City of Northfield
2025 Medical and Dental RFP Results & Ancillary Renewals

August 26, 2024

Gallagher

Insurance | Risk Management | Consulting

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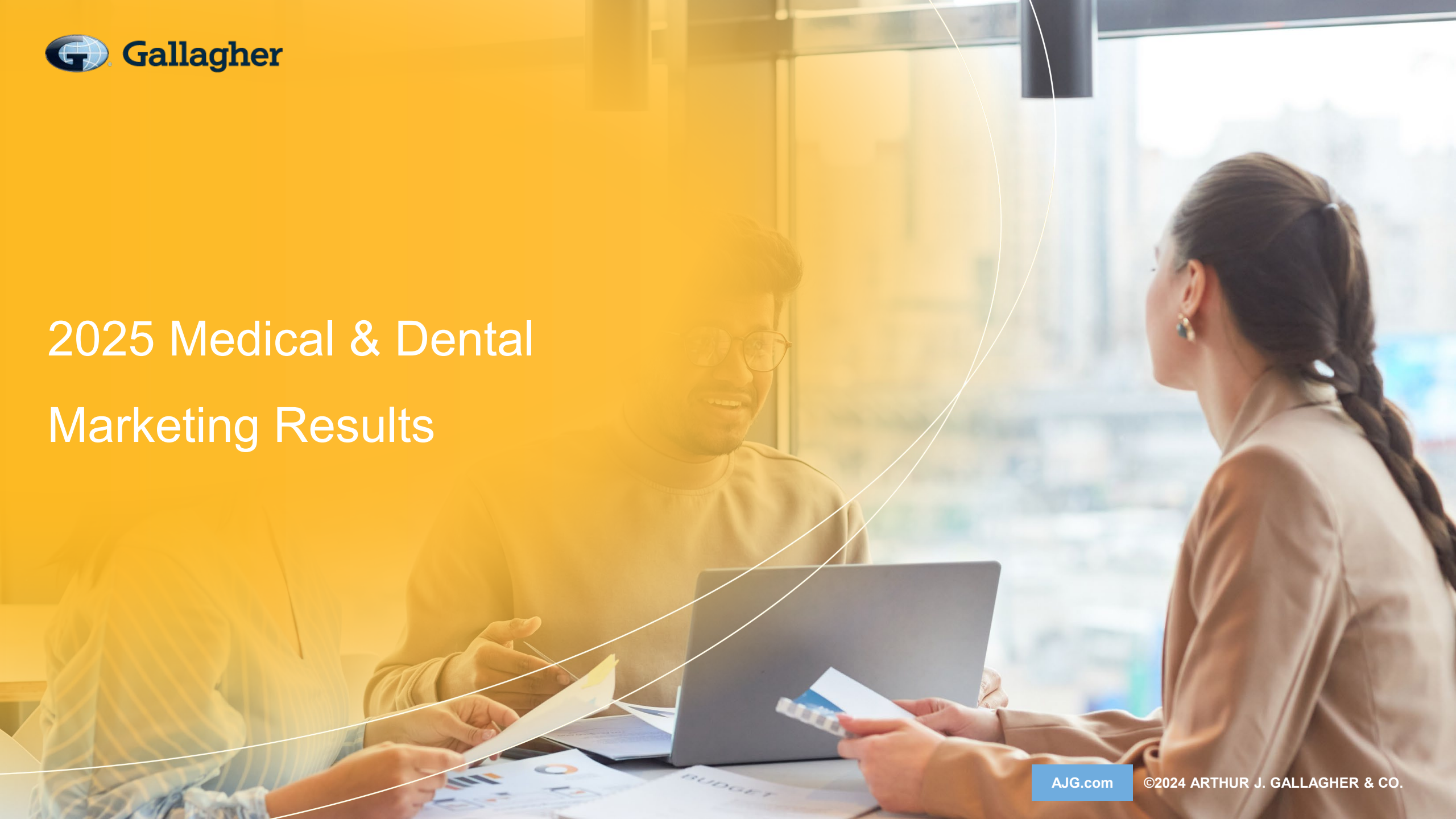
2025 Medical & Dental Marketing Results



2025 Medical Marketing Results

Marketing Summary

- Requested proposals and received the following Reponses:

Carrier	BCBS	Gravie	MHC	Sourcewell	UHC	PEIP	AllinaHealth Aetna	HP	Medica
2025 Offer	9.9% Initial *5% Negotiated*	-3%	2%	6.6%	8.3%	10.1%	DTQ	DTQ	DTQ
Additional Notes:	*Negotiated a 2026 Rate cap of 15%*	Level-funded Plan *contingent on updated claims through 8/31		2026 Rate cap of 15%	Additional 2% savings if bundled with UHC dental	4-year commitment required			

2025 Medical Marketing Results – Gravie, MHC & Sourcewell

Gravie

- New carrier to the market
- Aetna Network
- Level-Funded Plan
- Final rates contingent on claims through August

Plan Design Differences:

- Physical Therapy:
  - *Digital program, Sword*
- Prescription Drug:
  - *Prudent Rx*
- Deductible Adjustments on $500 and $1,000 plans

Minnesota Healthcare Consortium (MHC)

- Pool
- Medica (Administrator)
- No Rate Caps

Plan Design Differences:

- Prescription Drug:
  - *$20 / $50 / $95 copays*
  - *BCBS has 4 tiers of Rx*
  - *Slight Formulary Differences*

The Better Health Collective - Sourcewell

- Pool
- HP was administrator – beginning 2025 BCBS is administrator

Plan Design Differences:

- Smart Plan Menu
  - *All HSA compatible plans*
  - *No Traditional plan options*
- Significant changes to $500 and $1,000 plans

2025 Medical Plan Renewal - Negotiated

				CURRENT			NEGOTIATED RENEWAL		
Carrier Name				BlueCross BlueShield of Minnesota			BlueCross BlueShield of Minnesota		
Plan Name				T24075 HSA $3,200	T24111 $1,000	T24032 $500 Ded	T25075 Aware HSA $3,300 Ded 0% Coins	T25111 Aware $1,000 Ded 30% Coins	T25032 Aware $500 Ded 20% Coins
PLAN DESIGN*									
In-Network Benefits				Aware Network	Aware Network	Aware Network	Aware Network	Aware Network	Aware Network
Deductible Type				Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Calendar Year (CY) Deductible (Individual / Family)				$3,200 / $6,400	$1,000 / $3,000	$500 / $1,500	$3,300 / $6,600	$1,000 / $3,000	$500 / $1,500
Out-of-Pocket Max Type				Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
CY Out-of-Pocket Max (Individual / Family)				$3,200 / $6,400	$5,000 / $10,000	$2,000 / $4,000	$3,300 / $6,600	$5,000 / $10,000	$2,000 / $4,000
Coinsurance (member pays after deductible)				0%	30%	20%	0%	30%	20%
Preventive Care				Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Primary Care Visit				0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible
Specialist Visit				0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible
Urgent Care				0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible
Emergency Room				0% after deductible	30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible
Inpatient Hospital				0% after deductible	30% after deductible	20% after deductible	0% after deductible	30% after deductible	20% after deductible
Outpatient Surgery				0% after deductible	30% after deductible	20% after deductible	0% after deductible	30% after deductible	20% after deductible
Chiropractic (visit limits may apply)				0% after deductible	Spinal Manipulation: $40 Copay; Other Chiropractic: 30% after deductible	Spinal Manipulation: $25 Copay; Other Chiropractic: 30% after deductible	0% after deductible	Spinal Manipulation: $40 Copay; Other Chiropractic: 30% after deductible	Spinal Manipulation: $25 Copay; Other Chiropractic: 30% after deductible
Phys/Occ/Speech Therapy (visit limits may apply)				0% after deductible	30% after deductible	20% after deductible	0% after deductible	30% after deductible	20% after deductible
Diagnostic Test (X-ray, blood work)				0% after deductible	30% after deductible	20% after deductible	0% after deductible	30% after deductible	20% after deductible
Imaging (CT/PET scan, MRI)				0% after deductible	30% after deductible	20% after deductible	0% after deductible	30% after deductible	20% after deductible
Prescription Drug Benefit									
Retail				31 Days	31 Days	31 Days	31 Days	31 Days	31 Days
Tier I / Tier II / Tier III / Tier IV				0% after deductible	$20 / $50 / $75 / $120	$20 / $50 / $75 / $120	0% after deductible	$20 / $50 / $75 / $120	$20 / $50 / $75 / $120
Specialty				0% after deductible	30% to max $500	20% to max $500	0% after deductible	30% to max $500	20% to max $500
Mail Order				90 Days	90 Days	90 Days	90 Days	90 Days	90 Days
Tier I / Tier II / Tier III / Tier IV				0% after deductible	$60 / $150 / $225 / $360	$60 / $150 / $225 / $360	0% after deductible	$60 / $150 / $225 / $360	$60 / $150 / $225 / $360
Out-of-Network Benefits									
Deductible Type				Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
CY Deductible (Individual / Family)				$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000
Out-of-Pocket Max Type				Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
CY Out-of-Pocket Max (Individual / Family)				$10,000 / $20,000	$10,000 / $20,000	$10,000 / $20,000	$10,000 / $20,000	$10,000 / $20,000	$10,000 / $20,000
Coinsurance (member pays after deductible)				50%	50%	50%	50%	50%	50%
COST ANALYSIS									
PEPM Rates - Enrollment per Renewal	Plan 1	Plan 2	Plan 3	T24075 HSA $3,200	T24111 $1,000	T24032 $500 Ded	T25075 Aware HSA $3,300 Ded 0% Coins	T25111 Aware $1,000 Ded 30% Coins	T25032 Aware $500 Ded 20% Coins
Employee (EE) Only	46	2	11	$759.18	$834.18	$945.28	$798.38	$864.10	$985.84
EE + Family	38	1	3	$2,026.94	$2,227.18	$2,523.80	$2,131.59	$2,307.06	$2,632.11
Total Enrollment	**84**	**3**	**14**						
Estimated Monthly Premium				$111,946	$3,896	$17,969	$117,726	$4,035	$18,741
Estimated Annual Premium				**$1,343,352**	**$46,746**	**$215,634**	**$1,412,711**	**$48,423**	**$224,887**
Dollar Difference from Current							**$69,359**	**$1,677**	**$9,253**
Percent Change from Current							**5.2%**	**3.6%**	**4.3%**
Total Combined Annual Cost									
				CURRENT			NEGOTIATED RENEWAL		
Estimated Annual Premium				**$1,605,732**			**$1,686,021**		
Dollar Difference from Current							**$80,289**		
Percent Change from Current							**5.0%**		
PLAN PROVISIONS									
Rate Guarantee				1 Year rate guarantee ending 12/31/2024			2026 Rate Cap of 15%		

