Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

Translation: If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the customer service number on the back of your id card or in your enrollment booklet.

The DirigoChoice PPO Plan
Plan 2 – Group F

HPHC Insurance Company

This is a Summary of Benefits to your DirigoChoice PPO Plan. It is attached to and becomes part of your DirigoChoice Benefit Handbook.

Group Name: **Group Number:** **Effective Date:**

	Cost Shares	
Calendar Year Deductibles: General Deductible Mental Health (Non-Biologically Based Mental Illnesses)	 $1,750 Individual Deductible $3,500 Family Deductible $150	
Deductible Rollover Your Plan has a Deductible Rollover. This allows you to apply any Deductible amount incurred for Covered Benefits during the last three (3) months of a calendar year toward the Deductible for the next year. In order for the Deductible Rollover to apply, you, or your covered family, must have had continuous coverage under DirigoChoice at the time the charges for the prior year were incurred.		
Calendar Year Out-of-Pocket Limit	$5,600 Individual Limit $11,200 Family Limit	
Lifetime Benefit Maximum	No Limit	
	In-Network Benefit	**Out-of-Network Benefit**
Coinsurance	The Plan pays 70% The Member pays 30% Unless otherwise indicated	The Plan pays 50% The Member pays 50% Unless otherwise indicated
Copayment	$25 Copayment where indicated	$35 Copayment where indicated
Service	**In-Network Benefit The Plan Pays:**	**Out-of-Network Benefit The Plan Pays:**
Hospital Services Inpatient[1] Outpatient	70% after Deductible	50% after Deductible
Emergency Room Services	70% after Deductible	70% after Deductible
Screening Mammograms	100%, no Copayment or Deductible	100%, no Copayment or Deductible
Professional Services Inpatient Outpatient Diagnostic tests, x-rays, and surgery	70% after Deductible	50% after Deductible
Endoscopic Procedures (including Colonoscopies)	70% after Deductible	50% after Deductible
Maternity Pre- & Post-natal Delivery	 $25 Copayment first prenatal visit, then 100% 70% after Deductible	 $35 Copayment first prenatal visit, then 70% 50% after Deductible

[1] Failure to obtain Prior Approval for non-emergency inpatient hospital services may result in services not being covered or a penalty of $150. Please see your Benefit Handbook Section C.4 for further information.

Benefit payments are based on the applicable percentage of the Covered Charge after any Deductible and/or Copayment amount has been deducted.

Service	In-Network Benefit The Plan Pays:	Out-of-Network Benefit The Plan Pays:
Physician Office Visits		
Sick Care Specialists	100% after $25 Copayment, Deductible does not apply	70% after $35 Copayment, Deductible does not apply
Routine/Preventive (including any associated diagnostic tests and x-rays)	100%, no Copayment or Deductible	50% after $35 Copayment, Deductible does not apply
Hearing aids For Members through the age limit required by Maine law[2]. Limited to one (1) hearing aid every 36 months, per hearing impaired ear, up to a limit of $1,400	70% after Deductible	50% after Deductible
Other Services		
Occupational, Speech, and Physical Therapies – Combined limit of $3,000 per calendar year	70% after Deductible	50% after Deductible
Chiropractic Care / Manipulative Therapy Combined limit of 40 visits per calendar year	70% after Deductible	50% after Deductible
Skilled Nursing Facility – Up to 100 days per Member per calendar year	70% after Deductible	50% after Deductible
Hospice	100% after $25 Copayment, Deductible does not apply	50% after $35 Copayment, Deductible does not apply
Home Health Care	70% after Deductible	50% after Deductible
Ambulance	70% after Deductible	70% after Deductible
Cardiac Rehabilitation – Up to 24 visits per Member per calendar year	70% after Deductible	50% after Deductible
Durable Medical Equipment – Up to $3,500 per Member per calendar year	70% after Deductible	50% after Deductible
Prostheses (excluding limbs) Prostheses for limb replacement	70% after Deductible 70%, Deductible does not apply	50% after Deductible 70%, Deductible does not apply
Smoking Cessation: Smoking Cessation Program – up to $35 per program /$70 per lifetime	100%, no Copayment or Deductible	100%, no Copayment or Deductible
Physician Office Visits – up to 2 per Member per calendar year	100% after $25 Copayment, Deductible does not apply	70% after $35 Copayment, Deductible does not apply
Smoking Cessation Medications	See the Prescription Drug section for additional information	See the Prescription Drug section for additional information

[2] Effective January 1, 2008, for Members from birth through age 5. Effective January 1, 2009, for Members from birth through age 13. Effective January 1, 2010 and thereafter, for Members from birth through age 18. No coverage for Members over 18 years of age.

Mental Health and Substance Abuse Services

Mental Health and Substance Abuse services are managed and all Inpatient and Day Treatment services require preauthorization. Failure to comply with the requirements outlined in your Benefit Handbook may result in a penalty up to $150. Coinsurance for Non-Biologically Based Mental Illness services does not count toward meeting the annual Coinsurance limit. Coinsurance continues to apply to these services after the Coinsurance limit is met.

Service	In-Network Benefit The Plan Pays:	Out-of-Network Benefit The Plan Pays:
***Biologically Based Mental Illnesses including Substance Abuse services:**		
Inpatient, Day treatment, Outpatient	70% after Deductible	50% after Deductible
Office Visits	100% after $25 Copayment, Deductible does not apply	70% after $35 Copayment, Deductible does not apply
Home Health Care Services	70% after Deductible	50% after Deductible
Non-Biologically Based Mental Illnesses:		
Deductible – combined in and out of network	$150	$150
Inpatient – Combined limit of 30 days per calendar year. Two days of Day Treatment equal one day of Inpatient Treatment.	70% after mental health Deductible	50% after mental health Deductible
Outpatient – Combined limit of 40 visits per Member per calendar year	70% after mental health Deductible	50% after mental health Deductible
Home Health Care Services	70% after Deductible	50% after Deductible

Prescription Drug Coverage

The Plan provides prescription drug coverage with Copayments. The Plan places all covered drugs into one of three levels or "tiers." Each tier has its own Copayment amount. The specific Copayments for prescription drugs that apply to your Plan are listed below. Your Copayments are also listed on your Member ID card. Prescription drugs are not subject to the Deductible. Please see your Benefit Handbook Section O for further information.

Prescription Drug Tier	Participating & Non-Participating Pharmacies
Tier 1	$10 Copayment, up to a 30-day supply
Tier 2	$30 Copayment, up to a 30-day supply
Tier 3	$50 Copayment, up to a 30-day supply

***Biologically Based Mental Illnesses: State of Maine statute requires that benefits be provided at the same benefit level provided for medical treatment for the following Biologically Based 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.**