HEALTH, DENTAL AND VISION INSURANCE PLANS JULY 1, 2023 - JUNE 30, 2024

HNE Renewal		
Plan Name	**PPO $4000 w/ HRA**	**PPO $5000 w/ HRA**
Network	**National**	**National**
Referrals Required?	No	No
Out of Network Co-Insurance	Member pays **20%**	Member pays **20%**
Deductible	$4,000/person $8,000/family	$5,000/person $10,000/family
Deductible paid by: The CITY	$3,000/person $6,000/family	$3,000/person $6,000/family
Deductible paid by: The EMPLOYEE	***$1,000/person $2,000/family***	***$2,000/person $4,000/family***
Maximum Out of Pocket (MOOP)	$7,350/person $14,7000/family	$7,350/person $14,7000/family
MOOP City Reimbursement	$4,000/person $8,000/family	$4,000/person $8,000/family
Routine/Preventive Care	$0	$0
Non-Routine Office Visits	$20/$25	$20/$25
Speech & Physical Therapy	$25	$25
Chiropractic Visit	$20	$20
Diagnostic Labwork	$0	$0
Diagnostic Procedures & Imaging	deductible	deductible
High Tech Imaging	$100	$100
Retail Rx (30 day supply)	**$10/$20/$35**	**$10/$20/$35**
Mail Order Rx (90 day supply)	**$10/$20/$35**	**$10/$20/$35**
Ambulance	deductible	deductible
Emergency Room (covered worldwide)	$150	$150
Urgent Care Visit (covered worldwide)	$20	$20
Hospital Outpatient	deductible	deductible
Hospital Inpatient	deductible	deductible
Renewal Monthly Single	$699.70	$680.86
Renewal Monthly Family	$1,803.31	$1,754.77
City Contribution Single	71.50%	72.50%
City Contribution Family	67.50%	68.50%
BiWeekly Single Employee Deduction	$99.71	$93.62
BiWeekly Family Employee Deduction	$293.04	$276.38

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

2023 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**