To: Town Board

From Jean Gallucci, Comptroller

Date: October 5, 2023

Re: MVP Rates for 2024

The published rates for 2024 are 6.4% higher than 2023 and are as follows:

Individual	$972.02 p/month
Employee/Spouse	$1,944.04 p/month
Employee/Child(ren)	$1,652.43 p/month
Family	$2,700.26 p/month

The deductible has increased 5.68% from $4,400 Individual/$8,800 family to 2024 deductible: $4,650 Individual/$9,300 family, the town has always contributed 66.47% towards the employee deductible therefore, I am requesting an increase in the town's contribution for the 2024 year as follows:

Individual	from $2,925 to $3,090 annually
Employee/Spouse	from $5,850 to $6,180 annually
Employee/Child(ren)	from $5,850 to $6,180 annually
Family	from $5,850 to $6,180 annually

This is an increase of $330 annually for Employee/Spouse, Employee/Child(ren), and Family plans and an increase of $165 for Individual plans.

MVP Gold plans have increased 2.85% to $492.06 from $478.41.

Please advise.

New York Small Group 2024 Plans Quarter 1

MID-HUDSON REGION Delaware, Dutchess, Orange, Putnam, Sullivan, and Ulster Counties

We're here to help!
Call **1-800-TALK-MVP** (1-800-825-5687) or visit **mvphealthcare.com/plans** and select *Plan Options*, then *Employer-Sponsored*.

MVP HEALTH CARE

See other side for Platinum and Gold plans.

