IHIP
Integrated Health Insurance Program

Municipality
HDHP, Bronze, Wellnes, HSA
Plan Matrix
2017-2018

aetna

INTEGRATED HEALTH INSURANCE PROGRAM PPO PLANS						
Member Responsibility	HDHP 100	HDHP 200	HDHP 300	Bronze	Wellness	HSA
General Benefits						
Individual Calendar Year Deductible	$1,300	$2,000	$1,300	$5,000	$500	$5,500
Family Calendar Year Deductible	$3,000	$6,000	$5,000	$10,000	$1,000	$11,000
Coinsurance	20% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	10% After Deductible	20% After Deductible
Individual Calendar Year Out-of-Pocket Maximum	$4,250	$5,250	$6,250	$6,350	$1,750	$6,350
Family Calendar Year Out-of-Pocket Maximum	$10,100 (No family member will pay more than $6,850 per calendar year.)	$10,050 (No family member will pay more than $6,850 per calendar year.)	$12,500 (No family member will pay more than $6,850 per calendar year.)	$12,700	$5,250	$12,700
Doctor Visits						
Doctor Visits (Primary Care)	20% After Deductible	20% After Deductible	40% After Deductible	$60 Copay for first three (3) visits, 30% co-insurance after ded.	$20 Copay	20% After Deductible
Doctor Visits (Specialists)	20% After Deductible	20% After Deductible	40% After Deductible	$70 Copay after ded.	$40 Copay	20% After Deductible
Adult Preventive Care/Immunizations	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Child Preventive Care/Immunizations	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Lab & X-Ray						
Outpatient Diagnostic Tests/Imaging	20% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	10% After Deductible	20% After Deductible
Radiation Therapy Chemotherapy	20% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	10% After Deductible	20% After Deductible
Medical Benefits						
Ambulance-Ground/Air	20% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	10% After Deductible	20% After Deductible
Physical Therapy	20% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	10% After Deductible (Copay if applicable)	20% After Deductible
Acupuncture	20% After Deductible (12 visits per calendar max.)	20% After Deductible (12 visits per calendar max.)	40% After Deductible (12 visits per calendar max.)	30% After Deductible (12 visits per calendar max.)	10% After Deductible 12 visits per calendar max. (Copay if applicable)	20 % After Deductible Max 12 visits per year
Chiropractic	20% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	10% After Deductible (Copay if applicable)	20% After Deductible
Durable Medical Equipment	20% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	10% After Deductible	20% After Deductible

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Hospital Benefits						
Outpatient Surgery	20% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	10% After Deductible	20% After Deductible
Hospital Inpatient	20% After Deductible Semi Private Room Unlimited Days	20% After Deductible Semi Private Room Unlimited Days	40% After Deductible Semi Private Room Unlimited Days	30% After Deductible Semi Private Room Unlimited Days	10% After Deductible Semi Private Room Unlimited Days	20% After Deductible Semi Private Room Unlimited Days
Hospital Emergency Room	20% After Deductible	20% After Deductible	40% After Deductible	$250 Copay after ded. (Waived if Admitted as Inpatient)	$100 Copay (Waived if Admitted as Inpatient) 10% After Ded	20% After Deductible
Urgent Care	20% After Deductible	20% After Deductible	40% After Deductible	$120 Copay after ded.	$20 Copay	20% After Deductible
Home Health Care	20% After Deductible 100 visits max per calendar year	20% After Deductible 100 visits max per calendar year	40% After Deductible 100 visits max per calendar year	30% After Deductible 100 visits max per calendar year	10% After Deductible 100 visits max per calendar year	20% After Deductible 100 visits max per calendar year
Substance Abuse & Mental Health Benefits						
Teledoc-Medical Services	Teledoc - $5 Call Copay 800-835-2362 or visit www.teledoc.com/bsc for Non-Emergency Calls	Teledoc - $5 Call Copay 800-835-2362 or visit www.teledoc.com/bsc for Non-Emergency Calls	Teledoc - $5 Call Copay 800-835-2362 or visit www.teledoc.com/bsc for Non-Emergency Calls	Teledoc - $5 Call Copay 800-835-2362 or visit www.teledoc.com/bsc for Non-Emergency Calls	Teledoc-$40 Call Copay 800-835-2362 or visit www.teledoc.com/bsc for Non-Emergency Calls	Teledoc - $5 Call Copay 800-835-2362 or visit www.teledoc.com/bsc for Non-Emergency Calls
Life Referrals 24/7 EAP	Visit blueshieldca.com or call 800-985-2405.	Visit blueshieldca.com or call 800-985-2405.	Visit blueshieldca.com or call 800-985-2405.	Visit blueshieldca.com or call 800-985-2405.	Visit blueshieldca.com or call 800-985-2405.	Visit blueshieldca.com or call 800-985-2405.
Mental Health-Substance Abuse	Visit blueshieldca.com or call 877-263-9952.	Visit blueshieldca.com or call 877-263-9952.	Visit blueshieldca.com or call 877-263-9952.	Visit blueshieldca.com or call 877-263-9952.	Visit blueshieldca.com or call 877-263-9952.	Visit blueshieldca.com or call 877-263-9952.
	Prescription Drug Benefits					
	HDHP 100	HDHP 200	HDHP 300	Bronze	Wellness	HSA
Prescription Drugs-Generic	20% After Deductible	20% After Deductible	40% After Deductible	Ded. then $25 Copay	$7 Copay	20% After Deductible
Prescription Drugs-Brand	20% After Deductible	20% After Deductible	40% After Deductible	Ded. then $50 Copay	$25 Copay	20% After Deductible
Prescription Drugs-Non Preferred	20% After Deductible	20% After Deductible	40% After Deductible	Ded. then $75 Copay	$40 Copay	20% After Deductible
Mail Order-Generic	20% After Deductible	20% After Deductible	40% After Deductible	Ded. then $50 Copay	$15 Copay	20% After Deductible
Mail Order-Brand or Non-Preferred	20% After Deductible	20% After Deductible	40% After Deductible	Ded. then $100 Copay	$60/$90 Copay	20% After Deductible