General Information:

Your data is due by:	**May 1, 2025**
Facility Name:	**Iroquois Healthcare Alliance (IHA)**

Please tell us who is completing this Benefits Survey:
(in case we need to contact you for any clarifications)

First Name:	
Last Name:	
Phone:	
e-mail:	
Total Number FTEs:	
Total Beds:	
2024 Total Operational Expenses $:	
What are the minimum hours worked per week to be eligible for employer-sponsored benefits? (enter # hours/week, ie, 20, 24, etc):	
At what threshold (hours/week) is an employee considered Full Time and eligible to receive fully subsidized benefits? (enter # hours/week, ie, 20, 24, etc.):	

Continue to Benefits Survey

Medical Insurance Benefits

Year: **2025**
Facility: **Iroquois Healthcare Alliance (IHA)**

Instructions:

Please complete the following section using the plan utilized by the **majority** of employees.

The "TOTAL Monthly Premium" column is the Monthly TOTAL Premium amount - NOT just the portion paid by you, the employer for each level of coverage: Individual, Employee & Spouse / Domestice Partner, Employee & Child(ren) or Family for each of the four types of plans: Traditional Indemnity / HMO / PPO / EPO / Point of Service / High Deductible as defined below. In a situation where the benefit is 100% paid by the employee, please enter the same amount as the TOTAL Premium (ie, if the employee pays $20 per month for vision and it is 100% employee paid, the monthly TOTAL Premium should also be $20)

Please round dollar values to the **NEAREST DOLLAR**.

You can print out this survey at any time by clicking on the "Print" button at the bottom of this page.

Please report all survey information as of March 1, 2025.

	Total Monthly Premium $		**Monthly EMPLOYEE** Out of Pocket $ Contribution	
	Full Time	**Part Time**	**Full Time**	**Part Time**
INDIVIDUAL				
Traditional Indemnity (BC/BS)	$	$	$	$
HMO	$	$	$	$
PPO	$	$	$	$
EPO	$	$	$	$
Point of Service	$	$	$	$
High Deductible Health Plan	$	$	$	$
EMPLOYEE & SPOUSE / DOMESTIC PARTNER				
Traditional Indemnity (BC/BS)	$	$	$	$
HMO	$	$	$	$
PPO	$	$	$	$

EPO	$	$	$	$
Point of Service	$	$	$	$
High Deductible Health Plan	$	$	$	$

EMPLOYEE & CHILD(REN)

Traditional Indemnity (BC/BS)	$	$	$	$
HMO	$	$	$	$
PPO	$	$	$	$
EPO	$	$	$	$
Point of Service	$	$	$	$
High Deductible Health Plan	$	$	$	$

FAMILY

Traditional Indemnity (BC/BS)	$	$	$	$
HMO	$	$	$	$
PPO	$	$	$	$
EPO	$	$	$	$
Point of Service	$	$	$	$
High Deductible Health Plan	$	$	$	$

	Maximum Out of Pocket Cost (if applicable)		**Maximum Deductible (if applicable)**	
	Individual/ Single	**Family**	**Individual/ Single**	**Family**
Traditional Indemnity (BC/BS)	$	$	$	$
HMO	$	$	$	$
PPO	$	$	$	$

EPO	$	$	$	$
Point of Service	$	$	$	$
High Deductible Health Plan	$	$	$	$

Note: Only complete information in the next section if benefit is above and beyond regular insurance coverage.

	Total Monthly Premium $		Monthly EMPLOYEE Out of Pocket $ Contribution	
	Full Time	**Part Time**	**Full Time**	**Part Time**
INDIVIDUAL				
Vision Care	$	$	$	$
Basic Dental	$	$	$	$
Prescription Drug Rider	$	$	$	$
EMPLOYEE & SPOUSE / DOMESTIC PARTNER				
Vision Care	$	$	$	$
Basic Dental	$	$	$	$
Prescription Drug	$	$	$	$
EMPLOYEE & CHILD(REN)				
Vision Care	$	$	$	$
Basic Dental	$	$	$	$
Prescription Drug	$	$	$	$
FAMILY				
Vision Care	$	$	$	$
Basic Dental	$	$	$	$
Prescription Drug Rider	$	$	$	$

----------	Full Time	Part Time
Waiting Period to be eligibile for Medical Insurance benefit? (number of days) or		

☐ **Check if eligibility the first day of month following employment?**

Please indicate which of the following plan(s) are offered at your facility: (check all that apply)

- ☐ HRA (Health Reimbursement Arrangement)
- ☐ HSA (Health Savings Account)
- ☐ FSA (Flexible Spending Account)
- ☐ PRA (Premium Reimbursement Arrangement)
- ☐ None of the above

Please indicate which plan(s) that you as the EMPLOYER contribute: (check all that apply)

- ☐ HRA (Health Reimbursement Arrangement)
- ☐ HSA (Health Savings Account)
- ☐ FSA (Flexible Spending Account)
- ☐ PRA (Premium Reimbursement Arrangement)
- ☐ None of the above

Maximum ANNUAL EMPLOYER contribution $ amount

HRA	
HSA	
FSA	
PRA	
No Maximum	
Other (please explain)	

Do you have minimum and/or maximum EMPLOYEE contributions? (check if Yes)

- ☐ Minimum Contributions
- ☐ Maximum Contributions

Do you require your employees to complete a health risk assessment or submit other biometrics in order to receive EMPLOYER contributions to the HRA, HSA, etc?