	Silver EPO National Network					Silver HMO Regional Network			Bronze EPO National Network					Bronze HMO Regional Network		
	2	3 QHDHP	4 HRA	7	8 QHDHP	3 QHDHP	12	13	2	5 QHDHP	6 QHDHP	7 QHDHP	11 NEW!	2	9 QHDHP	10
Plan Deductible[2]																
Individual/Family	$4,500/$9,000	$2,550/ $5,100 AGG	$2,800/$5,600	$3,100/$6,200	$4,650/$9,300	$2,550/ $5,100 AGG	$2,000/$4,000	$3,500/$7,000	$6,150/$12,300	$6,500/$13,000	$7,100/$14,200	$6,350/$12,700	$9,150/$18,300	$6,150/$12,300	$6,250/$12,500	$9,450/$18,900
Out-of-Pocket Maximum[2]																
Individual/Family	$8,400/$16,800	$6,350/$12,700	$7,200/$14,400	$8,700/$17,400	$7,600/$15,200	$6,350/$12,700	$8,450/$16,900	$9,200/$18,400	$8,900/$17,800	$7,250/$14,500	$7,100/$14,200	$7,100/$14,200	$9,150/$18,300	$8,900/$17,800	$7,100/$14,200	$9,450/$18,900
Medical																
Primary Care/Specialist Visit	3 PCP visits at $0, then $35 NoDD/ $60	$25/$50	$20/$50	$35 NoDD/$50	$0/$0	$25/$50	$30/$50	$35 NoDD ($0 to age 26)/ $50	3 PCP visits at $0, then $35/$60	$5/50%	0%/0%	40%/40%	1 PCP visit at $0, then 0%/0%	3 PCP visits at $0, then $35/$60	50%/50%	$0/$0
Hospital Facility Inpatient/Outpatient	30%/$300	$500/$250	$800/$225	$750/$250	$0/$0	$500/$250	$1,500/$200	$1,000/$300	30%/$300	50%/50%	0%/0%	40%/40%	0%/0%	30%/$300	50%/50%	$0/$0
Urgent Care/Emergency Room	$60 NoDD/$350	$50/$300	$50/$300	$50 NoDD/$250	$0/$0	$50/$300	$50/$250	$50 NoDD/$275	$60/$350	50%/$100	0%/0%	40%/40%	0%/0%	$60/$350	50%/50%	$0/$0
Gia*Virtual Care Services	$0 NoDD	$0 NoDD	$0 NoDD	$0 NoDD	$0 NoDD	$0 NoDD	$0 NoDD	$0 NoDD	$0 NoDD	$0 NoDD	$0 NoDD	$0 NoDD	0% NoDD	$0 NoDD	$0 NoDD	$0 NoDD
Diagnostic Radiology/Laboratory Outpatient	$60/$60 NoDD	$50/$50	$100/$50	$50/$50 NoDD	$0/$0	$50/$50	$50/$50	$150/$50 NoDD	$60/$60	50%/50%	0%/0%	40%/40%	0%/0%	$60/$60	50%/50%	$0/$0
Diabetic Supplies	$35 NoDD	$25	$20	$35 NoDD	$0	$25	$30	$35 NoDD ($0 to age 26)	$35	$5	0%	40%	0%	$35	50%	$0
Pediatric Dental and Vision for Dependents to Age 19																
Pediatric Dental Class 1/Class 2/Class 3 and Orthodontia Two Dental Exams per Year	$25 NoDD/ 20%/50%	$25/20%/50%	$25 NoDD/ 20%/50%	$25 NoDD/ 20%/50%	$25/20%/50%	$25/20%/50%	$25 NoDD/ 20%/50%	$25 NoDD/ 20%/50%	$25 NoDD/ 20%/50%	$25/20%/50%	0%/0%/0%	$25/20%/50%	0%/0%/0%	$25 NoDD/ 20%/50%	$25/20%/50%	0%/0%/0%
Pediatric Vision Annual Eye Exam/Set of Eyewear	$60/50%	$50/50%	$50/50%	$50/50%	$0/$0	$50/50%	$50/50%	$50/50%	$60/50%	50%/50%	0%/0%	40%/40%	0%/0%	$60/50%	50%/50%	0%/0%
Pharmacy																
Prescription Deductible Individual/Family	Integrated with Medical	Integrated with Medical	$0/$0	$0/$0	Integrated with Medical	Integrated with Medical	$0/$0	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical
Prescription Cost-Share Tier1/Tier2/Tier3	$10/$45/$90	$15/$40/$60 (Preventive Drugs NoDD)	$15 NoDD/ $40 NoDD/ 50% NoDD	$15 NoDD/ $45 NoDD/ $90 NoDD	$15/$50/$65 (Preventive Drugs NoDD)	$15/$40/$60 (Preventive Drugs NoDD)	$10 NoDD/ $35 NoDD/ $70 NoDD	$15 NoDD ($0 to Age 26)/ $45/$90	$10/$40/$60	$5/$30/50% (Preventive Drugs NoDD)	0%/0%/0% (Preventive Drugs NoDD)	$10/$40/$60 (Preventive Drugs NoDD)	0% NoDD/ 0%/0%	$10/$40/$60	$10/$35/$70 (Preventive Drugs NoDD)	$0/$0/$0
Premium Monthly Rates	Rates effective January 1, 2024–March 31, 2024.															
Employee	$973.30	$1,005.60	$991.31	$1,027.61	$972.02	$925.51	$945.11	$908.68	$829.96	$831.07	$894.89	$855.90	$828.43	$763.86	$784.16	$744.83
Employee + Spouse	$1,946.60	$2,011.20	$1,982.62	$2,055.22	$1,944.04	$1,851.02	$1,890.22	$1,817.36	$1,659.92	$1,662.14	$1,789.78	$1,711.80	$1,656.86	$1,527.72	$1,568.32	$1,489.66
Employee + Child(ren)	$1,654.61	$1,709.52	$1,685.23	$1,746.94	$1,652.43	$1,573.37	$1,606.69	$1,544.76	$1,410.93	$1,412.82	$1,521.31	$1,455.03	$1,408.33	$1,298.56	$1,333.07	$1,266.21
Employee + Spouse + Child(ren)	$2,773.91	$2,865.96	$2,825.23	$2,928.69	$2,770.26	$2,637.70	$2,693.56	$2,589.74	$2,365.39	$2,368.55	$2,550.44	$2,439.32	$2,361.03	$2,177.00	$2,234.86	$2,122.77

Cost-share amounts below are the co-pay or co-insurance after deductible is met, unless otherwise noted as not subject to deductible (NoDD). All plans include dependent care coverage to age 26. **Cost-shares in red** indicate a change from the 2023 plan.

