Out-of-Pocket Maximum

After the out-of-pocket maximum has been satisfied, the plan will pay 100 percent of covered expenses for the remainder of the plan year. Charges that apply toward the out-of-pocket maximum for each type of plan varies and are outlined in the chart below.

Effective July 1, 2015, in accordance with the Affordable Care Act (ACA), prescription deductibles and copayments paid by members will also apply toward the out-of-pocket maximum; therefore, once the out-of-pocket maximum has been met, eligible medical, behavioral health and prescription drug charges will be covered at 100 percent for the remainder of the plan year.

The following are the types of charges that apply to the out-of-pocket maximum by plan type:

- **Quality Care Health Plan:**
  - Annual medical plan year deductible
  - Annual prescription plan year deductible
  - Prescription copayments
  - Medical coinsurance
  - QCHP additional medical deductibles

Eligible charges for in-network and out-of-network services will accumulate separately and will not cross accumulate.

- **HMO Plans:**
  - Annual prescription plan year deductible
  - Medical and prescription copayments
  - Medical coinsurance

- **OAP Plans (only applies to Tier I and Tier II providers):**
  - Annual medical plan year deductible (Tier II)
  - Annual prescription plan year deductible
  - Medical and prescription copayments
  - Medical coinsurance

Eligible charges from Tiers I and II will be added together when calculating the out-of-pocket maximum. **Tier III does not have an out-of-pocket maximum.**

Certain charges are always the member's responsibility and do not count toward the out-of-pocket maximum, nor are they covered after the out-of-pocket maximum has been met. Charges that do not count toward the out-of-pocket maximum include:

- Amounts over allowable charges for the plan;
- Noncovered services;
- Charges for services deemed to be not medically necessary; and
- Penalties for failing to precertify/provide notification.

CHARGES THAT APPLY TOWARD OUT-OF-POCKET MAXIMUM

PLAN	Out-of-Pocket Maximum Limits	Annual Plan Year Deductible	Additional Deductibles (QCHP)/ Copayments	Medical Coinsurance	Pharmacy Deductible/ Copayments	Amounts over Allowable Charges (QCHP out-of-network providers and OAP Tier III providers)
QCHP	**In-Network** Individual $1,500 Family $3,750	X	X	X	X	**Amounts over the plan's allowable charges are the member's responsibility and do not go toward the out-of-pocket maximum.**
	Out-of-Network Individual $6,000 Family $12,000	X	X	X	X	
HMO	Individual $3,000 Family $6,000	N/A	X	X	X	
OAP Tier I	Individual $6,600 Family $13,200 Tier I and Tier II charges combined	N/A	X	X	X	
OAP Tier II		X	X	X	X	
OAP Tier III	N/A	N/A	N/A	N/A	N/A	

Note: Eligible charges for medical, behavioral health and prescription drugs that the member pays toward the plan year deductibles (medical and prescription), as well as plan copayments and/or coinsurance will be added together for the out-of-pocket maximum calculation. OAP Tier III does not have an out-of-pocket maximum.

HMO Benefits

The HMO coverage described below represents the minimum level of coverage an HMO is required to provide. Benefits are outlined in each plan's summary plan document (SPD). It is the member's responsibility to know and follow the specific requirements of the HMO plan selected. Contact the plan for a copy of the SPD. A $100 prescription deductible applies to each plan participant (see page 21 for details).

HMO Plan Design	
Plan year maximum benefit	Unlimited
Lifetime maximum benefit	Unlimited
Hospital Services	
Inpatient hospitalization	100% after $350 copayment per admission
Alcohol and substance abuse	100% after $350 copayment per admission
Psychiatric admission	100% after $350 copayment per admission
Outpatient surgery	100% after $250 copayment
Diagnostic lab and x-ray	100%
Emergency room hospital services	100% after $250 copayment per visit
Professional and Other Services (Copayment not required for preventive services)	
Physician Office visit	100% after $20 copayment per visit
Preventive Services, including immunizations	100%
Specialist Office visit	100% after $30 copayment per visit
Well Baby Care (first year of life)	100%
Outpatient Psychiatric and Substance Abuse	100% after $20 or $30 copayment per visit
Prescription drugs ($100 deductible applies; formulary is subject to change during plan year)	$8 copayment for generic $26 copayment for preferred brand $50 copayment for nonpreferred brand
Durable Medical Equipment	80%
Home Health Care	$30 copayment per visit

Some HMOs may have benefit limitations based on a calendar year.

Open Access Plan (OAP) Benefits

The benefits described below represent the minimum level of coverage available in an OAP. Benefits are outlined in the plan's summary plan document (SPD). It is the member's responsibility to know and follow the specific requirements of the OAP plan. Contact the plan for a copy of the SPD. A $100 prescription deductible applies to each plan participant (see page 21 for details).

