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

August 26, 2024



Insurance

Risk Managemen

Consulting

# Agenda

2025 Medical & Dental

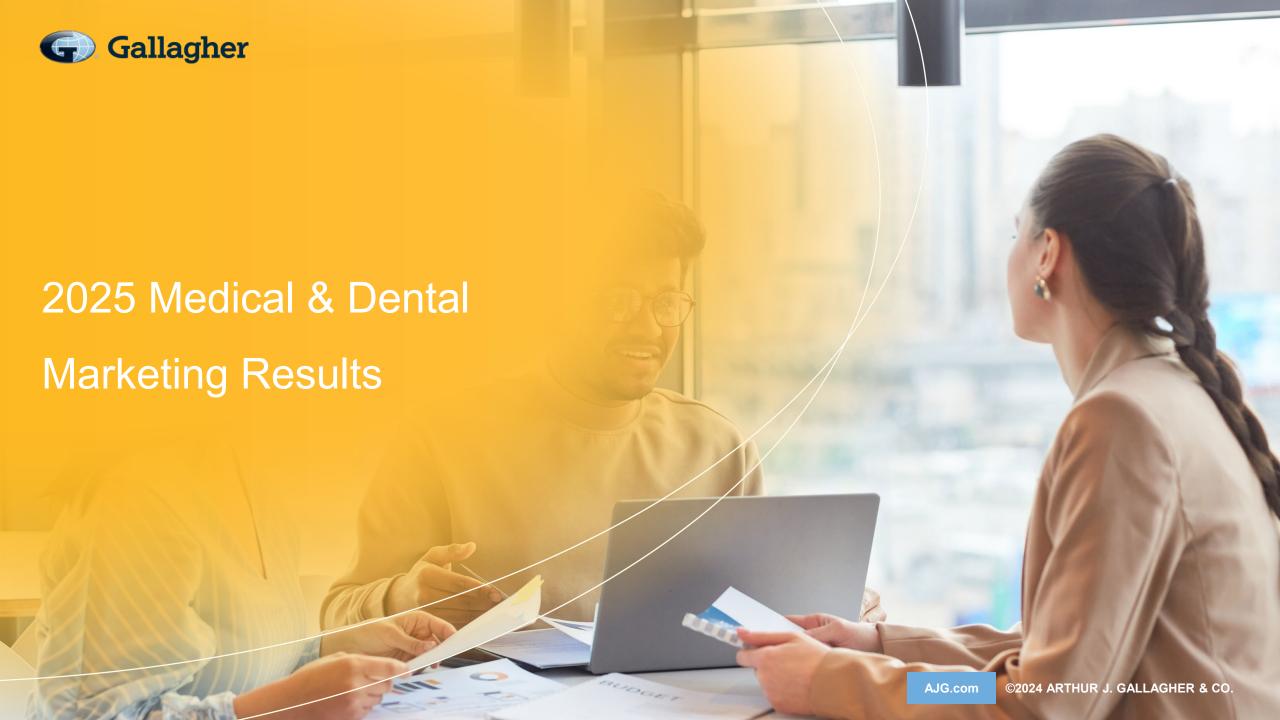
2025 Ancillary Renewals

**3**Benchmarking

4 Next Steps

Appendix:







# 2025 Medical Marketing Results

### **Marketing Summary**

Requested proposals and received the following Reponses:

Carrier	BCBS	Gravie	МНС	Sourcewell	UHC	PEIP	AllinaHealth Aetna	НР	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		
	С	arrier Name		BlueCross BlueShield of Minnesota	ı		BlueCross BlueShield of Minnesota	ı	
		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*									
n-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%	
				Office visits: \$40 Copay;	Office visits: \$25 Copay;		Office visits: \$40 Copay;	Office visits: \$25 Copay;	
Primary Care Visit			0% after deductible	All other services: 30% after	All other services: 20% after	0% after deductible	All other services: 30% after	All other services: 20% after	
· ····································			C70 ditor doddonoro	deductible	deductible	C / C GITCH GOGGODIO	deductible	deductible	
				Office visits: \$40 Copay ;	Office visits: \$25 Copay ;		Office visits: \$40 Copay ;	Office visits: \$25 Copay ;	
Specialist Visit			0% after deductible	All other services: 30% after	All other services: 20% after	0% after deductible	All other services: 30% after	All other services: 20% after	
Specialist visit			0% after deductible	deductible	deductible	0% after deductible	deductible	deductible	
			00/ 6 1 1 171	Office visits: \$40 Copay ;	Office visits: \$25 Copay ;	00/ 6 1 1 171	Office visits: \$40 Copay;	Office visits: \$25 Copay ;	
Urgent Care			0% after deductible	All other services: 30% after	All other services: 20% after	0% after deductible	All other services: 30% after	All other services: 20% after	
				deductible	deductible		deductible	deductible	
					Office visits: \$25 Copay;			Office visits: \$25 Copay;	
Emergency Room			0% after deductible	30% after deductible	All other services: 20% after deductible	0% after deductible	30% after deductible	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	
, , , , , , , , , , , , , , , , , , ,				Spinal Manipulation: \$40 Copay;	Spinal Manipulation: \$25 Copay;		Spinal Manipulation: \$40 Copay;	Spinal Manipulation: \$25 Copay;	
Chiropractic (visit limits may apply)			0% after deductible	Other Chiropractic: 30% after	Other Chiropractic: 30% after	0% after deductible	Other Chiropractic: 30% after	Other Chiropractic: 30% after	
omophasis (visit mints may apply)			C70 ditor doddonoro	deductible	deductible	C / C GITCH GOGGODIO	deductible	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	
			*				5.5		
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			0070	0070	0070	0070	0070	0070	
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%	T25111 Aware \$1,000 Ded 30%	T25032 Aware \$500 Ded 20% Coins	
Plan	Pian 2	Pian 3		, ,,,,,,,		Coins	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		14	7-,	<del></del>	<del>,</del>	1	ļ <del>-,</del>	<del>,</del>	
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	
	ar Difference f	rom Current		¥-0,740	Ψ2 : 3,034	\$69,359	\$1,677	\$9,253	
	rcent Change f					\$69,359 5.2%	3.6%	4.3%	
Fotal Combined Annual Cost	Cent Change I	ioni current				5.2 //	3.0%	4.376	
- Total Compilion Full duri Coot				CURRENT			NEGOTIATED RENEWAL		
Estimated Annual Premium				\$1,605,732		\$1,686,021			
	ar Difference f	rom Current					\$80,289		
	cent Change f						5.0%		
PLAN PROVISIONS							2.070		
Rate Guarantee			1	Year rate guarantee ending 12/31/202	24		2026 Rate Cap of 15%		
*NOTE: Panafit deviations from Current are identified in blue font				. our rate guarantee enamy 12/01/202	•		2020 Hate Oup of 1070		



