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.

In accordance with the Affordable Care Act (ACA), prescription coinsurance 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:

- **Local Care Health Plan:***
  - Medical plan year deductible
  - Prescription copayments
  - Medical coinsurance
  - LCHP additional medical deductibles
- **Local Consumer-Driven Health Plan:***
  - Medical plan year deductible
  - Medical and prescription coinsurance

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

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

- The dispense as written (DAW) penalty (i.e., the cost difference between a brand name medication and a generic, plus the brand copayment when a generic is available);
- Amounts over allowable charges (MRC, MAC, U+C**) 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	Plan Year Deductible	Additional Deductibles (LCHP)/ Copayments	Medical Coinsurance	Pharma Coinsurance/ Copayments/ Deductible	Amounts over Allowable Charges (LCHP and LCDHP out-of-network providers and OAP Tier III providers)
LCHP	**In-Network** Individual $2,000 Family $4,000	X	X	X	X	**Amounts over the plan's allowable charges (MRC, MAC, U+C**) 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	
LCDHP	**In-Network** Individual $5,000 Family $8,000	X	N/A	X	X	
	Out-of-Network Individual $7,000 Family $14,000	X	N/A	X	X	
HMO	Individual $3,000 Family $6,000	N/A	X	X	X	
OAP Tier I & OAP Tier II	Individual $7,250 Family $13,750	X	X	X	X	
		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, 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.

** MRC = Maximum Reimbursable Charge, MAC = Maximum Allowable Charge, U+C = Usual and Customary