**NOTE: Benefit deviations from Current are identified in blue font*

BCBS 2025 Change Grid

Plan Updates due to Legislation Changes:

Rare Disease Benefit

State Mandate (effective 1/1/2024)

The rare disease mandate requires that eligible, out-of-network services related to the diagnosis, monitoring, and treatment of an eligible rare disease or condition will apply the same benefit level as services provided by in-network providers, including member cost-share, benefit limitations, or service limitations. An eligible rare disease or condition means any disease or condition that is labeled as a rare disease or condition on the Genetic and Rare Diseases Information Center list created by the National Institute of Health.

Providers can submit the Rare Disease Benefit Mandate – Out of Network/Non-Participating Provider Notification form to determine if the members rare disease/condition qualifies under the benefit. This form is available at https://www.bluecrossmn.com/providers/forms-and-publications. Note, this form **must** be completed/submitted by the provider – not the member.

Routine Mammogram

State Mandate (effective 1/1/2024)

If a health care provider determines an enrollee requires additional diagnostic services or testing after a routine mammogram, the additional diagnostic services or testing will be covered with no cost-sharing, including copay, deductible, or coinsurance.

There is a limited exception for a high deductible health plan connected to a health savings account that permits cost-sharing until after the member has met their plan deductible.

BCBS 2025 Change Grid

Plan Updates due to Legislation Changes:

Chronic Disease Member Cost Share Mandate

Members diagnosed with certain chronic diseases will benefit from cost-sharing limits on their medical expenses. Prescription medications for these conditions will not exceed $25 per prescription monthly. Additionally, eligible medical supplies (combined medical and pharmacy) for chronic disease management will have a monthly cap of $50. This mandate includes chronic diseases such as diabetes, asthma, and allergies that require epinephrine auto-injectors. The standard benefit is applicable up to a maximum member cost share of either $25 or $50. For members with a Health Savings Account (HSA), the deductible must be met first if the drug or supply is not listed on the IRS preventive list (https://www.irs.gov/pub/irs-drop/n-19-45.pdf).

Insulin Cost-Share Change

State Mandate

Blue Cross is eliminating the $0 insulin member cost-share and will apply a $25 member cost-share per prescription per month. Insulin is included as part of the diabetes drugs capped at $25 per month under the chronic disease cost-share mandate.

Creditable coverage disclosure for pharmacy benefits

We are waiting for confirmation from BCBS on the creditability status of your medical plan(s) for 2025

2025 Dental Marketing Results

Marketing Summary

- Requested proposals and received the following Reponses:

Guardian	MetLife	BCBS	Delta Dental	UHC	HP
Rate Hold 0%	-2.3%	-9.1% or 17%	36.7% or 44%	0%	DTQ
Alternate Plan Design Options Available	2026 7% rate cap 2027 7% rate cap Proposal Received Late	**Unable to offer dual plan option**	**Unable to offer dual plan option** 2-year rate guarantee	1-year rate guarantee 2-year rate guarantee if UHC Medical sold Proposal Received Late	

2025 Guardian Dental – Current/Renewal (rate hold)

	CURRENT				RENEWAL			
Carrier Name	Guardian				Guardian			
Plan Name	Low Plan - DentalGuard Preferred Gold & Silver		High Plan - DentalGuard Preferred Gold & Silver		Low Plan-DentalGuard Preferred Gold & Silver		Buy up High Plan-DentalGuard Pref Gold & Silver	
PLAN DESIGN*								
Network	**INN [DentalGuard Preferred Network]**	**OON**	**INN [DentalGuard Preferred Network]**	**OON**	**INN [DentalGuard Preferred Network]**	**OON**	**INN [DentalGuard Preferred Network]**	**OON**
Calendar Year (CY) Deductible (Individual / Family)	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Annual Maximum	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000
Annual Maximum Provision	Rollover Threshold: $500; Maximum Rollover Reward: $250; Rollover Account Maximum: $1,000		Rollover Threshold: $500; Maximum Rollover Reward: $250; Rollover Account Maximum: $1,000		Rollover Threshold: $500; Maximum Rollover Reward: $250; Rollover Account Maximum: $1,000		Rollover Threshold: $500; Maximum Rollover Reward: $250; Rollover Account Maximum: $1,000	
Coinsurance								
Preventive Services	100%	100%	100%	100%	100%	100%	100%	100%
Cleaning Frequency	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months
Deductible Waived?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Basic	50%	50%	80%	80%	50%	50%	80%	80%
Periodontics	5%	5%	50%	50%	5%	5%	50%	50%
Endodontics	5%	5%	50%	50%	5%	5%	50%	50%
Major	5%	5%	50%	50%	5%	5%	50%	50%
Major Waiting period	none	none	none	none	none	none	none	none
Implants	5%	5%	50%	50%	5%	5%	50%	50%
Orthodontics	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
OON Reimbursement Level	90th percentile of the prevailing fee		90th percentile of the prevailing fee		90th percentile of the prevailing fee		90th percentile of the prevailing fee	
COST ANALYSIS								
PEPM Rates - Enrollment per AMP	Plan 1	Plan 2	Low Plan - DentalGuard Preferred Gold & Silver		High Plan - DentalGuard Preferred Gold & Silver		Low Plan-DentalGuard Preferred Gold & Silver	Buy up High Plan-DentalGuard Pref Gold & Silver
Employee (EE) Only	30	24	$18.56		$36.64		$18.56	$36.64
EE + Spouse	3	10	$37.66		$74.36		$37.66	$74.36
EE + Child(ren)	3	5	$60.46		$92.86		$60.46	$92.86
EE + Family	8	13	$86.00		$139.22		$86.00	$139.22
Total Enrollment	**44**	**52**						
Estimated Monthly Premium			$1,539		$3,897		$1,539	$3,897
Estimated Annual Premium			**$18,470**		**$46,765**		**$18,470**	**$46,765**
Dollar Difference from Current							**$0**	**$0**
Percent Change from Current							**0.0%**	**0.0%**
Total Combined Annual Cost								
Estimated Annual Premium			**$65,235**				**$65,235**	
Dollar Difference from Current							**$0**	
Percent Change from Current							**0.0%**	
PLAN PROVISIONS								
Rate Guarantee	1 Year rate guarantee ending 12/31/2024				1 Year rate Guarantee Ending 12/31/2025			