## 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 <a href="https://www.bluecrossmn.com/providers/forms-and-publications">https://www.bluecrossmn.com/providers/forms-and-publications</a>. 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-\$hare 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)



				CURI	RENT			REN	EWAL		
	Ca	arrier Name			rdian				rdian		
		DI N	Low Plan - Denta	IGuard Preferred	High Plan - Denta	alGuard Preferred	Low Plan-Dental	Guard Preferred	Buy up High Plan	DentalGuard Pref	
		Plan Name	Gold & Silver Gold & Silver			Gold & Silver 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) Annual Maximum Annual Maximum Provision			\$50 / \$150		Maximum Rollov	\$50 / \$150 \$1,000 eshold: \$500; er Reward: \$250; Maximum: \$1,000	\$50 / \$150   \$50 / \$150 \$1,000   \$1,000 Rollover Threshold: \$500; Maximum Rollover Reward: \$250; Rollover Account Maximum: \$1.000		\$50 / \$150		
Coinsurance Preventive Services Cleaning Frequency Deductible Waived? Basic Periodontics Endodontics Major Major Waiting period Implants Orthodontics OON Reimbursement Level			100% 1 in 6 months Yes 50% 5% 5% 5% none 5% Not Covered	100% 1 in 6 months Yes 50% 5% 5% 5% none 5% Not Covered of the prevailing	100% 1 in 6 months Yes 80% 50% 50% 50% none 50% Not Covered 90th percentile	100% 1 in 6 months Yes 80% 50% 50% 50% none 50% Not Covered of the prevailing	100% 1 in 6 months Yes 50% 5% 5% 5% none 5% Not Covered	100% 1 in 6 months Yes 50% 5% 5% 5% none 5% Not Covered of the prevailing	100% 1 in 6 months Yes 80% 50% 50% 50% none 50% Not Covered	100% 1 in 6 months Yes 80% 50% 50% 50% none 50% Not Covered of the prevailing	
COST ANALYSIS			fee fee			IG	<del>, C</del>	10	: <del>C</del>		
PEPM Rates - Enrollment per AMP	Plan 1	Plan 2		uard Preferred Gold ilver		alGuard Preferred & Silver	Low Plan-Denta Gold &	Guard Preferred Silver	Buy up High Plan-DentalGuard Pr Gold & Silver		
Employee (EE) Only EE + Spouse EE + Child(ren) EE + Family Total Enrollment	30 3 3 8 <b>44</b>	24 10 5 13 <b>52</b>	\$60	3.56 7.66 0.46 6.00	\$7 <sup>2</sup> \$92	5.64 4.36 2.86 9.22	1 -	7.66 0.46	\$36 \$74 \$92 \$139	36 86	
Estimated Monthly Premium Estimated Annual Premium  Dollar Difference from Current			\$1, <b>\$18</b>	539 <b>,470</b>	\$3, <b>\$46</b>	897 , <b>765</b>		,470	\$3, <b>\$46</b>	765	
Percen					\$ 0.0	0 0%	\$ 0.0				
	otal Combined Annual Cost				007.00-				. 005		
Percen	Dollar Difference from Current Percent Change from Current							\$65,235 \$0 0.0%			
PLAN PROVISIONS Rate Guarantee				1 Year rate guarante	ee ending 12/31/202	4	1 Year rate Guarantee Ending 12/31/2025				

