
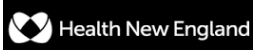







## City of Holyoke Medical & Dental Offering Effective July 1, 2016 - June 30, 2017

City of Holyoke

*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	Dental Option	
	For active employees (regularly working 20+hrs/wk) & Retirees under age 65 and/or not eligible for Medicare				For active employees (regularly working 20+hrs/wk) & Retirees	
						
<b>Plan Name</b>	<b>New Plan HMO Blue New England 1000</b>	<b>New Plan Essential 1000 HMO</b>	<b>New Plan Essential 2000 HMO</b>	<b>PPO 1000 National</b>	<b>Plan Name</b>	<b>Dental Blue 100/80/50 +Ortho</b>
<b>Network</b>	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		<b>Deductible</b>	\$50/person \$150/family
<b>Referrals Required?</b>	Yes	No	No	No	<b>Calendar Year Benefit</b>	\$1,000 per person
<b>Out of Network Co-Insurance</b>	member pays 100%	member pays 100%	member pays 100%	members pays 20%	<b>Out of Network Coverage</b>	none
<b>Deductible</b>	\$1,000/person \$2,000/family	\$1,000/person \$2,000/family	\$2,000/person \$4,000/family	\$1,000/person \$2,000/family	<b>Routine Cleanings</b>	100% covered
<b>Maximum Out of Pocket</b> (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 <i>(City to reimburse member after \$3,000/person \$6,000/family see flyer)</i>	\$2,000/person \$4,000/fam in netwk \$3,000/person \$6,000/fam out netwk	<b>Routine Exams</b>	100% covered
<b>Routine/Preventive Care:</b> Physicals, WellWoman, Well Child, Immunizations, Labs, Mammogram, Colonoscopy, Eye Exams	\$0	\$0	\$0	\$0	<b>Sealants to age 14</b>	100% covered
<b>Pediatric Dental (until age 12)</b>	not offered	not available as of 07/01/16	not available as of 07/01/16	not available as of 07/01/16	<b>Emergency Exams</b>	100% covered
<b>Non-Routine Office Visits</b>	\$20	\$20	\$20	\$20	<b>Routine Xrays</b>	100% covered
<b>Speech &amp; Physical Therapy</b>	deductible then \$20	deductible then \$20	deductible then \$20	deductible then \$20	<b>Labs, Panoramic Xrays</b>	<b>New enhancement!</b> deductible + 80% covered
<b>Chiropractic Visit</b>	\$20	\$15	\$15	\$15	<b>Fillings</b>	<b>New enhancement!</b> deductible + 80% covered
<b>Diagnostic Labwork</b>	deductible	\$0	\$0	\$0	<b>Periodontal Scaling</b>	<b>New enhancement!</b> deductible + 80% covered
<b>Diagnostic Procedures &amp; Imaging</b>	deductible	deductible	deductible	deductible	<b>Extractions</b>	<b>New enhancement!</b> deductible + 80% covered
<b>Fitness &amp; Weight Loss Benefit</b>	\$150 per family per yr	\$150 per family per yr	\$150 per family per yr	\$150 per family per yr	<b>Endodontics</b>	<b>New enhancement!</b> deductible + 80% covered
<b>Retail Rx (30 day supply)</b>	\$15/30/50	\$10/20/35	\$10/20/35	\$10/20/35	<b>Crowns</b>	deductible + 50% covered
<b>Mail Order RX (90 day supply)</b>	\$30/60/100	\$10/20/35	\$10/20/35	\$10/20/35	<b>Veneers</b>	deductible + 50% covered
<b>Emergency Room (covered worldwide)</b>	\$150	\$150	\$150	\$150	<b>Inlays/Onlays</b>	deductible + 50% covered
<b>Urgent Care Visit (covered worldwide)</b>	\$20	\$20	\$20	\$20	<b>Bridges</b>	deductible + 50% covered
<b>Hospital Outpatient</b>	deductible	deductible	deductible	deductible	<b>Dentures</b>	deductible + 50% covered
<b>Hospital Inpatient</b>	deductible	deductible	deductible	deductible	<b>Prosthodontic Repairs</b>	deductible + 50% covered
<b>Hospital Reimbursement (US Able)</b>	not available as of 07/01/16	not offered	not offered	not offered	<b>New! Orthodontia</b>	\$1,000 allowance to age 19
Total Monthly Cost of Single Plan	\$633.07	\$538.92	\$495.30	\$653.03		\$30.00
Total Monthly Cost of Family Plan	\$1,660.55	\$1,387.59	\$1,275.28	\$1,681.39		\$88.00
City Contribution	73% Single 71% Family	70% Single 66% Family	70% Single 66% Family	50% Single 50% Family		50% Single 50% Family
BiWeekly Single Deduction	\$85.46	\$80.84	\$74.30	\$163.26		\$7.50
BiWeekly Family Deduction	\$240.78	\$235.89	\$216.80	\$420.35		\$22.00
Monthly Single Deduction**	\$170.93	\$161.68	\$148.59	\$326.52		
Monthly Family Deduction**	\$481.56	\$471.78	\$433.60	\$840.70		

\*\* 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.