**NOTE: Benefit deviations from Current are identified in blue font*

2025 Guardian Dental – Alternate Plan Option $1250 Annual Max with Enhanced Benefits

	CURRENT				$1250 Annual Max with Enhanced Benefits Option			
Carrier Name	Guardian				Guardian			
Plan Name	Low Plan - DentalGuard Preferred Gold & Silver		High Plan - DentalGuard Preferred Gold & Silver		Low Plan-DentalGuard Preferred Gold & Silver		Buy up High Plan-DentalGuard Preferred Gold & Silver	
PLAN DESIGN*								
Network	**INN [DentalGuard Preferred Network]**	**OON**	**INN [DentalGuard Preferred Network]**	**OON**	**INN [DentalGuard Preferred Network]**	**OON**	**INN [DentalGuard Preferred Network]**	**OON**
Calendar Year (CY) Deductible (Individual / Family)	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Annual Maximum	$1,000	$1,000	$1,000	$1,000	$1,250	$1,250	$1,250	$1,250
Annual Maximum Provision	Rollover Threshold: $500; Maximum Rollover Reward: $250; Rollover Account Maximum: $1,000		Rollover Threshold: $500; Maximum Rollover Reward: $250; Rollover Account Maximum: $1,000		Rollover Threshold: $600; Maximum Rollover Reward: $300; Rollover Account Maximum: $1,250		Rollover Threshold: $600; Maximum Rollover Reward: $300; Rollover Account Maximum: $1,250	
Coinsurance								
Preventive Services	100%	100%	100%	100%	100%	100%	100%	100%
Cleaning Frequency	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months
Deductible Waived?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Basic	50%	50%	80%	80%	50%	50%	80%	80%
Periodontics	5%	5%	50%	50%	25%	25%	50%	50%
Endodontics	5%	5%	50%	50%	25%	25%	50%	50%
Major	5%	5%	50%	50%	25%	25%	50%	50%
Major Waiting period	none	none	none	none	none	none	none	none
Implants	5%	5%	50%	50%	25%	25%	50%	50%
Orthodontics	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
OON Reimbursement Level	90th percentile of the prevailing fee		90th percentile of the prevailing fee		90th percentile of the prevailing fee		90th percentile of the prevailing fee	
COST ANALYSIS								
PEPM Rates - Enrollment per AMP	Plan 1	Plan 2	Low Plan - DentalGuard Preferred Gold & Silver		High Plan - DentalGuard Preferred Gold & Silver		Low Plan-DentalGuard Preferred Gold & Silver	Buy up High Plan-DentalGuard Preferred Gold & Silver
Employee (EE) Only	30	24	$18.56		$36.64		$21.64	$38.84
EE + Spouse	3	10	$37.66		$74.36		$43.91	$78.82
EE + Child(ren)	3	5	$60.46		$92.86		$70.50	$98.43
EE + Family	8	13	$86.00		$139.22		$100.28	$147.57
Total Enrollment	**44**	**52**						
Estimated Monthly Premium			$1,539		$3,897		$1,795	$4,131
Estimated Annual Premium			**$18,470**		**$46,765**		**$21,536**	**$49,571**
Dollar Difference from Current							**$3,066**	**$2,806**
Percent Change from Current							**16.6%**	**6.0%**
Total Combined Annual Cost								
Estimated Annual Premium			**$65,235**				**$71,107**	
Dollar Difference from Current							**$5,872**	
Percent Change from Current							**9.0%**	
PLAN PROVISIONS								
Rate Guarantee			1 Year rate guarantee ending 12/31/2024				1 Year rate Guarantee Ending 12/31/2025	

**NOTE: Benefit deviations from Current are identified in blue font*

2025 MetLife Dental

Carrier Name	Guardian				MetLife			
Plan Name	Low Plan - DentalGuard Preferred Gold & Silver		High Plan - DentalGuard Preferred Gold & Silver		Low Plan		High Plan (Active / Retirees)	
PLAN DESIGN*								
Network	INN [DentalGuard Preferred Network]	OON	INN [DentalGuard Preferred Network]	OON	INN	OON	INN	OON
Calendar Year (CY) Deductible (Individual / Family)	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Annual Maximum	$1,000	$1,000	$1,000	$1,000	$1,250	$1,250	$1,250	$1,250
Annual Maximum Provision	Rollover Threshold: $500; Maximum Rollover Reward: $250; Rollover Account Maximum: $1,000		Rollover Threshold: $500; Maximum Rollover Reward: $250; Rollover Account Maximum: $1,000		not included	not included	not included	not included
Coinsurance								
Preventive Services	100%	100%	100%	100%	100%	100%	100%	100%
Cleaning Frequency	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months
Deductible Waived?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Basic	50%	50%	80%	80%	50%	50%	80%	80%
Periodontics	5%	5%	50%	50%	25%	25%	80%	80%
Endodontics	5%	5%	50%	50%	25%	25%	80%	80%
Major	5%	5%	50%	50%	25%	25%	50%	50%
Implants	5%	5%	50%	50%	25%	25%	50%	50%
Orthodontics	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
OON Reimbursement Level	90th percentile of the prevailing fee		90th percentile of the prevailing fee		90th R&C		90th R&C	
COST ANALYSIS								
PEPM Rates - Enrollment per AMP	Plan 1	Plan 2	Low Plan - DentalGuard Preferred Gold & Silver		High Plan - DentalGuard Preferred Gold & Silver		Low Plan	High Plan (Active / Retirees)
Employee (EE) Only	30	24	$18.56		$36.64		$18.12	$35.80
EE + Spouse	3	10	$37.66		$74.36		$36.79	$72.65
EE + Child(ren)	3	5	$60.46		$92.86		$59.07	$90.72
EE + Family	8	13	$86.00		$139.22		$84.02	$136.02
Total Enrollment	**44**	**52**						
Estimated Monthly Premium			$1,539		$3,897		$1,503	$3,808
Estimated Annual Premium			**$18,470**		**$46,765**		**$18,040**	**$45,691**
Dollar Difference from Current							**-$430**	**-$1,075**
Percent Change from Current							**-2.3%**	**-2.3%**
Total Combined Annual Cost								
Estimated Annual Premium			**$65,235**				**$63,731**	
Dollar Difference from Current							**-$1,505**	
Percent Change from Current							**-2.3%**	
PLAN PROVISIONS								
Rate Guarantee	1 Year rate guarantee ending 12/31/2024				2026 Rate cap of 7%; 2027 Rate cap of 7% Enrollment credit of 3% (one time credit to offset transition) 3% of total premium platform credit offset (paid to group quarterly)			

**NOTE: Benefit deviations from Current are identified in blue font*

Ancillary Renewals

Additional Ancillary Renewals

1/1/2025 Renewal

- Vision *(Began offering in 2022)*
  - Rate hold through 12/31/2025
- Life and Voluntary Life *(Went out to market for 2022 plan year. Next marketing required for 1/1/2027)*
  - Renewal received! 2-year rate hold offer
- LTD *(Went out to market for 2022 plan year. Next marketing required for 1/1/2027)*
  - Renewal received! 2-year rate hold offer

Benchmarking

2024 Benchmarking

- Data compiled from the Local Government Salary & Benefits 2024 Survey
- Data specific to the City's list of comparable organizations
- New Brighton and Columbia Heights did not report data and therefore are not included in the results
- Private Sector Benchmarking:
  - Received data from Northfield School District, Carlton College and St. Olaf College.
  - *POST Consumer Brands did not provide information*

City Name
Owatonna
White Bear Lake
Elk River
Faribault
Crystal
Hastings
New Brighton
New Hope
South St. Paul
Forest Lake
West St. Paul
Columbia Heights
Stillwater

Source: 2024 MN Local Government Salary & Benefits Survey unless noted.

Medical Benchmarking

2024 Survey of Comparable Organizations

- Themes:
  - Comparable Plan Design; “in-line” deductibles and out-of-pocket maximums
  - HSA Contributions are higher than comparable cities
  - Employee percentage of premiums slightly higher than some other comparable cities
  - Large network very predominant, multi-plan offering also very common
  - Dental: some plan design areas to consider
- Let’s talk changes and goals relating to what’s happening with your comparable organizations

2024 Benchmarking: Plan Design

Organization Name	Single Deductible	Single Out-Of-Pocket	Family Deductible	Family Out-Of-Pocket	Coinsurance
City of Crystal	$3,200	$3,200	$6,400	$6,400	0%
City of Elk River	$3,200	$3,200	$6,400	$6,400	0%
City of Faribault	$3,500	$3,500	$7,000	$7,000	0%
City of Forest Lake					
City of Hastings	$3,200	$3,200	$6,400	$6,400	0%
City of New Hope	$638	$1,600	$1,664	$3,200	0%
City of Owatonna	$5,000	$5,000	$10,000	$10,000	0%
City of South St. Paul	$3,200	$3,200	$6,400	$6,400	0%
City of Stillwater	$400	$2,000	$800	$4,000	20%
City of West St Paul					
City of White Bear Lake	$3,200	$3,200	$6,400	$6,400	0%
Average	$2,838	$3,122	$5,718	$6,244	2%
Most Common	$3,200	$3,200	$6,400	$6,400	0%
City of Northfield	$3,200	$3,200	$6,400	$6,400	0%

Source: 2024 MN Local Government Salary & Benefits Survey

Northfield School District	$2,000	$2,000	$4,000	$4,000	0%
Carlton College	$1,600	$3,000	$3,200	$6,000	25%
St. Olaf College	$4,000	$5,400	$8,000	$10,800	20%

Source: Northfield School District, Carlton College and St. Olaf College provided data

2024 Benchmarking: Plan Design

Organization Name	Single Coverage				Family Coverage				Opt out reward amount
	Total Monthly Premium (Single coverage)	Employer Monthly Contribution (Single coverage)	Employee Monthly Cost (Single coverage)	% Premium Employee pays (Single coverage)	Total Monthly Premium (Family coverage)	Employer Monthly Contribution (Family coverage)	Employee Monthly Cost (Family coverage)	% Premium Employee pays (Family coverage)	
City of Crystal	$871.00	$871.00	$0.00	0%	$2,264.00	$2,232.00	$32.00	1%	$250-$299
City of Elk River	$620.47	$652.00	$0.00	0%	$1,928.83	$1,929.00	$0.00	0%	$300-$349
City of Faribault	$892.61	$821.56	$71.05	8%	$2,857.44	$2,343.94	$513.50	18%	No dollars given to employees that waive coverage
City of Forest Lake	$880.80	$880.80	$0.00	0%	$2,479.52	$1,465.00	$1,014.52	41%	No dollars given to employees that waive coverage
City of Hastings	$891.50	$891.50	$0.00	0%	$2,853.64	$1,997.55	$856.09	30%	
City of New Hope	$638.01	$638.01	$0.00	0%	$1,664.84	$1,643.00	$21.84	1%	No dollars given to employees that waive coverage
City of Owatonna	$741.62	$596.00	$145.62	20%	$2,045.96	$1,664.00	$381.96	19%	No dollars given to employees that waive coverage
City of South St. Paul	$807.31	$807.31	$0.00	0%	$2,205.57	$1,696.00	$509.57	23%	No dollars given to employees that waive coverage
City of Stillwater	$866.56	$866.56	$0.00	0%	$1,838.75	$1,292.00	$546.75	30%	$250-$299
City of West St Paul	$803.00	$803.00	$0.00	0%	$1,860.00	$1,620.00	$0.00	0%	No dollars given to employees that waive coverage
City of White Bear Lake	$681.18	$665.00	$16.18	2%	$1,904.31	$1,691.00	$213.31	11%	$100-$149
Average	$790.37	$772.07	$21.17	3%	$2,172.99	$1,779.41	$371.78	16%	n/a
City of Northfield	$759.18	$692.09	$67.09	9%	$2,026.94	$1,438.47	$588.47	29%	No dollars given to employees that waive coverage