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



				OUD	DENT		64	050 Ammod Manorith	Enhanced Demofite Outin			
		Courier Name			RENT rdian		\$1		Enhanced Benefits Option	on		
		Carrier Name		Gua	raian			Guá	ardian			
		Plan Name	Low Plan - DentalGuard Preferred Gold & Silver High Plan - DentalGuard Preferred Gold & Silver				Low Plan-Dental Gold &		Buy up High Plan-De Gold &			
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) Annual Maximum			\$50 / \$150 \$1,000	\$50 / \$150 \$1,000	\$50 / \$150 \$1,000	\$50 / \$150 \$1,000	\$50 / \$150 \$1,250	\$50 / \$150 \$1,250	\$50 / \$150 \$1,250	\$50 / \$150 \$1,250		
Annual Maximum Provision			Rollover Thr Maximum Rollov Rollover Account	*/	Maximum Rollov	eshold: \$500; er Reward: \$250; Maximum: \$1,000	Rollover Thro Maximum Rollovo Rollover Account	er Reward: \$300;	Rollover Thre Maximum Rollove Rollover Account	er Reward: \$300;		
Coinsurance Preventive Services Cleaning Frequency Deductible Waived?			100% 1 in 6 months Yes 50%	100% 1 in 6 months Yes	100% 1 in 6 months Yes	100% 1 in 6 months Yes	100% 1 in 6 months Yes	100% 1 in 6 months Yes	100% 1 in 6 months Yes	100% 1 in 6 months Yes		
Basic Periodontics Endodontics	eriodontics ndodontics			50% 5% 5%	80% 50% 50%	80% 50% 50%	50% 25% 25%	50% 25% 25%	80% 50% 50%	80% 50% 50%		
Major Major Waiting period Implants Orthodontics			5% none 5% Not Covered	5% none 5% Not Covered	50% none 50% Not Covered	50% none 50% Not Covered	25% none 25% Not Covered	25% none 25% Not Covered	50% none 50% Not Covered	50% none 50% Not Covered		
OON Reimbursement Level					90th percentile	90th percentile of the prevailing fee		90th percentile of the prevailing fee		of the prevailing e		
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-Dental Gold &		Buy up High Plan-DentalGuard Preferred Gold & Silver			
Employee (EE) Only EE + Spouse EE + Child(ren)	30 3 3	24 10 5	\$60	7.66 0.46	\$7 <sup>2</sup> \$92	5.64 4.36 2.86	\$21 \$43 \$70	.91 .50	\$38.84 \$78.82 \$98.43			
EE + Family Total Enrollm	8 ent 44	13 <b>52</b>	\$86	5.00	\$13	9.22	\$100	0.28	\$147	7.57		
Estimated Monthly Premium	ICIII 44	32	\$1,	539	\$3.	897	\$1, <sup>7</sup>	795	\$4,	131		
Estimated Annual Premium				470		,765	\$21,	536	\$49,	571		
Dollar Difference from Current Percent Change from Current							\$3,1 16.		\$2,8 6.0			
Total Combined Annual Cost												
Estimated Annual Premium	Estimated Annual Premium  Dollar Difference from Current Percent Change from Current							\$71,107 \$5,872 9.0%				
PLAN PROVISIONS Rate Guarantee				1 Year rate guarant	ee ending 12/31/2024			1 Year rate Guarant	1 Year rate Guarantee Ending 12/31/2025			

### 2025 MetLife Dental



	С	arrier Name			rdian			Met	Life	
		Plan Name	Low Plan - DentalGu Silv		High Plan - DentalGu & Si		Low	Plan	High Plan (Ac	tive / Retirees)
PLAN DESIGN*			0.11	VO.		1001				
		Network	INN [DentalGuard Preferred Network]	OON	INN [DentalGuard Preferred Network]	OON	INN	OON	INN	OON
Calendar Year (CY) Deductible (Individual / Famil Annual Maximum	y)		\$50 / \$150 \$1,000	\$50 / \$150 \$1,000	\$50 / \$150 \$1,000	\$50 / \$150 \$1,000	\$50 / \$150 \$1,250	\$50 / \$150 \$1,250	\$50 / \$150 \$1,250	\$50 / \$150 \$1,250
Annual Maximum Provision			Rollover Thre Maximum Rollove Rollover Account	* /	Rollover Thre Maximum Rollove Rollover Account N	er Reward: \$250;	not included	not included	not included	not included
Coinsurance Preventive Services Cleaning Frequency Deductible Waived? Basic Periodontics Endodontics Major Implants Orthodontics			100% 1 in 6 months Yes 50% 5% 5% 5% 5% Not Covered	100% 1 in 6 months Yes 50% 5% 5% 5% 5% Not Covered	100% 1 in 6 months Yes 80% 50% 50% 50% Not Covered	100% 1 in 6 months Yes 80% 50% 50% 50% Not Covered	100% 1 in 6 months Yes 50% 25% 25% 25% Not Covered	100% 1 in 6 months Yes 50% 25% 25% 25% 25% Not Covered	100% 1 in 6 months Yes 80% 80% 50% 50% Not Covered	100% 1 in 6 months Yes 80% 80% 80% 50% 50% Not Covered
OON Reimbursement Level			90th percentile fe		90th percentile of		90th	R&C	90th	R&C
COST ANALYSIS						C				
PEPM Rates - Enrollment per AMP	Plan 1	Plan 2	Low Plan - DentalGu Silv		High Plan - DentalGuard Preferred Gold & Silver		Low Plan		High Plan (Active / Retirees)	
Employee (EE) Only EE + Spouse EE + Child(ren) EE + Family Total Enrollment	30 3 3 8 44	24 10 5 13 <b>52</b>	\$18 \$37 \$60 \$86	7.66 0.46	\$36 \$74 \$92 \$139	.36 .86	\$18 \$36 \$59 \$84	\$72.65 9.07 \$90.72		2.65 ).72
Estimated Monthly Premium Estimated Annual Premium	l		\$1, <sup>1</sup> <b>\$18</b> ,		\$3,8 <b>\$46,</b>		\$1,503 <b>\$18,040</b>		\$3,808 <b>\$45,691</b>	
Dollar Difference from Current Percent Change from Current Fotal Combined Annual Cost								130 3%	-\$1, -2.	075 3%
stimated Annual Premium  Dollar Difference from Curren  Percent Change from Curren			-				\$63,731 -\$1,505 -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)			





