City of Holyoke

City of Holyoke
Medical & Dental Insurance Offering
Effective July 1, 2017 - June 30, 2018

This document is for illustrative purposes only. Please refer to plan documents for detailed coverage information. Some procedures require prior approval, limit number of visits, and can be performed for preventive or diagnostic purposes. When certain preventive procedures are performed, they may be covered 100%. When certain procedures are performed diagnostically, the deductible or a co-pay may apply. The PPO option below illustrates in-network benefits only. Please refer to your plan documents for out-of-network benefit information as services may apply to the deductible and a co-insurance member responsibility.

	Medical Option 1	Medical Option 2	Medical Option 3	Medical Option 4
	Cigna	Cigna	Cigna	Cigna
	For Benefit Eligible Employees and Retirees under age 65 and/or not eligible for Medicare			
Plan Name	**Open Access Plus 1000**	**Open Access Plus 2000**	**Open Access Plus 3000**	**Open Access PPO 1000**
Network	National	National	National	National
Emergency Care	Covered Worldwide	Covered Worldwide	Covered Worldwide	Covered Worldwide
Out of network coverage	Not available	Not available	Not available	Available
Out of Network Co-Insurance	No Coverage	No Coverage	No Coverage	Member pays 20%
PCP Referrals Required	No	No	No	No
Deductible	$1,000/person $2,000/family	$2,000/person $4,000/family	$3,000/person $6,000/family	$1,000/person $2,000/family
Maximum Out of Pocket (The most a member will pay/plan year in copays, deductibles, and co-insurance)	$2,000/person $4,000/family	$5,000/person $10,000/family *(City will reimburse member after $3,000/person $6,000/family. Only applies to this plan.)*	$6,000/person $12,000/family *(City will reimburse member after $3,000/person $6,000/family. Only applies to this plan.)*	$3,000/person $6,000/family
Routine/Preventive Care	$0	$0	$0	$0
Non-Routine Office Visits	$20	$20	$20	$20
Speech & Physical Therapy	$20	$20	$20	$20
Chiropractic Visit	$20	$20	$20	$20
Diagnostic Lab work	$0	$0	$0	$0
Diagnostic Radiology & Imaging	deductible	deductible	deductible	deductible
Fitness & Weight Loss Benefit	Not available	Not available	Not available	Not available
Retail Rx (30 day supply)	$10/20/35	$10/20/35	$10/20/35	$10/20/35
Mail Order Rx (90 day supply)	$10/20/35	$10/20/35	$10/20/35	$10/20/35
Emergency Ambulance Transport	deductible	deductible	deductible	deductible
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
Total Monthly Cost of Single Plan	$630.58	$578.29	$550.00	$650.94
Total Monthly Cost of Family Plan	$1,623.75	$1,489.11	$1,417.27	$1,676.18
City Contribution	72% Single 68% Family	72% Single 68% Family	76% Single 70% Family	50% Single 50% Family
BiWeekly Single Deduction (24 pays)	**$88.28**	**$80.79**	**$66.00**	**$162.51**
BiWeekly Family Deduction (24 pays)	**$259.80**	**$237.81**	**$212.59**	**$418.46**
Monthly Single Deduction**	**$176.56**	**$161.58**	**$132.00**	**$325.02**
Monthly Family Deduction**	**$519.60**	**$475.62**	**$425.18**	**$836.92**

Dental Option	
BlueCross BlueShield	
For Benefit Eligible Employees and Retirees	
Plan Name	**Dental Blue With Ortho**
Deductible	$50/person $150/family
Calendar Year Benefit	$1,000 per person
Out of Network Coverage	none
Routine Cleanings & Scaling	100% covered
Routine Exams	100% covered
Emergency Exams	100% covered
Pediatric Fluoride (to age 19) **Pediatric Sealants (to age 14)** **Pediatric Spacers (to age 19)**	100% covered
Study Models and Casts	100% covered
Routine X-rays	100% covered
Labs, Panoramic X-rays	deductible + 80% covered
Fillings	deductible + 80% covered
Periodontal Scaling & Surgery	deductible + 80% covered
Oral Surgery	deductible + 80% covered
Extractions	deductible + 80% covered
Endodontics- Root Canal	deductible + 80% covered
Crowns	deductible + 50% covered
Veneers	deductible + 50% covered
Inlays/Onlays	deductible + 50% covered
Bridges	deductible + 50% covered
Dentures	deductible + 50% covered
Orthodontia (Braces)	$1,000 allowance to age 19
Total Monthly Cost of Single Plan	$30.00
Total Monthly Cost of Family Plan	$88.00
City Contribution	50% Single 50% Family
BiWeekly Single Deduction (24 pays)	**$7.50**
BiWeekly Family Deduction (24 pays)	**$22.00**
Monthly Single Deduction**	**$15.00**
Monthly Family Deduction**	**$44.00**

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

5/11/2017/ NAM DFS