Town of Cortland

Effective Date: January 1, 2025

Renewal Summary

Coverage	Carrier	Comment
Medical	Blue Cross	+6.7% Rate Increase - Equates to $11,025 Annual Increase
Dental (12/1 Renewal)	SunLife	No rate change
Vision	Humana	No rate change
Basic Life/AD&D	Principal	4% Rate Increase - Equates to $138 Annual Increase

Town of Cortland

MEDICAL CARRIER:				
Plan (Network)		G508OPT - Blue Choice Options PPO		
		Tier 1: BCO	Tier 2: PPO	Out-of-Network
Individual Deductible		$1,600 ($1,500)	$3,850 ($3,750)	$7,700 ($7,500)
Family Deductible		$4,800 ($4,500)	$11,550 ($11,250)	$23,100 ($22,500)
Coinsurance		10%	30%	50%
Individual OOP*		$6,150 ($5,850)	$8,150 ($7,850)	Unlimited
Family OOP*		$15,375 ($14,650)	$18,200	Unlimited
Primary Care Physician Services		$40/visit ($35)	$65/visit ($60)	Ded + 50%
Specialist Services		$60/visit ($50)	$110/visit ($100)	Ded + 50%
Virtual Visits		$40/visit ($35)	$40/visit ($35)	Ded + 50%
Urgent Care		$75/visit	$75/visit	Ded + 50%
Emergency Room			$600 + Deductible + 10%	
Inpatient Hospital Services		$250 + Ded + 10%	$500 + Ded + 30%	$600 + Ded + 50%
Outpatient Hospital Services		$200 + Ded + 10%	$400 + Ded + 30%	$500 + Ded + 50%
Rx Copay			$15/$25/$60/$110/$350/$450	
Monthly Rates		**Inforce**		**Renewal**
Employee Only	9	$833.86		$886.21
Employee + Spouse	1	$1,667.72		$1,772.42
Employee + Child(ren)	2	$1,542.64		$1,639.49
Family	1	$2,376.50		$2,525.70
		Inforce		**Renewal**
TOTAL Monthly		$14,634		$15,553
TOTAL Annually		$175,611		$186,636
			Renewal	
Plan Monthly Total			$14,634	
Plan Annual Total			$175,611	
Plan Difference vs Inforce			$11,025	
Plan % Change vs Inforce			6.3%	

*Out-of-Pocket limits include the deductible

*This spreadsheet is for comparison purposes only. Refer to your contract for actual benefits

DENTAL CARRIER:	SunLife	
Plan (Network)	Dental PPO	
	In-Network	Out-of-Network
Deductible		
Individual	$50	
Family	$150	
Waived for Preventive?	Yes	
Coinsurance		
Preventive	100%	100%
Basic	100%	80%
Major	60%	50%
Calendar Year Maximum	$1,000	
Monthly Rates	**Inforce**	**Renewal**
Employee:	9 $28.86	$28.86
Employee + Spouse:	2 $58.00	$58.00
Employee + Child(ren):	2 $76.07	$76.07
Family:	0 $105.20	$105.20
	Inforce	**Renewal**
TOTAL Monthly	$528	$528
TOTAL Annually	13 $6,335	$6,335
Plan Difference vs Inforce	$0	
Plan % Change vs Inforce	0%	

VISION CARRIER:	Humana	
Plan (Network)		
	In-Network	**Out-of-Network**
Eye Exam		Reimbursement:
Frequency	Once every 12 months	
Benefit	$10 copay	Up to $30
Lenses		
Frequency	Once every 12 months	
Benefit		Reimbursement:
Single Vision	$15 copay	Up to $25
Bifocal	$15 copay	Up to $40
Trifocal	$15 copay	Up to $60
Lenticular	$15 copay	Up to $100
Contact Lenses		
Frequency	Once every 12 months	
Allowance	Up to $40	N/A
Frames		
Frequency	Once every 24 months	
Allowance	$130; 20% off balance over $130	$65 Allowance
Monthly Rates	**Inforce**	**Renewal**
EE:	10 $7.31	$7.31
EE + SP:	2 $14.63	$14.63
EC:	2 $13.90	$13.90
Family:	0 $21.84	$21.84
	Inforce	**Renewal**
TOTAL Monthly	14 $130	$130
TOTAL Annually	$1,562	$1,562
Plan Annual Total		
Plan Difference vs Inforce	$0	
Plan % Change vs Inforce	0%	

