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By Marc J. Garofalo, MPA, MCC, MCTC at 3:55 pm, Sep 08, 2025



Public Health
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Naugatuck Valley Health District



Insurance Renewal Summary

October 1, 2025 – September 30, 2026

Information sourced by





MEDICAL

Director of Health recommendation is to renew the United Healthcare Oxford Gold PPO 35/75/4500/100 health insurance plan.

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Based on the current staff, the increase will be ~6%.

*Subject to change depending on add/drop staff.

	Current Plan	Renewal Plan	Option 1	Option 2	Option 5
October 1, 2025 Zip: 06483 New Haven County					
	CT G FRDM NG 35/75/4500/100 PPO 24 CAL	CT G FRDM NG 35/75/4500/100 PPO 25 CNT	CT G FRDM NG 30/50/2500/80 PPO 25 CNT	CT S FRDM NG 35/75/2500/100 PPO HSA 25 CNT	Silver Century Preferred PPO 4500/3000 80CL
	In Network	In Network	In Network	In Network	In Network
Deductible - Ind/Fam	\$4,500 / \$3,000	\$4,500 / \$3,000	\$2,500 / \$5,000	\$2,500 / \$5,000	\$4,500 / \$3,000
OOP Max - Ind/Fam	\$8,500 / \$17,000 (Including Ded)	\$8,500 / \$17,000 (Including Ded)	\$9,100 / \$18,200 (Including Ded)	\$7,900 / \$15,800 (Including Ded)	\$9,000 / \$18,000 (Including Ded)
Co-Insurance	0%	0%	20%	0%	0%
Primary Care	\$35 Ded Waived	\$35 Ded Waived	\$30 Ded Waived	\$35 After Ded	\$50 Ded Waived
Specialist	\$75 Ded Waived	\$75 Ded Waived	\$50 Ded Waived	\$75 After Ded	\$100 Ded Waived
Inpatient Hospital	No Charge After Ded	No Charge After Ded	20% After Ded	\$750 per Day After Ded; \$3,000 Max Per Admit	\$700 per Day After Ded; \$2,800 Max Per Admit
Outpatient Surgical Facility	No Charge After Ded	No Charge After Ded	20% After Ded	Hosp:\$750 After Ded; Freestanding:\$450 After Ded	Hosp:\$500 After Ded; Freestanding:\$500 Ded
Outpatient Surgeon	No Charge After Ded	No Charge After Ded	20% After Ded	No Charge After Ded	Hosp:0% After Ded; Freestanding:No Charge
X-Ray	\$50 Ded Waived	\$50 Ded Waived	\$30 Ded Waived	\$75 After Ded	Freestanding:\$50 Ded Waived / Outpatient Hospital:\$100 After Ded
Lab	Des:\$35 Ded Waived Non-Des:50% After Ded	Des:\$35 Ded Waived Non-Des:50% After Ded	Des:No Charge Non-Des:50% After Ded	Des:\$25 After Ded Non-Des:50% After Ded	Office:\$100 Ded Waived/FS:No Charge/OP Hospital:\$100 After Ded
Advanced Radiology	Hosp:50% After Ded; Freestanding:\$75 Ded Waived; \$375 Max Per Year	Hosp:50% After Ded; Freestanding:\$75 Ded Waived; \$375 Max Per Year	Hosp:0% After Ded; Freestanding:\$75 Ded Waived; \$375 Max Per Year	\$75 After Ded; \$375 Max Per Year	Freestanding:\$75 Ded Waived; OP:\$75 After Ded
Emergency Room	\$400 Ded Waived	\$400 Ded Waived	20% After Ded	\$400 After Ded	20% After Ded
Urgent Care	\$75 Ded Waived	\$75 Ded Waived	\$50 Ded Waived	\$75 After Ded	\$100 Ded Waived
	Prescription Drugs	Prescription Drugs	Prescription Drugs	Prescription Drugs	Prescription Drugs
Rx Deductible	None	None	None	Integrated w/ Medical	None
Tier 1 Rx	\$5	\$10	\$10	\$10 After Ded	\$5
Tier 2 Rx	\$60	\$60	\$60	\$60 After Ded	\$60
Tier 3 Rx	50% to \$500	50% to \$500	50% to \$500	50% to \$500 After Ded	25% to \$500
Tier 4 Rx	50% to \$750	50% to \$750	50% to \$750	50% to \$750 After Ded After Ded	30% to \$1000
	Out of Network	Out of Network	Out of Network	Out of Network	Out of Network
Deductible - Ind/Fam	\$7,500 / \$15,000	\$7,500 / \$15,000	\$4,000 / \$8,000	\$7,500 / \$15,000	\$13,500 / \$27,000
OOP Max - Ind/Fam	\$15,000 / \$30,000 (Including Deductible)	\$15,000 / \$30,000 (Including Deductible)	\$10,000 / \$20,000 (Including Deductible)	\$15,000 / \$30,000 (Including Deductible)	\$27,000 / \$54,000 (Including Deductible)
Co-Insurance	30%	30%	50%	30%	50%
	Rates	Rates	Rates	Rates	Rates
Number Covered	8 of 7	7 of 7	7 of 7	7 of 7	7 of 7
Monthly Premium	\$9,559.41	\$7,487.06	\$7,442.29	\$7,322.20	\$7,317.74
Annual Premium	\$114,712.92	\$89,844.72	\$89,307.48	\$87,866.40	\$87,812.88
% Change from Current	N/A	-21.68%	-22.15%	-23.40%	-23.45%
\$ Change from Current	N/A	-\$24868.20	-\$25405.44	-\$26846.52	-\$26900.04
% Change From Renewal	N/A	N/A	-0.60%	-2.20%	-2.26%
\$ Change from Renewal	N/A	N/A	-\$537.24	-\$1978.32	-\$2031.84
	Provider Search	Provider Search	Provider Search	Provider Search	Provider Search
	Rx Search	Rx Search	Rx Search	Rx Search	Rx Search
	Benefit Summary	Benefit Summary	Benefit Summary	Benefit Summary	Benefit Summary
	Employee Rates	Employee Rates	Employee Rates	Employee Rates	Employee Rates
Core Employee A	\$740.37	\$775.83	\$771.19	\$758.75	\$758.28
Core Employee B	\$605.87	\$633.28	\$629.49	\$618.33	\$618.36
Core Employee C	\$677.97	\$715.91	\$711.63	\$700.14	\$699.72
Core Employee D	\$1,476.51	\$1,537.15	\$1,527.96	\$1,503.30	\$1,502.39
Core Employee E	\$1,293.53	\$1,406.58	\$1,398.17	\$1,375.61	\$1,374.77
Grant Employee 1	\$1,621.30	\$1,757.28	\$1,746.77	\$1,718.59	\$1,717.54
Grant Employee 2	\$620.41	\$661.03	\$657.08	\$646.48	\$646.08
Total Monthly Premium	\$7,035.96	\$7,487.06	\$7,442.29	\$7,322.20	\$7,317.74
Total Premium Minus Grant	\$4,794.25	\$5,068.75	\$5,038.44	\$4,957.13	\$4,954.12



