Definitions

- **Plan Year Deductible** is the amount for which the member is responsible for *certain* services (see documents from BCBS and HPHC identifying the services) before the coverage will begin. Effective 7/1/12, the CCMHG will have a Plan Year Deductible on all active employee plans. The deductible amount will be $250 per member, not to exceed $750 per family. Once an individual family member has paid $250 for the deductible, there is no additional deductible charge for that family member for the remainder of that plan year. Once a family has paid a total of $750, regardless of how much any one individual has contributed to the deductible, there will be no more deductible taken for the entire family for the remainder of the plan year. Each plan year runs from July 1 through June 30.

  The deductible applies to Inpatient admissions; Outpatient surgery; Emergency Room (waived if admitted); MRI, PET, CT and other diagnostic tests and procedures; Durable Medical Equipment (DME); and prosthetics. It does not apply to Office Visits or Pharmacy.

  Certain services are subject to both the deductible and a co-pay. Co-pays do not count towards the deductible.

- **Copayment (also called co-pay)** is a *fixed dollar amount* that the member pays at the time of service for certain services identified by The Plan as taking a co-pay. For certain services both a co-pay and the deductible may apply if the member has not already met the deductible. An example of this is *Inpatient Admission* to which the deductible applies (if it has not already been met) *and* which takes a $500 co-pay.

- **Coinsurance** is the *percentage* of charges for a service for which the member is responsible. For example, the Durable Medical Equipment (DME) and prosthetics benefits require the member to pay 20% of the equipment charges negotiated by the health plan. The plan pays the remaining 80%.

- **Out Of Pocket (OOP) Maximum:** Out-of Pocket (OOP) costs are defined as the sum of a member's coinsurance, copayment, and deductible charges. Balance bills and costs of services not covered by the plan are not included in the out-of-pocket expenses. The OOP Maximum is the maximum amount that a member has to pay out-of-pocket in a plan year for certain services that take coinsurance, copayments, and/or deductibles. Balance bills and costs of services not covered by the plan are not included in the out-of-pocket expenses.

  For CCMHG the Medical Out-of-Pocket (OOP) Maximum is $2,000 for an Individual and $4,000 for a Family for the following: Network Blue HMO, HPHC EPO (HMO), Blue Care Elect Preferred PPO in-network services, HPHC PPO in-network medical services. For the PPO plans, there will also be a Medical Out-of-Network Out of Pocket Max. of $3,000 per member with no limit per family.

  Effective July 1, 2015, the Affordable Care Act (ACA) requires OOP Maximums for in-network Prescription expenses.

  For CCMHG the Prescription OOP Maximum is $3,000 for an Individual and $6,000 for a Family for the following: Network Blue HMO, HPHC EPO (HMO), Blue Care Elect Preferred PPO in-network services, HPHC PPO in-network prescription copays. OOP Maximums are not required for out-of-network services. There are no OOP Maximums for the CCMHG out-of-network Prescription services.

  The following member payments count towards the OOP maximum: (1) plan year deductible, (2) copayments, and (3) coinsurance.

  The maximum medical out-of-pocket liability for a Family will be $4,000 for medical expenses and $6,000 for prescription expenses, regardless of the expenditures per individual family member.