LIFE INSURANCE CARRIER:	Principal	
Employee Life/AD&D Benefit	$50,000	
Employee Life/AD&D Maximum	$50,000	
Employee Guarantee Issue	$50,000	
Employee Count	16	
Volume	$766,000	
	Inforce	**Renewal**
Life/AD&D Rate	$0.334	$0.349
Monthly Premium	$256	$267
Annual Premium	$3,070	$3,208

HRA Summary

Envision Healthcare Medical Reimbursement Account

Summary of Benefits for Town of Cortland — Effective: 1/1/2025

Underwritten By: BCBSIL G508OPT Administered as Embedded	**Insurance Guidelines** (In-Network)	**HRA Guidelines**
Individual Deductible The amount you would pay each calendar year before payments begin for covered services	$1,600 BCE $3,850 PPO	**Covered in Full by HRA, Employer pays first $5,050 of deductible, coinsurance, and hospital copays (max $5,050)**
Employee + 1 Deductible The amount an employee + 1 would pay each calendar year before payments begin for covered services	$3,200 BCE $7,700 PPO	**Covered in Full by HRA, Employer pays first $5,050 (x2) of deductible, coinsurance, and hospital copays (max $10,100)**
Family Deductible The amount your family would pay each calendar year before payments begin for covered services	$4,800 BCE $11,550 PPO	**Covered in Full by HRA, Employer pays first $14,975 of deductible, coinsurance, and hospital copays (max $14,975)**
Employee Out of Pocket Total amount the employee would pay if they exhaust their deductible, HRA, and coinsurance. (Does not include standard copays	$1,100 BC $3,100 PPO (Net after HRA)	Not Covered by HRA
Family Out of Pocket Total amount the employee would pay if they exhaust their deductible, HRA, and coinsurance.(Does not include standard copays)	$400 BC $3,225 PPO (Net after HRA)	Not Covered by HRA
Coinsurance Percentage paid by Insurance Carrier after the appropriate deductible is met	Plan covers at either 90% or 70%	**Covered by above HRA guidelines, paid to provider**
Physician Office Visit Copays for services based on medical carrier guidelines	$40 or $65 PCP Copay $60 or $110 Spec $75 Urgent Care Copay $600 ER Copay	Not Covered by above HRA guidelines
Well Care Covers annual adult/child physical and OB/GYN exam including routine diagnostic tests received on the same day as part of the physical exam	Paid at 100%, not subject to deductible	Not Covered by above HRA guidelines
Inpatient/Outpatient Hospital Services Room allowance based on the hospital's most common semi-private room rate. Includes pre-admission testing and all ancillary services	Applied to deductible or $200, $250, $400, $500, $600 per occurrence deductible and coinsurance	**Covered by above HRA guidelines, paid to provider**
Prescriptions Rx Co-pay.	Applied to various copays, refer to carrier SBC for details	Not Covered by HRA or applied to funding formula

This provides only a general summary of the benefit plan. Consult your Certificate of Coverage for specific guidelines and limitations.

_____ _____

Employers Signature of Approval *Date*

Town of Cortland
PLAN AMENDMENT

As of **1/1/2025,** your **HRA** Plan will be changed as follows;

"1.09 "Deductible" means the amount of Eligible Medical Expenses that must be incurred in a Plan Year prior to reimbursement under the Group Health Plan. The annual deductible under the Group Health Plan for Employee is $1,600BC/$3,850PPO for an Employee with one dependent it is $3,200BC/$7,700PPO and for a family of three or more it is $4,800BC/$11,550PPO."

"3.02 Annual Benefits Provided by the Plan. It is understood that the Employer has made available coverage under the Group Health Plan to each Participant. The Group Health Plan coverage is subject to an annual Deductible for Eligible Medical Expenses covered there under (see Section 1.09). If a Participant incurs Eligible Medical Expenses in a Plan Year, this Health Reimbursement Arrangement (HRA) will reimburse, Employer pays up to $5,050 for deductible and coinsurance for a single participant, Employer pays up to $10,100 for deductible and coinsurance for a Participant with one Dependent and Employer pays up to $14,975 for deductible and coinsurance for a family of three or more."

IN WITNESS WHEREOF, the parties have executed this Agreement effective as of the date stated.

COVERED ENTITY:	**BUSINESS ASSOCIATE:**
Town of Cortland	Envision Healthcare Inc.
By_____	By_____
Title_____	Title_____
Date_____	Date_____