## 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





## 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



# 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%

### 2024 Benchmarking: Plan Design



		Single Cov	erage			Family Co	verage		
Organization Name	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)	Opt out reward amount
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



### 2025 Gravie Offer Details



	Crowle USA \$2 200 Crowle Cone					Gravie			
	Plan N	me 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		
LAN DESIGN*									
-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 Outpatient Surgery		0% after deductible 0% after deductible	30% after deductible 30% after deductible	20% after deductible 20% after deductible	0% 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	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		
maging (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% af deductible		
Mail Order		90 Days	90 Days	90 Days	90 Days	90 Days	90 Days		
Tier I / Tier II / 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		
		0 % after deductible	\$007\$1307\$2237\$300	\$00 / \$130 / \$223 / \$300	0% after deductible	\$20 / \$100 / 50 % after deductible	\$107\$50750% after deduction		
out-of-Network Benefits				5 1 11 1		<u> </u>			
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%		
EPM Rates - Enrollment per Renewal Plan 1	Plan 2 P	an 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		
Imployee (EE) Only 46	2	11 \$759.18	\$834.18	\$945.28	\$740.96	\$769.99	\$892.54		
E + Family Total Enrollment 84	1	3 \$2,026.94 14	\$2,227.18	\$2,523.80	\$1,978.31	\$2,055.80	\$2,383.01		
stimated Monthly Premium		\$111,946	\$3,896	\$17,969	\$109,260	\$3,596	\$16,967		
stimated Annual Premium		\$1,343,352	\$46,746	\$215,634	\$1,311,119	\$43,149	\$203,604		
Dollar Difference		ent .			-\$32,233	-\$3,597	-\$12,030		
otal Combined Annual Cost	ge from Cur	rent			-2.4%	-7.7%	-5.6%		
			CURRENT			Market Opt-Gravie			
stimated Annual Premium			\$1,605,732			\$1,557,872			
Dollar Difference Percent Chang LAN PROVISIONS						-\$47,860 -3.0%			
tate Guarantee			1 Year rate guarantee ending 12/31/2024	4	1 Year rate guarantee ending 12/31/2025 \$10,000 Implementation/Wellness Credit				

<sup>\*</sup>NOTE: Benefit deviations from Current are identified in blue font

### 2025 MHC Offer Details



Carrier Name		BlueCross BlueShield of Minnesota	1		Minnesota Healthcare Consortium	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Plan Name	T24075 HSA \$3,200	T24111 \$1,000	T24032 \$500 Ded	MSI Medica Choice Passport ASO 3300-		MSI Medica Choice Passport ASO 500-25
PLAN DESIGN*	. ,	. ,	·	0% HSA	40-30%	20%
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	\$3,200 / \$6,400 Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
	\$3,200 / \$6,400			\$3,300 / \$6,600		
CY Out-of-Pocket Max (Individual / Family) Coinsurance (member pays after deductible)	\$3,200 / \$6,400 0%	\$5,000 / \$10,000 30%	\$2,000 / \$4,000 20%	\$3,300 / \$6,600 0%	\$5,000 / \$10,000 30%	\$2,000 / \$4,000 20%
Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Freventive Care	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 Outpatient Surgery	0% after deductible 0% after deductible	30% after deductible 30% after deductible	20% after deductible 20% after deductible	0% after deductible 0% after deductible	30% after deductible 30% after deductible	20% 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	0 % after deductible	30% after deductible	20% after deductible	0% after deductible	30% after deductible	20% after deductible
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
Tier I/ Tier II/ Tier III/ Tier IV	0% after deductible	\$207\$307\$737\$120	\$20 / \$30 / \$73 / \$120	0% after deductible	Preferred: 20% to max \$200	Preferred: 20% to max \$200
Specialty	0% after deductible	30% to max \$500	20% to max \$500	0% after deductible	Non Preferred: 40%	Non Preferred: 40%
Mail Order	90 Days	90 Days	90 Days	93 Davs	93 Days	93 Days
Tier I / Tier II / 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	0 % after deductible	\$007\$1307\$2237\$300	\$00 / \$130 / \$223 / \$300	0% after deductible	\$40 / \$100 / \$190	\$40 / \$100 / \$190
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	0070	5070	5670	5570	5570	5575
PEPM Rates - Enrollment per Renewal Plan 1 Plan 2 Plan 3	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
Employee (EE) Only 46 2 11	\$759.18	\$834.18	\$945.28	\$781.14	\$819.22	\$919.46
EE + Family 38 1 3 Total Enrollment 84 3 14	\$2,026.94	\$2,227.18	\$2,523.80	\$2,085.54	\$2,187.26	\$2,454.88
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 Percent Change from Current				\$38,844 2.9%	-\$838 -1.8%	-\$5,889 -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	
		gg /2/01/2021			g 2	