Source: 2024 MN Local Government Salary & Benefits Survey

Northfield School District	$774.25	$532.93	$241.32	31%	$2,353.99	$1,707.73	$646.26	27%
Carlton College	$721.26	$575.36	$145.91	20%	$2,277.76	$1,828.33	$449.43	20%
St. Olaf College	$728	$574	$154	21%	$1,999	$1,450	$549	27%

Source: Northfield School District, Carlton College and St. Olaf College provided data

2024 Benchmarking: HSA Contributions

Organization Name	Annual employer HSA contribution (Single coverage)	Annual employer HSA contribution (Family coverage)
City of Crystal	$2,750-$2,999	N/A
City of Elk River	$500-$999	$1-$999
City of Faribault	$500-$999	$1-$999
City of Forest Lake	$3,000+	N/A
City of Hastings	$2,000-$2,249	$3,000-$3,249
City of New Hope	$500-$999	N/A
City of Owatonna	$1,000-$1,249	$2,500-$2,749
City of South St. Paul	$3,000+	$1,750-$1,999
City of Stillwater	$500-$999	$1,500-$1,749
City of West St Paul	$2,000-$2,249	$4,000+
City of White Bear Lake	$500-$999	$1,500-$1,749
City of Northfield	$1,750-$1,999	$3,500-$3,749

Source: 2024 MN Local Government Salary & Benefits Survey

Northfield School District	$1,000 (HRA)	$2,000 (HRA)
Carlton College	$1,200	$3,000
St. Olaf College	$1,200	$2,400

Source: Northfield School District, Carlton College and St. Olaf College provided data

2024 Benchmarking: Dental

Organization Name	Dental plans offered	Annual maximum for the most popular plan	Single deductible for the most popular plan	Family deductible for the most popular plan	Lifetime orthodontia maximum for the most popular plan	Monthly cost dental insurance on the most popular plan (Single coverage)	Monthly cost dental insurance on the most popular plan (Family coverage)
City of Crystal	1	$2,000	$2,000	$2,000	$1,000-$1,499	$40-$49.99	$100-$199.99
City of Elk River	1	$1,500	$25	$75	No orthodontia coverage	$40-$49.99	$100-$199.99
City of Faribault	1	$2,000	$50	$150	$2,000+	$0-$9.99	$40-$59.99
City of Forest Lake	1	$4,000	$40	$121	$2,000+	$0-$9.99	$0-$19.99
City of Hastings	1	$2,000	$0	$0	No orthodontia coverage	$40-$49.99	$100-$199.99
City of New Hope	1	$3,000	$45	$134	No orthodontia coverage	EE uses Cafeteria plan $	$100-$199.99
City of Owatonna	3 or more	$750			$2,000+	$60+	$100-$199.99
City of South St. Paul	1	$2,000	$25	$75	No orthodontia coverage	$0-$9.99	$60-$79.99
City of Stillwater	1	$1,000	$0	$0	$1,000-$1,499	$0-$9.99	$80-$99.99
City of West St Paul	1	$2,000	$25	$75	$2,000+	$30-$39.99	$0-$19.99
City of White Bear Lake	1	$1,500	$25	$75	No orthodontia coverage	$40-$49.99	$100-$199.99
Average	1	$1,977	$223	$270	n/a	n/a	n/a
Most Common	1	$2,000	$25	$75	No orthodontia coverage	$0-$9.99	$100-$199.99
City of Northfield	2	$1,000	$50	3 per family; applies to all levels	No orthodontia coverage	$0-$9.99	$20-$39.99

Source: 2024 MN Local Government Salary & Benefits Survey unless noted.

Next Steps

Next Steps

2025 Renewal

- City Council Approval
- Open Enrollment
    - Ease

Gallagher

Appendix:

2025 Gravie Offer Details

Carrier Name	BlueCross BlueShield of Minnesota			Gravie		
Plan Name	**T24075 HSA $3,200**	**T24111 $1,000**	**T24032 $500 Ded**	**Gravie HSA $3,200 Ded/$3,200 OOPM**	**Gravie Copay $1,000 Ded/$5,000 OOPM V**	**Gravie Copay $500 Ded/$2,000 OOPM V**
PLAN DESIGN*						
In-Network Benefits	Aware Network	Aware Network	Aware Network	Traditional - Aetna Network	Traditional - Aetna Network	Traditional - Aetna Network
Deductible Type	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Calendar Year (CY) Deductible (Individual / Family)	$3,200 / $6,400	$1,000 / $3,000	$500 / $1,500	$3,200 / $6,400	$1,000 / $2,000	$500 / $1,000
Out-of-Pocket Max Type	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
CY Out-of-Pocket Max (Individual / Family)	$3,200 / $6,400	$5,000 / $10,000	$2,000 / $4,000	$3,200 / $6,400	$5,000 / $10,000	$2,000 / $4,000
Coinsurance (member pays after deductible)	0%	30%	20%	0%	30%	20%
Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Primary Care Visit	0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	$30 Copay	$25 Copay
Specialist Visit	0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	$50 Copay	$25 Copay
Urgent Care	0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	$75 Copay	$25 Copay
Emergency Room	0% after deductible	30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	$500 Copay	10% after deductible
Inpatient Hospital	0% after deductible	30% after deductible	20% after deductible	0% after deductible	30% after deductible	20% after deductible
Outpatient Surgery	0% after deductible	30% after deductible	20% after deductible	0% after deductible		
Chiropractic (visit limits may apply)	0% after deductible	Spinal Manipulation: $40 Copay; Other Chiropractic: 30% after deductible	Spinal Manipulation: $25 Copay; Other Chiropractic: 30% after deductible	0% after deductible	subject to copay	subject to copay
Phys/Occ/Speech Therapy (visit limits may apply)	0% after deductible	30% after deductible	20% after deductible	Sword Program	Sword Program	Sword Program
Diagnostic Test (X-ray, blood work)	0% after deductible	30% after deductible	20% after deductible	0% after deductible	30% after deductible	20% after deductible
Imaging (CT/PET scan, MRI)	0% after deductible	30% after deductible	20% after deductible	0% after deductible	30% after deductible	20% after deductible
Prescription Drug Benefit						
Retail	31 Days	31 Days	31 Days	30 Days	30 Days	30 Days
Tier I / Tier II / Tier III / Tier IV	0% after deductible	$20 / $50 / $75 / $120	$20 / $50 / $75 / $120	0% after deductible	$10 / $50 / 50% after deductible	$5 / $25 / 50% after deductible
Specialty	0% after deductible	30% to max $500	20% to max $500	0% after deductible	No cost with Prudent Rx; 20% after deductible	No cost with Prudent Rx; 20% after deductible
Mail Order	90 Days	90 Days	90 Days	90 Days	90 Days	90 Days
Tier I / Tier II / Tier III / Tier IV	0% after deductible	$60 / $150 / $225 / $360	$60 / $150 / $225 / $360	0% after deductible	$20 / $100 / 50% after deductible	$10 / $50 / 50% after deductible
Out-of-Network Benefits						
Deductible Type	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
CY Deductible (Individual / Family)	$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000
Out-of-Pocket Max Type	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
CY Out-of-Pocket Max (Individual / Family)	$10,000 / $20,000	$10,000 / $20,000	$10,000 / $20,000	$10,000 / $20,000	$10,000 / $20,000	$10,000 / $20,000
Coinsurance (member pays after deductible)	50%	50%	50%	50%	50%	50%
COST ANALYSIS						
PEPM Rates - Enrollment per Renewal	Plan 1 / Plan 2 / Plan 3	T24075 HSA $3,200	T24111 $1,000	T24032 $500 Ded	Gravie HSA $3,200 Ded/$3,200 OOPM	Gravie Copay $1,000 Ded/$5,000 OOPM V	Gravie Copay $500 Ded/$2,000 OOPM V
Employee (EE) Only	46 / 2 / 11	$759.18	$834.18	$945.28	$740.96	$769.99	$892.54
EE + Family	38 / 1 / 3	$2,026.94	$2,227.18	$2,523.80	$1,978.31	$2,055.80	$2,383.01
Total Enrollment	**84 / 3 / 14**						
Estimated Monthly Premium		$111,946	$3,896	$17,969	$109,260	$3,596	$16,967
Estimated Annual Premium		**$1,343,352**	**$46,746**	**$215,634**	**$1,311,119**	**$43,149**	**$203,604**
Dollar Difference from Current					**-$32,233**	**-$3,597**	**-$12,030**
Percent Change from Current					**-2.4%**	**-7.7%**	**-5.6%**
Total Combined Annual Cost							
		CURRENT			**Market Opt-Gravie**		
Estimated Annual Premium		**$1,605,732**			**$1,557,872**		
Dollar Difference from Current					**-$47,860**		
Percent Change from Current					**-3.0%**		
PLAN PROVISIONS							
Rate Guarantee		1 Year rate guarantee ending 12/31/2024			1 Year rate guarantee ending 12/31/2025 $10,000 Implementation/Wellness Credit Contingencies: Receipt of Renewal and updated monthly claims through 8/31/24		