[1] Silver 4 Health Reimbursement Arrangement (HRA) comes with an Embedded HRA plan and requires a $50 employer contribution.
[2] Unless otherwise noted, all plan deductibles and/or out-of-pocket maximums are embedded.

Aggregate vs. Embedded **Aggregate (AGG):** For a family plan with an aggregate deductible, all individuals on the plan pay together toward one deductible amount before the plan will make payments. **Embedded (EMB):** For a family plan with an embedded deductible, each member pays their own, individual deductible. Once an individual has met their deductible, no further deductible is required of them for that plan year. Other family members continue to pay toward their individual deductibles until the family deductible is met. An embedded out-of-pocket maximum works the same way.
QHDHP: Qualified High-Deductible Health Plan **HRA:** Health Reimbursement Arrangement **NoDD:** Not subject to deductible

All MVP NY Small Group plans are pending Medicare Creditable Coverage determinations. All QHDHPs are Health Savings Account qualified.

These plan overviews are intended to provide a general outline of coverage. For comprehensive benefit details, please review your Certificate of Coverage (COC), Schedule of Benefits, Summary of Benefits and Coverage (SBC), and any applicable Rider(s). Your COC, SBC, and Rider(s) will be controlling. These documents can be found in your MVP online account, or are available by request. For details, call 1-800-TALK-MVP (1-800-825-5687).

Health benefit plans are issued and administered by MVP Health Plan, Inc.; MVP Health Insurance Company; MVP Select Care, Inc.; and MVP Health Services Corp., operating subsidiaries of MVP Health Care, Inc. Not all plans available in all states and counties.

$600 Well-Being Reimbursement
Get reimbursed up to $600 per contract, per calendar year for well-being items, programs, and activities.

nystateofhealth
The Official Health Plan Marketplace

To learn more about applying for health insurance, including Medicaid, Child Health Plus, Essential Plan, and Qualified Health Plans through NY State of Health, The Official Health Plan Marketplace, visit www.nystateofhealth.ny.gov or call 1-855-355-5777.

MVP Health Care
MEDICARE RATE QUOTE
Triple Offering

Customer Name: **THE TOWN OF NEW PALTZ**
Group Number: 212174 ***Contract Period:*** 1/1/2024 - 12/31/2024
Quote Expires: 12/2/2023

Benefit Summary **Product Scenario 1**

	Option 1	Option 1	Option 1
Product	**USA Care PPO**	**USA Care PPO**	**USA Care PPO**
Base Plan	**MRPUOPT3**	**MRPUOPT3**	**MRPUOPT3**
Rate Region	**East**	**West**	**OSA**
In Network:			
PCP OV:	$10	$10	$10
SPC OV:	$15	$15	$15
Deductible:	$0	$0	$0
Out of Pocket Max:	$4000 combined IN and OON	$4000 combined IN and OON	$4000 combined IN and OON
Inpatient:	$0	$0	$0
Emergency:	$65	$65	$65
SNF:	$0 days 1-100	$0 days 1-100	$0 days 1-100
Out of Network:			
PCP OV:	$10	$10	$10
SPC OV:	$15	$15	$15
Out of Pocket Max:	$4000 combined IN and OON	$4000 combined IN and OON	$4000 combined IN and OON
Inpatient:	$0	$0	$0
Emergency:	$65	$65	$65
SNF:	$0 days 1-100	$0 days 1-100	$0 days 1-100
Additional:			
Pharmacy:	$0/$5/$15/$30/$30; Copays thru Gap	$0/$5/$15/$30/$30; Copays thru Gap	$0/$5/$15/$30/$30; Copays thru Gap
Optional Riders:	Eyewear Rider Hearing Aid Rider	Eyewear Rider Hearing Aid Rider	Eyewear Rider Hearing Aid Rider

Additional Information

- All of the benefits noted above are a summary. Please see the plans benefit document for full details.

Marketing Representative: **Date:**

Group Representative/Broker: **Date:**