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



								0	danagner
					CURRENT			MARKET OPTION 4	
		С	arrier Name		BlueCross BlueShield of Minnesota	l -r		he Better Health Collective - Sourcev	
			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	Office visits: \$25 Copay ; All other services: 20% after	0% after deductible	20% after deductible	0% after deductible
					deductible Office visits: \$40 Copay;	deductible Office visits: \$25 Copay;			
Specialist Visit				0% after deductible	All other services: 30% after	All other services: 20% after	0% after deductible	20% after deductible	0% after deductible
					deductible	deductible			
					Office visits: \$40 Copay;	Office visits: \$25 Copay;			
Urgent Care				0% after deductible	All other services: 30% after deductible	All other services: 20% after deductible	0% after deductible	20% after deductible	0% after deductible
						Office visits: \$25 Copay;			
Emergency Room				0% after deductible	30% after deductible	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 copa	Prev. Rx Generic \$0: Brand \$50 con
Retail				24 Davis	24 Davis	31 Dave	1 11	1.0	, , , , , , , , , , , , , , , , , , , ,
Tier I / Tier II / Tier III / Tier IV				31 Days 0% after deductible	31 Days \$20 / \$50 / \$75 / \$120	31 Days \$20 / \$50 / \$75 / \$120	31 Days 0% after deductible	31 Days 20% after deductible	31 Days 0% after deductible
Specialty				0% after deductible	30% to max \$500	20% to max \$500	0% after deductible 0% after deductible	20% 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 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				0 % after deductible	φ00 / φ130 / φ223 / φ300	φ00 / φ130 / φ223 / φ300	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 Total Enrollment	38 t <b>84</b>	1 3	3 <b>14</b>	\$2,026.94	\$2,227.18	\$2,523.80	\$2,156.00	\$2,246.00	\$2,418.00
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
		Difference fr nt Change fr					\$108,432 8.1%	\$1,398 3.0%	-\$3,582 -1.7%
Total Combined Annual Cost									
					CURRENT			MARKET OPTION 4	
Estimated Annual Premium		D			\$1,605,732			\$1,711,980	
		Difference fi nt Change fi						\$106,248 6.6%	
PLAN PROVISIONS					4.				
Rate Guarantee					1 Year rate guarantee ending 12/31/20	<u>24</u>			

<sup>\*</sup>NOTE: Benefit deviations from Current are identified in blue font

### 2025 UHC Offer Details

Gallagher
Gallagher

Carrier Name		BlueCross BlueShield of Minnesota			l laite all l	ealthcare	<b>-</b>
Carrier name		BlueCross BlueShield of Minnesota	<u> </u>	DQ-DD MOD (CH+ HSA) Rx Plan:	DQ-EH MOD (CH+ Premier) Rx	DQ-EE MOD (CH+ Premier) Rx	
Plan Name	T24075 HSA \$3,200	T24111 \$1,000	T24032 \$500 Ded	2V - HSA	Plan: EJ	Plan: EJ	Surest A+1500 Option
PLAN DESIGN*				21 116/1		<u></u>	
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) Imaging (CT/PET scan, MRI)	0% after deductible 0% after deductible	30% after deductible 30% after deductible	20% after deductible 20% after deductible	0% after deductible 0% after deductible	\$0 copay 30% after deductible	\$0 copay 20% after deductible	\$0 copay \$0 copay
Prescription Drug Benefit	0 // aitel deductible	30 % after deductible	20 % after deductible	0 % after deductible	30 % after deductible	20 % after deductible	фо сорау
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 Mail Order	0% after deductible 90 Days	30% to max \$500 90 Days	20% to max \$500 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-EE MOD (CH+ Premier) Rx Plan:	Surest A+1500 Option
	\$759.18	\$834.18	\$945,28	2V - HSA \$825.04	EJ \$891,22	EJ \$1.006.71	•
Imployee (EE) Only	\$759.18 \$2,026.94	\$834.18 \$2,227.18	\$945.28 \$2,523.80	\$825.04 \$2,202.77	\$891.22 \$2,379.47	\$1,006.71 \$2,687.81	\$1,029.99 \$2,749.97
Stimated 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  Total Combined Annual Cost				8.7%	6.8%	6.5%	9.0%
		CURRENT				OPTION 6	
Estimated Annual Premium		\$1,605,732				39,475	
Dollar Difference from Current Percent Change from Current				3,743 3%			
PLAN PROVISIONS							
Rate Guarantee		1 Year rate guarantee ending 12/31/20	24		1 Year rate guarante	ee ending 12/31/2025	
NOTE: Benefit deviations from Current are identified in blue							