**NOTE: Benefit deviations from Current are identified in blue font*

2025 MHC Offer Details

Carrier Name	BlueCross BlueShield of Minnesota			Minnesota Healthcare Consortium		
Plan Name	**T24075 HSA $3,200**	**T24111 $1,000**	**T24032 $500 Ded**	**MSI Medica Choice Passport ASO 3300-0% HSA**	**MSI Medica Choice Passport ASO 1000-40-30%**	**MSI Medica Choice Passport ASO 500-25-20%**
PLAN DESIGN*						
In-Network Benefits	Aware Network	Aware Network	Aware Network	Choice Passport	Choice Passport	Choice Passport
Deductible Type	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Calendar Year (CY) Deductible (Individual / Family)	$3,200 / $6,400	$1,000 / $3,000	$500 / $1,500	$3,300 / $6,600	$1,000 / $3,000	$500 / $1,500
Out-of-Pocket Max Type	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
CY Out-of-Pocket Max (Individual / Family)	$3,200 / $6,400	$5,000 / $10,000	$2,000 / $4,000	$3,300 / $6,600	$5,000 / $10,000	$2,000 / $4,000
Coinsurance (member pays after deductible)	0%	30%	20%	0%	30%	20%
Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Primary Care Visit	0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	$40 Copay	$25 Copay
Specialist Visit	0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	$40 Copay	$25 Copay
Urgent Care	0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	$40 Copay	$25 Copay
Emergency Room	0% after deductible	30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	30% after deductible	20% after deductible
Inpatient Hospital	0% after deductible	30% after deductible	20% after deductible	0% after deductible	30% after deductible	20% after deductible
Outpatient Surgery	0% after deductible	30% after deductible	20% after deductible	0% after deductible	30% after deductible	20% after deductible
Chiropractic (visit limits may apply)	0% after deductible	Spinal Manipulation: $40 Copay; Other Chiropractic: 30% after deductible	Spinal Manipulation: $25 Copay; Other Chiropractic: 30% after deductible	0% after deductible	$40 Copay	$25 Copay
Phys/Occ/Speech Therapy (visit limits may apply)	0% after deductible	30% after deductible	20% after deductible	0% after deductible	$40 Copay	$25 Copay
Diagnostic Test (X-ray, blood work)	0% after deductible	30% after deductible	20% after deductible	0% after deductible	Lab: Covered 100% X-ray: 30% after deductible	Lab: Covered 100% X-ray: 20% after deductible
Imaging (CT/PET scan, MRI)	0% after deductible	30% after deductible	20% after deductible	0% after deductible	30% after deductible	20% after deductible
Prescription Drug Benefit						
Retail	31 Days	31 Days	31 Days	31 Days	31 Days	31 Days
Tier I / Tier II / Tier III / Tier IV	0% after deductible	$20 / $50 / $75 / $120	$20 / $50 / $75 / $120	0% after deductible	$20 / $50 / $95	$20 / $50 / $95
Specialty	0% after deductible	30% to max $500	20% to max $500	0% after deductible	Preferred: 20% to max $200 Non Preferred: 40%	Preferred: 20% to max $200 Non Preferred: 40%
Mail Order	90 Days	90 Days	90 Days	93 Days	93 Days	93 Days
Tier I / Tier II / Tier III / Tier IV	0% after deductible	$60 / $150 / $225 / $360	$60 / $150 / $225 / $360	0% after deductible	$40 / $100 / $190	$40 / $100 / $190
Out-of-Network Benefits						
Deductible Type	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
CY Deductible (Individual / Family)	$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000	$5,500 / $11,000	$5,000 / $10,000	$5,000 / $10,000
Out-of-Pocket Max Type	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
CY Out-of-Pocket Max (Individual / Family)	$10,000 / $20,000	$10,000 / $20,000	$10,000 / $20,000	$11,000 / $22,000	$10,000 / $20,000	$10,000 / $20,000
Coinsurance (member pays after deductible)	50%	50%	50%	50%	50%	50%
COST ANALYSIS						
PEPM Rates - Enrollment per Renewal	T24075 HSA $3,200	T24111 $1,000	T24032 $500 Ded	MSI Medica Choice Passport ASO 3300-0% HSA	MSI Medica Choice Passport ASO 1000-40-30%	MSI Medica Choice Passport ASO 500-25-20%
Employee (EE) Only (Plan 1: 46, Plan 2: 2, Plan 3: 11)	$759.18	$834.18	$945.28	$781.14	$819.22	$919.46
EE + Family (Plan 1: 38, Plan 2: 1, Plan 3: 3)	$2,026.94	$2,227.18	$2,523.80	$2,085.54	$2,187.26	$2,454.88
Total Enrollment (Plan 1: **84**, Plan 2: **3**, Plan 3: **14**)						
Estimated Monthly Premium	$111,946	$3,896	$17,969	$115,183	$3,826	$17,479
Estimated Annual Premium	**$1,343,352**	**$46,746**	**$215,634**	**$1,382,196**	**$45,908**	**$209,744**
Dollar Difference from Current				**$38,844**	**-$838**	**-$5,889**
Percent Change from Current				**2.9%**	**-1.8%**	**-2.7%**
Total Combined Annual Cost						
	CURRENT			**MARKET OPTION 3**		
Estimated Annual Premium	**$1,605,732**			**$1,637,848**		
Dollar Difference from Current				**$32,116**		
Percent Change from Current				**2.0%**		
PLAN PROVISIONS						
Rate Guarantee	1 Year rate guarantee ending 12/31/2024			1 Year rate guarantee ending 12/31/2025		