VISION (under MEDICAL)

Vision Renewal

Vision Benefit Summary

Current		
Plan: S1001 / Type: 100% Employer Paid		
	Services & Materials	Amount
In-Network Copay	Exam	\$10
	Materials	\$10
Allowances	Frame	\$130
	Elective Contact Lens	\$105
	Contact Lens Fit & Eval	\$30
Coinsurance	Necessary Contact Lens	100%
Frequencies	Exam	1 x per 12 mos
	Lenses	1 x per 12 mos
	Frame	1 x per 12 mos
Out-of-Network Reimbursement	Exam	Up to \$40
	Eyeglass Lenses	Up to \$40
	Frame	Up to \$45
	Elective Contact Lens	Up to \$80
	Necessary Contact Lens	Up to \$210

Monthly Rates/Premiums

	Enrollment	Rate
Employee	6	\$6.25
Empl + Spouse	0	\$11.87
Empl + Child	1	\$13.87
Empl + Fam	1	\$19.56
Monthly Premium		\$70.93

Renewal		
Plan: S1001 / Type: 100% Employer Paid		
	Services & Materials	Amount
In-Network Copay	Exam	\$10
	Materials	\$10
Allowances	Frame	\$130
	Elective Contact Lens	\$105
	Contact Lens Fit & Eval	\$30
Coinsurance	Necessary Contact Lens	100%
Frequencies	Exam	1 x per 12 mos
	Lenses	1 x per 12 mos
	Frame	1 x per 12 mos
Out-of-Network Reimbursement	Exam	Up to \$40
	Eyeglass Lenses	Up to \$40
	Frame	Up to \$45
	Elective Contact Lens	Up to \$80
	Necessary Contact Lens	Up to \$210

	Enrollment	Rate
Employee	6	\$6.25
Empl + Spouse	0	\$11.87
Empl + Child	1	\$13.87
Empl + Fam	1	\$19.56
Monthly Premium		\$70.93

Change in Rate: 0.00%

- Vision plans have a 24 month rate guarantee. The rates displayed in this package will be effective through 9/30/2027. The rate guarantee is subject to change based upon changes to the policy and/or plan structure.



Renewal Rates effective October 1, 2025

*Specific group coverages not listed below will be renewed at current rates

RECEIVED
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Director of Health recommendation is to renew the MetLife Dental Insurance Plan.

Based on the current staff, the increase will be 3%.

*Subject to change depending on add/drop staff.

Coverage	Current Rate(s)	Renewal Rate(s)	Lives	Renewal Annual Premium	% Change
Dental				\$8,827.80	3.0%
Employee Only	\$51.63	\$53.18	5		
Employee + Spouse	\$105.36	\$108.52	0		
Employee + Child(ren)	\$109.12	\$112.39	1		
Employee + Family	\$173.48	\$178.68	2		
Total Lives			8		

Rates are guaranteed from October 1, 2025 - September 30, 2026 (12 months)