<sup>\*</sup>NOTE: Benefit deviations from Current are identified in b

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### 2025 PEIP Offer Details



The Control of Process   Line 12   Line 12   Line 13   Line 14   Line 15   Line 15   Line 15   Line 16	Carrier Name Plan Name		HSA Pla	an Option	Public Employees	Insurance Program	Advantage Healt	n Plan High option		
Light   Ligh			I III III III III III III III III III	In Option			Advantage fleate	I all riigh option		
Circocioned	In-Network Benefits	Level 1	Level 2	Level 3	Level 4	Level 1	Level 2	Level 3	Level 4	
Columnitary (***)   Description   Perfect (***)   Perfect (*										
\$\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Calendar Year (CY) Deductible (Individual / Family)					\$250 / \$500	\$400 / \$800	\$750 / \$1,500	\$1,500 / \$3,000	
Concessance   Individual stamp   Security   Security   Security   Security   Concessance   Individual stamp   Concessance   Individual stamp   Security	Out-of-Pocket Max Type					Embedded	Embedded	Embedded	Embedded	
Covered 100%   Cove	CY Out-of-Pocket Max (Individual / Family)					\$1,700 / \$3,400	\$1,700 / \$3,400	\$2,400 / \$4,800	3,600 / \$7,200	
Primary Case Visit   Sp6 Copy wither deductable   S10 Copy wither deduct		4								
Separation   Sep	Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	
## SCopay after deductible   \$100 Copay after deductible   \$100 C	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	
Emergency Room   3/20 Copay after deductible   500 Copay after deductibl	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	
Paper   Pape	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	
Section   Surgery   Section   Surgery   Section   Surgery   Section   Surgery   Surg	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	
Chropractic (visit limits may apply)	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	
PhysiocidSpeech Therapy (visit limits may appty)   245 Copay after deductible   20% after	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	
Diagnostic Test [X-rey, blood work)   20% after deductible   20% a	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	
Diagnostic Test [X-rey, blood work)   20% after deductible   20% a	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	
Imaging (CT/PET scan, MR)   20% after deductible   30% after deductible   50% after deductible   10% after deductible   15% after deductible   25% after deductible   25% after deductible   25% after deductible   25% after deductible   30% after deductible   30% after deductible   30% after deductible   300 pays   30 pays		1 2	The state of the s	1 7			The state of the s	1 2	The state of the s	
Retail   30 Days   30 Da										
Specialty   Spec		30 Days	30 Days	30 Days	30 Days	30 Days	30 Days	30 Days	30 Days	
Mail Order   90 Days   9	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	
Out-of-Pocket Max Type	Mail Order	90 Days	90 Days	90 Days	90 Days	90 Days	90 Days	90 Days	90 Days	
Deductible Type										
You clot Pocket Max Type			Λ.	I/A				I/A		
CY Out-of-Pocket Max (Individual / Family)         N/A N/A         N/A N/A           Coinsurance (member pays after deductive)         N/A         N/A           Coinsurance (member pays after deductive)         N/A         N/A           Coinsurance (member pays after deductive)         N/A         N/A           Coinsurance (member pays after deductive)         Plan 1 plan 2 plan 3 plan 3 plan 3 plan 3 plan 4 plan 1 plan 1 plan 1 plan 2 plan 3 plan	CY Deductible (Individual / Family)		N	I/A			N	I/A		
Coinstrance (member pays after deductible)         N/A         N/A           COST ANALYSIS         COST ANALYSIS           PEPM Rates - Enrollment per Renewal   Plan   1   Plan   2   Plan   3   1   2   1   1   2   Plan   3   3   1   3   3   3   1   3   3   3										
COST ANALYSIS   PEPM Rates - Enrollment per Renewal   Plan   Pl										
Employee (EE) Only	COST ANALYSIS									
EE + Family   38   1   3     3     1   3	PEPM Rates - Enrollment per Renewal Plan 1 Plan 2 Plan 3		HSA Pla	an Option			Advantage Healt	n Plan High option		
Total Enrollment   84   3   14	Employee (EE) Only 46 2 11	•	\$83	35.18			\$1,1	73.40		
Stimated Monthly Premium			\$2,1	44.26			\$3,0	47.28		
Stimated Annual Premium			***					110		
Dollar Difference from Current Percent Change from Current Total Combined Annual Cost  Setimated Annual Premium  Estimated Annual Premium  Dollar Difference from Current Percent Change from Current Percent Change from Current Percent Change from Current Percent Change from Current PLAN PROVISIONS Rate Guarantee  1 Year rate guarantee ending 12/31/2025 - 4 Year Commitment Required										
Percent Change from Current Total Combined Annual Cost  Settimated Annual Premium  Dollar Difference from Current Percent Change from Current Percent Change from Current Percent Change from Current Percent Change from Current Page 19 19 19 19 19 19 19 19 19 19 19 19 19										
Total Combined Annual Cost  Estimated Annual Premium  Dollar Difference from Current Percent Change from Current Percent Change from Current Plan PROVISIONS Rate Guarantee  1 Year rate guarantee ending 12/31/2025 - 4 Year Commitment Required										
Estimated Annual Premium  Dollar Difference from Current Percent Change from Current PLAN PROVISIONS Rate Guarantee  1 Year rate guarantee ending 12/31/2025  1 Year Commitment Required										
Dollar Difference from Current Percent Change from Current PLAN PROVISIONS Rate Guarantee  1 Year rate guarantee ending 12/31/2025 - 4 Year Commitment Required										
Percent Change from Current  PLAN PROVISIONS  Rate Guarantee  1 Year rate guarantee ending 12/31/2025 - 4 Year Commitment Required										
PLAN PROVISIONS  Rate Guarantee										
Rate Guarantee 1 Year rate guarantee ending 12/31/2025 - 4 Year Commitment Required					10.	170				
	Rate Guarantee			1 Ye	ear rate guarantee ending 12/31/20	25 - 4 Year Commitment Reg	uired			
	Required Participation									

