandibular joints. Orthodontic care not covered.	For referred level, no copayment, but deductible applies; for self-referred, 25% coinsurance after deductible. Coverage is provided for the treatment of a specific organic condition of or physical trauma to the temporomandibular joint	Not covered	Covers surgery; requires PA.

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		(jaw hinge). Coverage is limited to surgery or injections of the temporomandibular joint, physical therapy, or other medical treatments.		
Vision	Eye exam covered when related to a specific medical condition. \$20 copayment (no deductible) preferred; 30% for non-preferred. One pair of eyeglasses or contact lenses to correct impairment caused by accidental injury or intraocular surgery, or when surgery precluded because of age or medical condition. 15% copayment for preferred; 30% for non-preferred.	Covers one routine eye exam every two years for adults; once per year for those with diabetes. Those related to medical condition are covered as needed. Corrective lenses not covered except glasses or contact lenses when medically necessary to treat accommodative strabismus, cataracts, or aphakia. (See preventative services for cost-sharing on eye exams).	\$25 specialist copayment. Covers one routine eye exam every two years for adults. Covers urgent eye care services related to an examination, diagnosis, treatment, and management of conditions, illnesses, and diseases of the eye and related structures that if not treated within 24 hours present a serious risk of harm.	Covers one routine eye exam every two years for adults, brief, intermediate and comprehensive exam required for evaluation/diagnosis of a problem; brief corrective treatment; orthoptic therapy or visual training with PA; one pair of eye glasses per life time with a power at or exceeding 10.00 diopters; low-vision aids, with PA, only when best correctable vision of 20/70 or poorer can be improved to a more useful level for specific visual tasks. Copayments for opticians are \$2 up to a cap

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				of \$20 per month; for optometrists, \$3 up to a cap of \$30 per month.

Sources:

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22 M.R.S.A. Section 3174-FF (MaineCare Basic).

*The HMO Maine Anthem Blue Cross Blue Shield product is likely to vary some based on the particular contract; the premiums would also vary based upon the group covered. The coverage information in the chart is taken from the sample certificate provided by Anthem on the internet; the cost-sharing information is from the HMO Maine Benefit Overview for 2008 for the Maine Medical Association, which was available on the internet.