Benefit	Tier I 100% Benefit	Tier II 90% Benefit	Tier III (Out-of-Network) 60% Benefit
Plan Year Maximum Benefit	Unlimited	Unlimited	Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Annual Out-of-Pocket Max Per Individual Enrollee Per Family	$6,600 (includes eligible charges from Tier I and Tier II combined) $13,200 (includes eligible charges from Tier I and Tier II combined)		Not Applicable
Annual Plan Deductible (must be satisfied for all services)	$0	$250 per enrollee*	$350 per enrollee*
Hospital Services			
Inpatient	100% after $350 copayment per admission	90% of network charges after $400 copayment per admission	60% of allowable charges after $500 copayment per admission
Inpatient Psychiatric	100% after $350 copayment per admission	90% of network charges after $400 copayment per admission	60% of allowable charges after $500 copayment per admission
Inpatient Alcohol and Substance Abuse	100% after $350 copayment per admission	90% of network charges after $400 copayment per admission	60% of allowable charges after $500 copayment per admission
Emergency Room	100% after $250 copayment per visit	100% after $250 copayment per visit	100% after $250 copayment per visit
Outpatient Surgery	100% after $250 copayment per visit	90% of network charges after $250 copayment	60% of allowable charges after $250 copayment
Diagnostic Lab and X-ray	100%	90% of network charges	60% of allowable charges
Physician and Other Professional Services (Copayment not required for preventive services)			
Physician Office Visits	100% after $20 copayment	90% of network charges	60% of allowable charges
Specialist Office Visits	100% after $30 copayment	90% of network charges	60% of allowable charges
Preventive Services, including immunizations	100%	100%	Covered under Tier I and Tier II only
Well Baby Care (first year of life)	100%	100%	Covered under Tier I and Tier II only
Outpatient Psychiatric and Substance Abuse	100% after $20 or $30 copayment	90% of network charges	60% of allowable charges
Other Services			
Prescription Drugs – $100 deductible applies Generic $8 Preferred Brand $26 Nonpreferred Brand $50			
Durable Medical Equipment	80% of network charges	80% of network charges	60% of allowable charges
Skilled Nursing Facility	100%	90% of network charges	Covered under Tier I and Tier II only
Transplant Coverage	100%	90% of network charges	Covered under Tier I and Tier II only
Home Health Care	100% after $30 copayment	90% of network charges	Covered under Tier I and Tier II only

* An annual plan deductible must be met before Tier II and Tier III plan benefits apply. Benefit limits are measured on a plan year basis.

The Quality Care Health Plan (QCHP)

Plan Year Maximums and Deductibles		
Plan Year and Lifetime Maximum	Unlimited	
Employee's Annual Salary (based on each employee's annual salary as of April 1st)	Individual Plan Year Deductible	Family Plan Year Deductible Cap
$60,700 or less	$375	$937
$60,701 - $75,900	$475	$1,187
$75,901 and above	$525	$1,312
Retiree/Annuitant/Survivor	$375	$937
Dependents	$375	N/A
Additional Deductibles* * These are in addition to the plan year deductible.	Each emergency room visit QCHP hospital admission Non-QCHP hospital admission	$450 $100 $500

Out-of-Pocket Maximum Limits			
In-Network Individual	In-Network Family	Out-of-Network Individual	Out-of-Network Family
$1,500	$3,750	$6,000	$12,000

Hospital Services	
QCHP Hospital Network	$100 deductible per hospital admission. 85% after annual plan deductible.
Non-QCHP Hospitals	$500 deductible per hospital admission. 60% of allowable charges after annual plan deductible.

Outpatient Services	
Preventive Services, including immunizations	100% in-network, 60% of allowable charges out-of-network, after annual plan deductible.
Diagnostic Lab/X-ray	85% in-network, 60% of allowable charges out-of-network, after annual plan deductible.
Approved Durable Medical Equipment (DME) and Prosthetics	
Licensed Ambulatory Surgical Treatment Centers	

Professional and Other Services	
Services included in the QCHP Network	85% after the annual plan deductible.
Services not included in the QCHP Network	60% of allowable charges after the annual plan deductible.
Chiropractic Services – medical necessity required (up to a maximum of 30 visits per plan year)	85% in-network, 60% of allowable charges out-of-network, after the annual plan deductible.

Transplant Services	
Organ and Tissue Transplants	85% after $100 transplant deductible, limited to network transplant facilities as determined by the medical plan administrator. Benefits are not available unless approved by the Notification Administrator, Cigna. To assure coverage, the transplant candidate must contact Cigna prior to beginning evaluation services.

Prescription Drugs		
Plan Year Pharmacy Deductible		$125
Copayments (30-day supply)	Generic	$10
	Preferred Brand	$30
	Nonpreferred Brand	$60