\*NOTE: Benefit deviations from Current are identified

in blue font

### 2025 BCBS Dental



	Ca	arrier Nam	е	Gua	rdian		Blue Cross B	lue Sheild #1	Blue Cross E	lue Sheild #2
		Plan Nam	e Low Plan - D Preferred Go		High Plan - D Preferred Go		Freedom	Standard	Freedom Enha	nanced Plan 1
PLAN DESIGN*										
		Networ	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) Annual Maximum			\$50 / \$150 \$1,000	\$50 / \$150 \$1,000	\$50 / \$150 \$1,000	\$50 / \$150 \$1,000	\$50 / \$150 \$1,000	\$50 / \$150 \$1,000	\$50 / \$150 \$1,000	\$50 / \$150 \$500
Annual Maximum Provision				r Reward: \$250;	Rollover Thre Maximum Rollove Rollover Account N	r Reward: \$250;	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 yea
Basic Periodontics			50% 5%	50% 5%	80% 50%	80% 50%	50% 50%	50% 50%	80% 80%	80% 80%
Endodontics			5%	5%	50%	50%	50% includes root canal	50% includes root canal	80% includes root canal	80% includes root
Major Implants Orthodontics			5% 5% Not Covered	5% 5% Not Covered	50% 50% Not Covered	50% 50% Not Covered	5% 5% Not Covered	5% 5% Not Covered	50% 50% Not Covered	50% 50% Not Covered
OON Reimbursement Level			90th percentile of	, ,	90th percentile of		Maximum allo	wable charge	Maximum allo	wable charge
COST ANALYSIS			ice		ice					
PEPM Rates - Enrollment per AMP	Р	Plan 1 Plan	2 Low Plan - Dental Gold &		High Plan - Dental Gold &		Freedom	Standard	Freedom Enha	nanced Plan 1
Employee (EE) Only EE + Spouse EE + Child(ren) EE + Family Total	Enrollment	30 24 3 10 3 5 8 13 44 52	\$37. \$60. \$86.	66 46	\$36. \$74. \$92. \$139	36 86	\$27 \$55 \$69 \$10	5.59 9.42	\$7 <sup>2</sup> \$89	5.25 1.55 0.35 3.95
Estimated Monthly Premium			\$1,5		\$3,8		\$4,			361
Estimated Annual Premium  Total Combined Annual Cost			\$18,4	1/0	\$46,7	/65	\$59	,311	\$76	,33/
Estimated Annual Premium				\$65	,235		\$59	,311	\$76	,337
Perc	r Difference fro ent Change fro						-\$5,925 -9.1%		\$11,101 17.0%	
PLAN PROVISIONS Rate Guarantee			1 Y	ear rate guarante	ee ending 12/31/202	24		l Year rate guarante	ee ending 12/31/202	25

<sup>\*</sup>NOTE: Benefit deviations from Current are identified in blue font

### 2025 Delta Dental



		Carrier Name		Gua	rdian		Delta	Dental	Delta	Dental
		Plan Name		ard Preferred Gold & ver	High Plan - DentalGu Silv		Dental PPO / P	remier - Plan A	Dental PPO / F	remier - 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 vear	2 times per calendar vear	2 times per calendar year	2 times per calendar year
Deductible Waived? Basic Periodontics Endodontics Major			Yes 50% 5% 5% 5%	Yes 50% 5% 5% 5%	Yes 80% 50% 50% 50%	Yes 80% 50% 50% 50%	Yes 80% 50% 50% 50%	Yes 80% 50% 50% 50%	Yes 80% 50% 50% 50%	Yes 80% 50% 50% 50%
Major Waiting period			none	none	none	none	None	None	None	None
Implants Orthodontics Maximum Age Deductible Lifetime Max Ortho Waiting Period			5% Not Covered N/A N/A N/A N/A	5% Not Covered N/A N/A N/A N/A	50% Not Covered N/A N/A N/A N/A	50% Not Covered N/A N/A N/A N/A	50% Not Covered N/A N/A N/A N/A	50% Not Covered N/A N/A N/A N/A	50% Not Covered N/A N/A N/A N/A	50% Not Covered N/A N/A N/A N/A
OON Reimbursement Level			· ·	of the prevailing	90th percentile	of the prevailing	50th Pe	ercentile	50th Po	ercentile
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 / P	remier - Plan A	Dental PPO / F	Premier - Plan B
Employee (EE) Only EE + Spouse EE + Child(ren) EE + Family Total Enrollment	30 3 3 8 44	24 10 5 13 <b>52</b>	\$18.56 \$37.66 \$60.46 \$86.00		\$36 \$74 \$92 \$139	l.36 2.86	\$83 \$10	I.18 3.58 4.36 6.48	\$86 \$10	3.38 3.04 9.94 4.84
Estimated Monthly Premium Estimated Annual Premium	- 17		\$1,539 <b>\$18,470</b>		\$3,8 <b>\$46</b> ,		\$7, <b>\$89</b>	431 <b>,175</b>		828 , <b>938</b>
P	ollar Difference ercent Change			\$65	,235		\$23	,175 ,939 7%	\$93,938 \$28,703 44.0%	
PLAN PROVISIONS Rate Guarantee				1 Year rate guarante	ee ending 12/31/2024			2 Year rate guarante	ee ending 12/31/2026	