**NOTE: Benefit deviations from Current are identified in blue font*

2025 The Better Health Collective - Sourcewell Offer Details – Smart Plans

				CURRENT			MARKET OPTION 4		
			Carrier Name	BlueCross BlueShield of Minnesota			The Better Health Collective - Sourcewell		
			Plan Name	T24075 HSA $3,200	T24111 $1,000	T24032 $500 Ded	Smart Plan 3: 3300-100-3300-PrevRx-Aware	Smart Plan 2: 1650NE-80-3650-PrevRx-Aware	Smart Plan 1: 1650NE-100-1650-PrevRx-Aware
PLAN DESIGN*									
In-Network Benefits				Aware Network	Aware Network	Aware Network	Aware Network	Aware Network	Aware Network
Deductible Type				Embedded	Embedded	Embedded	Embedded	Aggregate	Aggregate
Calendar Year (CY) Deductible (Individual / Family)				$3,200 / $6,400	$1,000 / $3,000	$500 / $1,500	$3,300 / $6,600	$1,650 / $3,300	$1,650 / $3,300
Out-of-Pocket Max Type				Embedded	Embedded	Embedded	Embedded	Aggregate	Aggregate
CY Out-of-Pocket Max (Individual / Family)				$3,200 / $6,400	$5,000 / $10,000	$2,000 / $4,000	$3,300 / $6,600	$3,650 / $7,300	$1,650 / $3,300
Coinsurance (member pays after deductible)				0%	30%	20%	0%	20%	0%
Preventive Care				Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Primary Care Visit				0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	20% after deductible	0% after deductible
Specialist Visit				0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	20% after deductible	0% after deductible
Urgent Care				0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	20% after deductible	0% after deductible
Emergency Room				0% after deductible	30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	20% after deductible	0% after deductible
Inpatient Hospital				0% after deductible	30% after deductible	20% after deductible	0% after deductible	20% after deductible	0% after deductible
Outpatient Surgery				0% after deductible	30% after deductible	20% after deductible	0% after deductible	20% after deductible	0% after deductible
Chiropractic (visit limits may apply)				0% after deductible	Spinal Manipulation: $40 Copay; Other Chiropractic: 30% after deductible	Spinal Manipulation: $25 Copay; Other Chiropractic: 30% after deductible	0% after deductible	20% after deductible	0% after deductible
Phys/Occ/Speech Therapy (visit limits may apply)				0% after deductible	30% after deductible	20% after deductible	0% after deductible	20% after deductible	0% after deductible
Diagnostic Test (X-ray, blood work)				0% after deductible	30% after deductible	20% after deductible	0% after deductible	20% after deductible	0% after deductible
Imaging (CT/PET scan, MRI)				0% after deductible	30% after deductible	20% after deductible	0% after deductible	20% after deductible	0% after deductible
Prescription Drug Benefit							Prev. Rx Generic $0; Brand $50 copay	Prev. Rx Generic $0; Brand $50 copay	Prev. Rx Generic $0; Brand $50 copay
Retail				31 Days	31 Days	31 Days	31 Days	31 Days	31 Days
Tier I / Tier II / Tier III / Tier IV				0% after deductible	$20 / $50 / $75 / $120	$20 / $50 / $75 / $120	0% after deductible	20% after deductible	0% after deductible
Specialty				0% after deductible	30% to max $500	20% to max $500	0% after deductible	20% after deductible	0% after deductible
Mail Order				90 Days	90 Days	90 Days	93 Days	93 Days	93 Days
Tier I / Tier II / Tier III / Tier IV				0% after deductible	$60 / $150 / $225 / $360	$60 / $150 / $225 / $360	0% after deductible	20% after deductible	0% after deductible
Out-of-Network Benefits							Non-Creditable	Non-Creditable	Creditable
Deductible Type				Embedded	Embedded	Embedded	Embedded	Aggregate	Aggregate
CY Deductible (Individual / Family)				$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000	$6,600 / $13,200	$3,300 / $6,600	$3,300 / $6,600
Out-of-Pocket Max Type				Embedded	Embedded	Embedded	Embedded	Aggregate	Aggregate
CY Out-of-Pocket Max (Individual / Family)				$10,000 / $20,000	$10,000 / $20,000	$10,000 / $20,000	$9,900 / $19,800	$7,300 / $14,600	$4,950 / $9,900
Coinsurance (member pays after deductible)				50%	50%	50%	20%	40%	20%
COST ANALYSIS									
PEPM Rates - Enrollment per Renewal	Plan 1	Plan 2	Plan 3	T24075 HSA $3,200	T24111 $1,000	T24032 $500 Ded	Smart Plan 3: 3300-100-3300-PrevRx-Aware	Smart Plan 2: 1650NE-80-3650-PrevRx-Aware	Smart Plan 1: 1650NE-100-1650-PrevRx-Aware
Employee (EE) Only	46	2	11	$759.18	$834.18	$945.28	$849.00	$883.00	$947.00
EE + Family	38	1	3	$2,026.94	$2,227.18	$2,523.80	$2,156.00	$2,246.00	$2,418.00
Total Enrollment	**84**	**3**	**14**						
Estimated Monthly Premium				$111,946	$3,896	$17,969	$120,982	$4,012	$17,671
Estimated Annual Premium				**$1,343,352**	**$46,746**	**$215,634**	**$1,451,784**	**$48,144**	**$212,052**
			Dollar Difference from Current				**$108,432**	**$1,398**	**-$3,582**
			Percent Change from Current				**8.1%**	**3.0%**	**-1.7%**
Total Combined Annual Cost									
				CURRENT			MARKET OPTION 4		
Estimated Annual Premium				**$1,605,732**			**$1,711,980**		
			Dollar Difference from Current				**$106,248**		
			Percent Change from Current				**6.6%**		
PLAN PROVISIONS									
Rate Guarantee				1 Year rate guarantee ending 12/31/2024					

**NOTE: Benefit deviations from Current are identified in blue font*

2025 UHC Offer Details

Carrier Name	BlueCross BlueShield of Minnesota			UnitedHealthcare			
Plan Name	**T24075 HSA $3,200**	**T24111 $1,000**	**T24032 $500 Ded**	**DQ-DD MOD (CH+ HSA) Rx Plan: 2V - HSA**	**DQ-EH MOD (CH+ Premier) Rx Plan: EJ**	**DQ-EE MOD (CH+ Premier) Rx Plan: EJ**	**Surest A+1500 Option**
PLAN DESIGN*							
In-Network Benefits	Aware Network	Aware Network	Aware Network	Choice Plus	Choice Plus	Choice Plus	Choice Plus
Deductible Type	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Calendar Year (CY) Deductible (Individual / Family)	$3,200 / $6,400	$1,000 / $3,000	$500 / $1,500	$3,300 / $6,600	$1,000 / $2,000	$500 / $1,000	$0 / $0
Out-of-Pocket Max Type	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
CY Out-of-Pocket Max (Individual / Family)	$3,200 / $6,400	$5,000 / $10,000	$2,000 / $4,000	$3,300 / $6,600	$5,000 / $10,000	$2,000 / $4,000	$1,500 / $3,000
Coinsurance (member pays after deductible)	0%	30%	20%	0%	30%	20%	n/a
Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Primary Care Visit	0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	$40 Copay; For Child: Covered 100%	$25 Copay; For Child: Covered 100%	$5 to $25 Copay
Specialist Visit	0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	$40 Copay; $80 Copay	$25 Copay; $50 Copay	$5 to $25 Copay
Urgent Care	0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	$40 Copay	$25 Copay	$10 copay
Emergency Room	0% after deductible	30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	30% after deductible	20% after deductible	$100 copay
Inpatient Hospital	0% after deductible	30% after deductible	20% after deductible	0% after deductible	30% after deductible	20% after deductible	$75 to $1,200 copay
Outpatient Surgery	0% after deductible	30% after deductible	20% after deductible	0% after deductible	30% after deductible	20% after deductible	$5 to $1,200 copay
Chiropractic (visit limits may apply)	0% after deductible	Spinal Manipulation: $40 Copay; Other Chiropractic: 30% after deductible	Spinal Manipulation: $25 Copay; Other Chiropractic: 30% after deductible	0% after deductible	30% after deductible	20% after deductible	Copays - details not provided in proposal
Phys/Occ/Speech Therapy (visit limits may apply)	0% after deductible	30% after deductible	20% after deductible	0% after deductible	30% after deductible	20% after deductible	Copays - details not provided in proposal
Diagnostic Test (X-ray, blood work)	0% after deductible	30% after deductible	20% after deductible	0% after deductible	$0 copay	$0 copay	$0 copay
Imaging (CT/PET scan, MRI)	0% after deductible	30% after deductible	20% after deductible	0% after deductible	30% after deductible	20% after deductible	$0 copay
Prescription Drug Benefit							
Retail	31 Days	31 Days	31 Days	30 Days	30 Days	30 Days	30 Days
Tier I / Tier II / Tier III / Tier IV	0% after deductible	$20 / $50 / $75 / $120	$20 / $50 / $75 / $120	$10 / $35 / $60 after deductible	$15 / $45 / $85 / $200	$15 / $45 / $85 / $200	$10 / $35 / $70
Specialty	0% after deductible	30% to max $500	20% to max $500				
Mail Order	90 Days	90 Days	90 Days	90 Days	90 Days	90 Days	90 Days
Tier I / Tier II / Tier III / Tier IV	0% after deductible	$60 / $150 / $225 / $360	$60 / $150 / $225 / $360	$25 / $87.50 / $150 after deductible	$37.50 / $112.50 / $212.50 / $500	$37.50 / $112.50 / $212.50 / $500	$25/ $87.50 / $175
Out-of-Network Benefits							
Deductible Type	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
CY Deductible (Individual / Family)	$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000	$0 / $0
Out-of-Pocket Max Type	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
CY Out-of-Pocket Max (Individual / Family)	$10,000 / $20,000	$10,000 / $20,000	$10,000 / $20,000	$10,000 / $20,000	$10,000 / $20,000	$10,000 / $20,000	$8,000 / $16,000
Coinsurance (member pays after deductible)	50%	50%	50%	30%	50%	50%	n/a
COST ANALYSIS							

PEPM Rates - Enrollment per Renewal	Plan 1	Plan 2	Plan 3	T24075 HSA $3,200	T24111 $1,000	T24032 $500 Ded	DQ-DD MOD (CH+ HSA) Rx Plan: 2V - HSA	DQ-EH MOD (CH+ Premier) Rx Plan: EJ	DQ-EE MOD (CH+ Premier) Rx Plan: EJ	Surest A+1500 Option
Employee (EE) Only	46	2	11	$759.18	$834.18	$945.28	$825.04	$891.22	$1,006.71	$1,029.99
EE + Family	38	1	3	$2,026.94	$2,227.18	$2,523.80	$2,202.77	$2,379.47	$2,687.81	$2,749.97
Total Enrollment	**84**	**3**	**14**							
Estimated Monthly Premium				$111,946	$3,896	$17,969	$121,657	$4,162	$19,137	$19,580
Estimated Annual Premium				**$1,343,352**	**$46,746**	**$215,634**	**$1,459,885**	**$49,943**	**$229,647**	**$234,958**
Dollar Difference from Current							**$116,533**	**$3,196**	**$14,013**	**$19,324**
Percent Change from Current							**8.7%**	**6.8%**	**6.5%**	**9.0%**

Total Combined Annual Cost	**CURRENT**	**MARKET OPTION 6**
Estimated Annual Premium	**$1,605,732**	**$1,739,475**
Dollar Difference from Current		**$133,743**
Percent Change from Current		**8.3%**
PLAN PROVISIONS		
Rate Guarantee	1 Year rate guarantee ending 12/31/2024	1 Year rate guarantee ending 12/31/2025

