City of Holyoke

City of Holyoke
Medical & Dental Offering
Effective July 1, 2016 - June 30, 2017

This document is for illustrative purposes only. Please refer to plan documents for detailed coverage information. Some procedures require prior approval or limit number of visits and can be performed for either preventive or diagnostic reasons. When certain preventive procedures are performed, they are covered 100%. When certain procedures are performed diagnostically, the deductible or co-pay may apply. PPO's shown illustrate in-network benefits only. Please refer to detailed plan summary for out-of-network benefits, deductibles, & maximums.

	Medical Option 1	Medical Option 2	Medical Option 3	Medical Option 4
	For active employees (regularly working 20+hrs/wk) & Retirees under age 65 and/or not eligible for Medicare			
	Blue Cross Blue Shield	Health New England	Health New England	Health New England
Plan Name	**New Plan HMO Blue New England 1000**	**New Plan Essential 1000 HMO**	**New Plan Essential 2000 HMO**	**PPO 1000 National**
Network	New England	All WMASS counties & part of Worcester County; The Lahey Clinic; "Here to There" Boston access program		HNE HMO Network; PHCS National Network; Out of Network Coverage
Referrals Required?	Yes	No	No	No
Out of Network Co-Insurance	member pays 100%	member pays 100%	member pays 100%	members pays 20%
Deductible	$1,000/person $2,000/family	$1,000/person $2,000/family	$2,000/person $4,000/family	$1,000/person $2,000/family
Maximum Out of Pocket (the most a member pays in copay, deductible, and coinsurance)	$2,000/person $4,000/family	$2,000/person $4,000/family	$5,000/person $10,000/family *(City to reimburse member after $3,000/person $6,000/family see flyer)*	$2,000/person $4,000/fam in netwk $3,000/person $6,000/fam out netwk
Routine/Preventive Care: Physicals, WellWoman, Well Child, Immunizations, Labs,Mammogram, Colonoscopy, Eye Exams	$0	$0	$0	$0
Pediatric Dental (until age 12)	not offered	not available as of 07/01/16	not available as of 07/01/16	not available as of 07/01/16
Non-Routine Office Visits	$20	$20	$20	$20
Speech & Physical Therapy	deductible then $20	deductible then $20	deductible then $20	deductible then $20
Chiropractic Visit	$20	$15	$15	$15
Diagnostic Labwork	deductible	$0	$0	$0
Diagnostic Procedures & Imaging	deductible	deductible	deductible	deductible
Fitness & Weight Loss Benefit	$150 per family per yr	$150 per family per yr	$150 per family per yr	$150 per family per yr
Retail Rx (30 day supply)	$15/30/50	$10/20/35	$10/20/35	$10/20/35
Mail Order Rx (90 day supply)	$30/60/100	$10/20/35	$10/20/35	$10/20/35
Emergency Room (covered worldwide)	$150	$150	$150	$150
Urgent Care Visit (covered worldwide)	$20	$20	$20	$20
Hospital Outpatient	deductible	deductible	deductible	deductible
Hospital Inpatient	deductible	deductible	deductible	deductible
Hospital Reimbursement (USAble)	not available as of 07/01/16	not offered	not offered	not offered
Total Monthly Cost of Single Plan	$633.07	$538.92	$495.30	$653.03
Total Monthly Cost of Family Plan	$1,660.55	$1,387.59	$1,275.28	$1,681.39
City Contribution	73% Single 71% Family	70% Single 66% Family	70% Single 66% Family	50% Single 50% Family
BiWeekly Single Deduction	**$85.46**	**$80.84**	**$74.30**	**$163.26**
BiWeekly Family Deduction	**$240.78**	**$235.89**	**$216.80**	**$420.35**
Monthly Single Deduction**	**$170.93**	**$161.68**	**$148.59**	**$326.52**
Monthly Family Deduction**	**$481.56**	**$471.78**	**$433.60**	**$840.70**

	Dental Option
	For active employees (regularly working 20+hrs/wk) & Retirees
	Blue Cross Blue Shield
Plan Name	**Dental Blue 100/80/50 +Ortho**
Deductible	$50/person $150/family
Calendar Year Benefit	$1,000 per person
Out of Network Coverage	none
Routine Cleanings	100% covered
Routine Exams	100% covered
Sealants to age 14	100% covered
Emergency Exams	100% covered
Routine Xrays	100% covered
Labs, Panoramic Xrays	New enhancement! deductible + 80% covered
Fillings	New enhancement! deductible + 80% covered
Periodontal Scaling	New enhancement! deductible + 80% covered
Extractions	New enhancement! deductible + 80% covered
Endodontics	New enhancement! deductible + 80% covered
Crowns	deductible + 50% covered
Veneers	deductible + 50% covered
Inlays/Onlays	deductible + 50% covered
Bridges	deductible + 50% covered
Dentures	deductible + 50% covered
Prosthodontic Repairs	deductible + 50% covered
New! Orthodontia	$1,000 allowance to age 19
Dental rates will remain the same as last year, even with the new plan enhancements	$30.00 $88.00
	50% Single 50% Family
	$7.50 **$22.00**

***** Surviving spouses will continue to pay 50% of the total monthly premium.***

Any text denoted in red represents a change from the previous plan year.