<sup>\*</sup>NOTE: Benefit deviations from Current are identified in blue font

### 2025 Guardian Dental – Alternate Plan Option \$1500 Annual Max



				CURI	RENT			\$1500 Annu	al Max Option	
	C	Carrier Name		Guai					ardian	
		Plan Name	Low Plan - DentalGu & Si	uard Preferred Gold Iver		alGuard Preferred & Silver		IGuard Preferred & Silver	Buy up High Pla Prefe Gold &	rred
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) Annual Maximum			\$50 / \$150 \$1,000 Rollover Thre	\$50 / \$150 \$1,000 eshold: \$500;	\$50 / \$150 \$1,000 Rollover Thr	\$50 / \$150 \$1,000 eshold: \$500;	\$50 / \$150 \$1,500 Rollover Thre	\$50 / \$150 \$1,500 eshold: \$700;	\$50 / \$150 \$1,500 Rollover Thre	\$50 / \$150 \$1,500 shold: \$700;
Annual Maximum Provision			Maximum Rollove Rollover Account I	,,		er Reward: \$250; Maximum: \$1,000		er Reward: \$350; Maximum: \$1,250	Maximum Rollove Rollover Account N	' '
Coinsurance Preventive Services Cleaning Frequency Deductible Waived? Basic Periodontics Endodontics Major Major Waiting period Implants			100% 1 in 6 months Yes 50% 5% 5% 5% none 5%	100% 1 in 6 months Yes 50% 5% 5% 5% none 5%	100% 1 in 6 months Yes 80% 50% 50% 50% none 50%	100% 1 in 6 months Yes 80% 50% 50% 50% none 50%	100% 1 in 6 months Yes 50% 5% 5% 5% none 5%	100% 1 in 6 months Yes 50% 5% 5% 5% none 5%	100% 1 in 6 months Yes 80% 50% 50% 50% none 50%	100% 1 in 6 months Yes 80% 50% 50% 50% none 50%
Orthodontics OON Reimbursement Level				Not Covered of the prevailing	· ·	Not Covered of the prevailing		Not Covered of the prevailing	Not Covered 90th percentile of	
COST ANALYSIS			fe	е	fe	ee	fe	ee	fe	Э
PEPM Rates - Enrollment per AMP	Plan 1	Plan 2	Low Plan - DentalGua Silv			uard Preferred Gold & ver		IGuard Preferred & Silver	Buy up High Plan-De Gold &	
Employee (EE) Only EE + Spouse EE + Child(ren) EE + Family	30 3 3 8	24 10 5 13	\$18 \$37 \$60 \$86	.66 .46	\$74 \$92	3.64 4.36 2.86 9.22	\$48 \$77	3.68 3.05 7.15 9.74	\$46 \$94 \$118 \$177	88 .49
Estimated Monthly Premium Estimated Annual Premium	44	52	\$1,5 <b>\$18</b> ,			897 , <b>765</b>		964 , <b>567</b>	\$4,9 <b>\$59</b> ,	
Perce		rom Current rom Current						\$12,9 27.6		
Total Combined Annual Cost				<b></b>	225			<b>*</b>	2 220	
Perce		rom Current rom Current		\$65	,235			\$18	3,238 3,003 7.6%	
PLAN PROVISIONS Rate Guarantee *NOTE: Renefit deviations from Current are identified in h	olue font			1 Year rate guarante	ee ending 12/31/2024			1 Year rate Guarant	ee Ending 12/31/2025	

<sup>\*</sup>NOTE: Benefit deviations from Current are identified in blue font

### 2025 UHC Dental



	Carrier Name		Gua	rdian			Ul	HC	
	Plan Name	Low Plan - DentalGu & Si		High Plan - DentalG & Si		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) Annual Maximum		\$50 / \$150 \$1,000	\$50 / \$150 \$1,000	\$50 / \$150 \$1,000	\$50 / \$150 \$1,000	\$50 / \$150 \$1,000	\$50 / \$150 \$1,000	\$50 / \$150 \$1,000	\$50 / \$150 \$1,000
Annual Maximum Provision		Rollover Thre Maximum Rollove Rollover Account I	er Reward: \$250;	Rollover Thre Maximum Rollove Rollover Account	+ /	N	No		О
Coinsurance Preventive Services Cleaning Frequency Deductible Waived? Basic Periodontics Endodontics Major Implants Orthodontics  OON Reimbursement Level		100% 1 in 6 months Yes 50% 5% 5% 5% 5% Not Covered 90th percentile	е	fe	100% 1 in 6 months Yes 80% 50% 50% 50% Not Covered of the prevailing	100% 1 in 6 months Yes 50% 50% 50% 50% Not Covered Not Covered	1 in 6 months Yes 50% 50% 50% 50% 50% 50% 50% 50% 50% Not Covered  1 in 6 months Yes 50% 50% 50% 50% 50% Not Covered		100% 1 in 6 months Yes 80% 80% 50% Not Covered Not Covered
PEPM Rates - Enrollment per AMP	an 1 Plan 2	Low Plan - DentalGua Silv		High Plan - DentalGu Silv		Passive PPO	31256204 V1	Passive PPO	31256203 V1
EE + Spouse EE + Child(ren) EE + Family	30 24 3 10 3 5 8 13 44 <b>52</b>	\$18 \$37 \$60 \$86	.66 .46	\$36 \$74 \$92 \$138	5.64 4.36 2.86	\$60 \$86	7.66 0.46 6.00	\$36 \$74 \$92 \$13	.36
Estimated Monthly Premium Estimated Annual Premium Total Combined Annual Cost		\$1,5 <b>\$18</b> ,		\$3,6 <b>\$46</b> ,		\$1,539 <b>\$18,470</b>		\$3, <b>\$46</b>	897 , <b>765</b>
Estimated Annual Premium  Dollar Differ Percent Ch	rence from Current nange from Current		\$65	,235			\$	,235 0 0%	
PLAN PROVISIONS Rate Guarantee **NOTE: Ponsifi dovictions from Current are identified in blu			1 Year rate guarante	ee ending 12/31/2024		1 year	rate gaurantee; 2 yea	r gaurantee if Medical	is sold

<sup>\*</sup>NOTE: Benefit deviations from Current are identified in blue font

<sup>\*\*</sup>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.

#### <u>Legal</u>

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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