HEALTH, DENTAL AND VOLUNTARY VISION INSURANCE PLANS JULY 1, 2024 - JUNE 30, 2025

2024-25 BCBSMA Plan Options			
Plan Name	HMO Blue New England $1000/$2000	HMO Blue New England $2000/$4000	Blue Care Elect PPO $2000/$4000
Network	HMO Blue New England	HMO Blue New England	PPO
Referrals Required?	Yes	Yes	No
Primary Care Required?	Yes	Yes	No
Out of Network Co-Insurance	N/A	N/A	20%
Deductible	$1000/Person $2000/Family	$2000/Person $4000/Family	$2000/Person $4000/Family
Maximum Out of Pocket (MOOP)	$7,350/Person $14,700/Family	$7,350/Person $14,700/Family	$7,350/$14,700 in network $9,000/$18,000 out of network - cross accumulates
MOOP City Reimbursement	$4,000/Person $8,000/Family	$4,000/Person $8,000/Family	$4,000/Person $8,000/Family
Routine/Preventative Care	No Charge	No Charge	No Charge
Non-Routine Office Visits	$20/$25	$20/$25	$20/$25
Speech & Physical Therapy	$25	$25	$25
Chiropractic Visit	$20	$20	$20
Diagnostic Labwork	No Charge	No Charge	No Charge
Diagnostic Procedures and Imaging	Deductible	Deductible	Deductible
High Tech Imaging	$100	$100	$100
Retail RX (30 day supply)	$10/$20/$35	$10/$20/$35	$10/$20/$35
Mail Order RX (90 day supply)	$10/$20/$35	$10/$20/$35	$10/$20/$35
Ambulance	No Charge	No Charge	Deductible
Emergency Care (covered worldwide)	$150	$150	$150
Urgent Care Visit (covered worldwide)	$20	$20	$20
Hospital Outpatient	Deductible	Deductible	Deductible
Hospital Inpatient	Deductible	Deductible	Deductible
Renewal Monthly Single	$768.62	$747.92	$785.32
Renewal Monthly Family	$1,980.94	$1,927.61	$2,024.00
City Contribution Single	71.50%	72.50%	66.00%
City Contribution Family	67.50%	68.50%	64.00%
BiWeekly Single Employee Deduction	$109.53	$102.84	$133.50
BiWeekly Family Employee Deduction	$321.90	$303.60	$364.32

OPTIONAL VISION INS BCBS BLUE 20/20
$10 Exam Copay
$25 Lens Copay
$130 Frames Allowance
$130 Contacts Allowance

INSIGHT NETWORK MONTHLY PREMIUMS	
Employee	$7.40
Empl + Spouse or Domestic Partner	$12.58
Empl + One or More Children	$12.95
Family	$20.36

2024-25 BCBSMA Dental	
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	100% covered
Fillings	deductible + 20%
Periodontal Scaling & Surgery	deductible + 20%
Oral Surgery	deductible + 20%
Extractions	deductible + 20%
Endodontics- Root Canal	deductible + 20%
Crowns	deductible + 50%
Inlays/Onlays	deductible + 50%
Bridges	deductible + 50%
Dentures	deductible + 50%
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
Employee Portion	
Monthly Single	**$15.00**
Monthly Family	**$44.00**