**NOTE: Benefit deviations from Current are identified in blue font*

2025 PEIP Offer Details

Carrier Name	Public Employees Insurance Program							
Plan Name	HSA Plan Option				Advantage Health Plan High option			
PLAN DESIGN*								
In-Network Benefits	Level 1	Level 2	Level 3	Level 4	Level 1	Level 2	Level 3	Level 4
Deductible Type	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Calendar Year (CY) Deductible (Individual / Family)	$1,600 / $3,400 (Individual within family: $3,200)	$2,000 / $4,000 (Individual within family: $3,200)	$3,000 / $6,000 (Individual within family: $4,800)	$4,000 / $8,000 (Individual within family: $6,400)	$250 / $500	$400 / $800	$750 / $1,500	$1,500 / $3,000
Out-of-Pocket Max Type	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
CY Out-of-Pocket Max (Individual / Family)	$3,000 / $6,000 (Individual within family: $5,000)	$3,000 / $6,000 (Individual within family: $5,000)	$4,000 / $8,000 (Individual within family: $6,900)	$5,000 / $10,000 (Individual within family: $6,900)	$1,700 / $3,400	$1,700 / $3,400	$2,400 / $4,800	3,600 / $7,200
Coinsurance (member pays after deductible)	0%	0%	0%	50%	0%	0%	0%	25%
Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Primary Care Visit	$45 Copay after deductible	$55 Copay after deductible	$105 Copay after deductible	$130 Copay after deductible	$30 Copay after deductible	$35 Copay after deductible	$65 Copay after deductible	$85 Copay after deductible
Specialist Visit	$45 Copay after deductible	$55 Copay after deductible	$105 Copay after deductible	$130 Copay after deductible	$30 Copay after deductible	$35 Copay after deductible	$65 Copay after deductible	$85 Copay after deductible
Urgent Care	$45 Copay after deductible	$55 Copay after deductible	$105 Copay after deductible	$130 Copay after deductible	$30 Copay after deductible	$35 Copay after deductible	$65 Copay after deductible	$85 Copay after deductible
Emergency Room	$250 Copay after deductible	$300 Copay after deductible	$350 Copay after deductible	$600 Copay after deductible	$100 Copay	$125 Copay	$150 Copay	$350 Copay
Inpatient Hospital	$400 Copay after deductible	$650 Copay after deductible	$1,500 Copay after deductible	50% after deductible	$100 Copay after deductible	$200 Copay after deductible	$500 Copay after deductible	25% after deductible
Outpatient Surgery	$250 Copay after deductible	$400 Copay after deductible	$800 Copay after deductible	50% after deductible	$60 Copay after deductible	$120 Copay after deductible	$250 Copay after deductible	25% after deductible
Chiropractic (visit limits may apply)	$45 Copay after deductible	$55 Copay after deductible	$105 Copay after deductible	$130 Copay after deductible	$30 Copay after deductible	$35 Copay after deductible	$65 Copay after deductible	$85 Copay after deductible
Phys/Occ/Speech Therapy (visit limits may apply)	$45 Copay after deductible	$55 Copay after deductible	$105 Copay after deductible	$130 Copay after deductible	$30 Copay after deductible	$35 Copay after deductible	$65 Copay after deductible	$85 Copay after deductible
Diagnostic Test (X-ray, blood work)	20% after deductible	25% after deductible	30% after deductible	50% after deductible	10% after deductible	10% after deductible	20% after deductible	25% after deductible
Imaging (CT/PET scan, MRI)	20% after deductible	25% after deductible	30% after deductible	50% after deductible	10% after deductible	15% after deductible	25% after deductible	30% after deductible
Prescription Drug Benefit								
Retail	30 Days	30 Days	30 Days	30 Days	30 Days	30 Days	30 Days	30 Days
Tier I / Tier II / Tier III / Tier IV	$30 / $50 / $75 after deductible	$30 / $50 / $75 after deductible	$30 / $50 / $75 after deductible	$30 / $50 / $75 after deductible	$18 / $30 / $55	$18 / $30 / $55	$18 / $30 / $55	$18 / $30 / $55
Specialty								
Mail Order	90 Days	90 Days	90 Days	90 Days	90 Days	90 Days	90 Days	90 Days
Tier I / Tier II / Tier III / Tier IV								
Out-of-Network Benefits								
Deductible Type	N/A				N/A			
CY Deductible (Individual / Family)	N/A				N/A			
Out-of-Pocket Max Type	N/A				N/A			
CY Out-of-Pocket Max (Individual / Family)	N/A				N/A			
Coinsurance (member pays after deductible)	N/A				N/A			

COST ANALYSIS					
PEPM Rates - Enrollment per Renewal	Plan 1	Plan 2	Plan 3	HSA Plan Option	Advantage Health Plan High option
Employee (EE) Only	46	2	11	$835.18	$1,173.40
EE + Family	38	1	3	$2,144.26	$3,047.28
Total Enrollment	**84**	**3**	**14**		
Estimated Monthly Premium				$119,900	$27,443
Estimated Annual Premium				**$1,438,802**	**$329,320**
Dollar Difference from Current				**$95,450**	**$282,573**
Percent Change from Current				**7.1%**	**604.5%**
Total Combined Annual Cost					
				MARKET OPTION 1	
Estimated Annual Premium				**$1,768,122**	
Dollar Difference from Current				**$162,390**	
Percent Change from Current				**10.1%**	
PLAN PROVISIONS					
Rate Guarantee	1 Year rate guarantee ending 12/31/2025 - 4 Year Commitment Required				
Required Participation	PEIP medical coverage requires that 75% of your group's insurance eligible individuals must participate.				

**NOTE: Benefit deviations from Current are identified in blue font*

2025 BCBS Dental

Carrier Name	Guardian				Blue Cross Blue Sheild #1		Blue Cross Blue Sheild #2	
Plan Name	**Low Plan - DentalGuard Preferred Gold & Silver**		**High Plan - DentalGuard Preferred Gold & Silver**		**Freedom Standard**		**Freedom Enhananced Plan 1**	
PLAN DESIGN*								
Network	**INN [DentalGuard Preferred Network]**	**OON**	**INN [DentalGuard Preferred Network]**	**OON**	**INN [Advantage Plus AXS]**	**OON**	**INN [Advantage Plus AXS]**	**OON**
Calendar Year (CY) Deductible (Individual / Family)	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Annual Maximum	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$500
Annual Maximum Provision	Rollover Threshold: $500; Maximum Rollover Reward: $250; Rollover Account Maximum: $1,000		Rollover Threshold: $500; Maximum Rollover Reward: $250; Rollover Account Maximum: $1,000		not included	not included	not included	not included
Coinsurance								
Preventive Services	100%	100%	100%	100%	100%	100%	100%	100%
Cleaning Frequency	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	2 per calendar year	2 per calendar year	2 per calendar year	2 per calendar year
Basic	50%	50%	80%	80%	50%	50%	80%	80%
Periodontics	5%	5%	50%	50%	50%	50%	80%	80%
Endodontics	5%	5%	50%	50%	50% includes root canal	50% includes root canal	80% includes root canal	80% includes root canal
Major	5%	5%	50%	50%	5%	5%	50%	50%
Implants	5%	5%	50%	50%	5%	5%	50%	50%
Orthodontics	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
OON Reimbursement Level	90th percentile of the prevailing fee		90th percentile of the prevailing fee		Maximum allowable charge		Maximum allowable charge	
COST ANALYSIS								
PEPM Rates - Enrollment per AMP	Plan 1	Plan 2	Low Plan - DentalGuard Preferred Gold & Silver	High Plan - DentalGuard Preferred Gold & Silver	Freedom Standard		Freedom Enhananced Plan 1	
Employee (EE) Only	30	24	$18.56	$36.64	$27.39		$35.25	
EE + Spouse	3	10	$37.66	$74.36	$55.59		$71.55	
EE + Child(ren)	3	5	$60.46	$92.86	$69.42		$89.35	
EE + Family	8	13	$86.00	$139.22	$104.07		$133.95	
Total Enrollment	**44**	**52**						
Estimated Monthly Premium			$1,539	$3,897	$4,943		$6,361	
Estimated Annual Premium			**$18,470**	**$46,765**	**$59,311**		**$76,337**	
Total Combined Annual Cost								
Estimated Annual Premium			**$65,235**		**$59,311**		**$76,337**	
Dollar Difference from Current					**-$5,925**		**$11,101**	
Percent Change from Current					**-9.1%**		**17.0%**	
PLAN PROVISIONS								
Rate Guarantee	1 Year rate guarantee ending 12/31/2024				1 Year rate guarantee ending 12/31/2025			

**NOTE: Benefit deviations from Current are identified in blue font*

2025 Delta Dental

Carrier Name	Guardian				Delta Dental		Delta Dental	
Plan Name	Low Plan - DentalGuard Preferred Gold & Silver		High Plan - DentalGuard Preferred Gold & Silver		Dental PPO / Premier - Plan A		Dental PPO / Premier - Plan B	
PLAN DESIGN*								
Network	INN [DentalGuard Preferred Network]	OON	INN [DentalGuard Preferred Network]	OON	INN [Delta Dental PPO Plus Premier]	OON	INN [Delta Dental PPO Plus Premier]	OON
Calendar Year (CY) Deductible (Individual / Family)	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Annual Maximum	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,500	$1,500
Annual Maximum Provision	Rollover Threshold: $500; Maximum Rollover Reward: $250; Rollover Account Maximum: $1,000		Rollover Threshold: $500; Maximum Rollover Reward: $250; Rollover Account Maximum: $1,000		not included	not included	not included	not included
Coinsurance								
Preventive Services	100%	100%	100%	100%	100%	100%	100%	100%
Cleaning Frequency	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	2 times per calendar year	2 times per calendar year	2 times per calendar year	2 times per calendar year
Deductible Waived?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Basic	50%	50%	80%	80%	80%	80%	80%	80%
Periodontics	5%	5%	50%	50%	50%	50%	50%	50%
Endodontics	5%	5%	50%	50%	50%	50%	50%	50%
Major	5%	5%	50%	50%	50%	50%	50%	50%
Major Waiting period	none	none	none	none	None	None	None	None
Implants	5%	5%	50%	50%	50%	50%	50%	50%
Orthodontics	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Maximum Age	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Lifetime Max	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Ortho Waiting Period	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
OON Reimbursement Level	90th percentile of the prevailing fee		90th percentile of the prevailing fee		50th Percentile		50th Percentile	

COST ANALYSIS						
PEPM Rates - Enrollment per AMP	Plan 1	Plan 2	Low Plan - DentalGuard Preferred Gold & Silver	High Plan - DentalGuard Preferred Gold & Silver	Dental PPO / Premier - Plan A	Dental PPO / Premier - Plan B
Employee (EE) Only	30	24	$18.56	$36.64	$41.18	$43.38
EE + Spouse	3	10	$37.66	$74.36	$83.58	$88.04
EE + Child(ren)	3	5	$60.46	$92.86	$104.36	$109.94
EE + Family	8	13	$86.00	$139.22	$156.48	$164.84
Total Enrollment	**44**	**52**				
Estimated Monthly Premium			$1,539	$3,897	$7,431	$7,828
Estimated Annual Premium			**$18,470**	**$46,765**	**$89,175**	**$93,938**
Total Combined Annual Cost						
Estimated Annual Premium			**$65,235**		**$89,175**	**$93,938**
Dollar Difference from Current					**$23,939**	**$28,703**
Percent Change from Current					**36.7%**	**44.0%**
PLAN PROVISIONS						
Rate Guarantee			1 Year rate guarantee ending 12/31/2024		2 Year rate guarantee ending 12/31/2026	

**NOTE: Benefit deviations from Current are identified in blue font*

2025 Guardian Dental – Alternate Plan Option $1500 Annual Max

	CURRENT				$1500 Annual Max Option			
Carrier Name	Guardian				Guardian			
Plan Name	Low Plan - DentalGuard Preferred Gold & Silver		High Plan - DentalGuard Preferred Gold & Silver		Low Plan-DentalGuard Preferred Gold & Silver		Buy up High Plan-DentalGuard Preferred Gold & Silver	
PLAN DESIGN*								
Network	**INN [DentalGuard Preferred Network]**	**OON**	**INN [DentalGuard Preferred Network]**	**OON**	**INN [DentalGuard Preferred Network]**	**OON**	**INN [DentalGuard Preferred Network]**	**OON**
Calendar Year (CY) Deductible (Individual / Family)	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Annual Maximum	$1,000	$1,000	$1,000	$1,000	$1,500	$1,500	$1,500	$1,500
Annual Maximum Provision	Rollover Threshold: $500; Maximum Rollover Reward: $250; Rollover Account Maximum: $1,000		Rollover Threshold: $500; Maximum Rollover Reward: $250; Rollover Account Maximum: $1,000		Rollover Threshold: $700; Maximum Rollover Reward: $350; Rollover Account Maximum: $1,250		Rollover Threshold: $700; Maximum Rollover Reward: $350; Rollover Account Maximum: $1,250	
Coinsurance								
Preventive Services	100%	100%	100%	100%	100%	100%	100%	100%
Cleaning Frequency	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months
Deductible Waived?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Basic	50%	50%	80%	80%	50%	50%	80%	80%
Periodontics	5%	5%	50%	50%	5%	5%	50%	50%
Endodontics	5%	5%	50%	50%	5%	5%	50%	50%
Major	5%	5%	50%	50%	5%	5%	50%	50%
Major Waiting period	none	none	none	none	none	none	none	none
Implants	5%	5%	50%	50%	5%	5%	50%	50%
Orthodontics	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
OON Reimbursement Level	90th percentile of the prevailing fee		90th percentile of the prevailing fee		90th percentile of the prevailing fee		90th percentile of the prevailing fee	
COST ANALYSIS								
PEPM Rates - Enrollment per AMP	Plan 1	Plan 2	Low Plan - DentalGuard Preferred Gold & Silver		High Plan - DentalGuard Preferred Gold & Silver		Low Plan-DentalGuard Preferred Gold & Silver	Buy up High Plan-DentalGuard Preferred Gold & Silver
Employee (EE) Only	30	24	$18.56		$36.64		$23.68	$46.75
EE + Spouse	3	10	$37.66		$74.36		$48.05	$94.88
EE + Child(ren)	3	5	$60.46		$92.86		$77.15	$118.49
EE + Family	8	13	$86.00		$139.22		$109.74	$177.64
Total Enrollment	**44**	**52**						
Estimated Monthly Premium			$1,539		$3,897		$1,964	$4,973
Estimated Annual Premium			**$18,470**		**$46,765**		**$23,567**	**$59,671**
Dollar Difference from Current							**$5,097**	**$12,905**
Percent Change from Current							**27.6%**	**27.6%**
Total Combined Annual Cost								
Estimated Annual Premium			**$65,235**				**$83,238**	
Dollar Difference from Current							**$18,003**	
Percent Change from Current							**27.6%**	
PLAN PROVISIONS								
Rate Guarantee	1 Year rate guarantee ending 12/31/2024				1 Year rate Guarantee Ending 12/31/2025			

**NOTE: Benefit deviations from Current are identified in blue font*

2025 UHC Dental

Carrier Name	Guardian				UHC			
Plan Name	Low Plan - DentalGuard Preferred Gold & Silver		High Plan - DentalGuard Preferred Gold & Silver		Passive PPO 31256204 V1		Passive PPO 31256203 V1	
PLAN DESIGN*								
Network	INN [DentalGuard Preferred Network]	OON	INN [DentalGuard Preferred Network]	OON	INN	OON	INN	OON
Calendar Year (CY) Deductible (Individual / Family)	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Annual Maximum	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000
Annual Maximum Provision	Rollover Threshold: $500; Maximum Rollover Reward: $250; Rollover Account Maximum: $1,000		Rollover Threshold: $500; Maximum Rollover Reward: $250; Rollover Account Maximum: $1,000		No		No	
Coinsurance								
Preventive Services	100%	100%	100%	100%	100%	100%	100%	100%
Cleaning Frequency	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months	1 in 6 months
Deductible Waived?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Basic	50%	50%	80%	80%	50%	50%	80%	80%
Periodontics	5%	5%	50%	50%	50%	50%	80%	80%
Endodontics	5%	5%	50%	50%	50%	50%	80%	80%
Major	5%	5%	50%	50%	5%	5%	50%	50%
Implants	5%	5%	50%	50%	Not Covered	Not Covered	Not Covered	Not Covered
Orthodontics	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
OON Reimbursement Level	90th percentile of the prevailing fee		90th percentile of the prevailing fee		UCR 90th		UCR 90th	
COST ANALYSIS								
PEPM Rates - Enrollment per AMP	Plan 1	Plan 2	Low Plan - DentalGuard Preferred Gold & Silver		High Plan - DentalGuard Preferred Gold & Silver		Passive PPO 31256204 V1	Passive PPO 31256203 V1
Employee (EE) Only	30	24	$18.56		$36.64		$18.56	$36.64
EE + Spouse	3	10	$37.66		$74.36		$37.66	$74.36
EE + Child(ren)	3	5	$60.46		$92.86		$60.46	$92.86
EE + Family	8	13	$86.00		$139.22		$86.00	$139.22
Total Enrollment	44	52						
Estimated Monthly Premium			$1,539		$3,897		$1,539	$3,897
Estimated Annual Premium			$18,470		$46,765		$18,470	$46,765
Total Combined Annual Cost								
Estimated Annual Premium			$65,235				$65,235	
Dollar Difference from Current							$0	
Percent Change from Current							0.0%	
PLAN PROVISIONS								
Rate Guarantee			1 Year rate guarantee ending 12/31/2024				1 year rate gaurantee; 2 year gaurantee if Medical is sold	

**NOTE: Benefit deviations from Current are identified in blue font*

***Exclusions/limitations may apply*

City of Northfield
Disclaimers

Coverage Disclaimer

This proposal is an outline of the coverages proposed by the carrier(s) based upon the information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. See the policies and contracts for actual language. This proposal is not a contract and offers no contractual obligation on behalf of GBS. Policy forms for your reference will be made available upon request.

Renewal / Financial Disclaimer

This analysis is for illustrative purposes only, and is not a proposal for coverage or a guarantee of future expenses, claims costs, managed care savings, etc. There are many variables that can affect future health care costs including utilization patterns, catastrophic claims, changes in plan design, health care trend increases, etc. This analysis does not amend, extend, or alter the coverage provided by the actual insurance policies and contracts. See your policy or contact us for specific information or further details in this regard.

Legal

The intent of this analysis is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It should not be construed as, nor is it intended to provide, legal advice. Laws may be complex and subject to change. This information is based on current interpretation of the law and is not guaranteed. Questions regarding specific issues should be addressed by legal counsel who specializes in this practice area.

Thank You!

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