- ◯ Yes
- ◯ No

Indicate who administers the plan(s) offered:

	Employer	3rd Party Administrator
HRA	☐	☐
HSA	☐	☐
FSA	☐	☐
PRA	☐	☐

Additional Questions

Do you offer Medical Insurance coverage for domestic partner/non-married couples?

- ◯ Yes
- ◯ No

Do you offer salary-banded employee contributions for some/all of your medical plans -- meaning do lower paid employees pay less than higher paid employees to enroll in the same medical insurance plan?

- ◯ Yes
- ◯ No

Do you offer point solutions/digital vendors (tools and services that help users address specific issues/conditions/areas of concern ie, mental health, diabetes, hypertension, oncology, etc).

- ◯ Yes
- ◯ No

If you have an in-house pharmacy, are employees enrolled in your hospital-sponsored medical plans required to use the in-house pharmacy for all prescriptions?

- ◯ Yes
- ◯ No

Domestic utilization is how a health system's employees (and their dependents) utilize their own providers (doctors, practitioners, lab, imaging and all services) within the system. **Do you incentivize employees to use providers/services within your own organization?**

- ◯ Yes
- ◯ No

If yes, please briefly describe method(s)

What percentage of your claims are paid domestically (incurred by your own providers/facilities)?

%

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Life Insurance Benefits

Year: **2025**
Facility: **Iroquois Healthcare Alliance (IHA)**

Instructions:

Please complete the following section based on the majority of employees.

If the listed benefit is offered, place a check in the appropriate box. Otherwise, leave box blank. Please round dollar values to the **NEAREST DOLLAR**.

You can print out this survey at any time by clicking on the "Print" button at the bottom of the survey.

Please report all survey information as of March 1, 2025.

		Full Time	Part Time
EmployER-paid Group Term Life Insurance Plan			
Employee		☐	☐
Spouse		☐	☐
Dependent		☐	☐
EmployER-based coverage in Dollar Amount	AND/OR	$ ☐	$ ☐
Multiple of Annual Salary		☐	☐
(express in dollar amount OR in multiples of annual salary (e.g.: 1.0 times, 1.5 times, etc. times annual salary, enter number only, no X needed.)			
Maximum cap dollar amount of coverage		$ ☐	$ ☐
Waiting period for eligibility? (express in number of days)		days ☐	days ☐
Subsidized or fully employEE-paid Group Term Life Insurance Plan			
Employee		☐	☐
Spouse		☐	☐
Dependent		☐	☐
Other Insurance Plans			
Short-Term Disability		☐	☐
Long-Term Disability		☐	☐
Employee Whole/Universal		☐	☐
Spouse/Dependent Whole/Universal		☐	☐
Split Dollar Life		☐	☐
Employer-Paid AD&D		☐	☐
Subsidized or Fully Employee Paid AD&D		☐	☐

Retiree Life Employer-Paid	☐	☐

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Time Off Benefits

Year: **2025**
Facility: **Iroquois Healthcare Alliance (IHA)**

Instructions:

PTO (Paid Time Off) refers to programs where a single accrual system is used for employee paid time off. The time can be used as vacation, holiday, sick, personal or some combination of these. It is sometimes referred to as Earned Benefit Time or Earned Time Off (ETO).

Some employers use this method rather than a traditional method where accruals are done separately for each type of paid time off.

If you utilize a PTO system, check off those leave categories for which you use PTO in the first section below.

For those leave categories for which you **DO NOT** use PTO (do not check off), you will be taken to additional survey sections for time off benefits upon clicking the "Save&Continue" button at the bottom of this page.

You can print out this survey at any time by clicking on the "Print" button at the bottom of the survey.

Please report all survey information as of March 1, 2025.

	Full Time	**Part Time**
Do you have a Paid Time Off program?		
If YES, what benefits are included? (check all that apply)		
Sick days	☐	☐
Vacation days	☐	☐
Personal days	☐	☐
Holidays	☐	☐
Other	☐	☐

Total Time Worked	**MAX days awarded per Time Worked**	
6 months		
1 year		
2 years		
3 years		
5 years		
10 years		
15 years		
20 years		
25 years		
Maximum PTO Days Balance before stop accruing?	days	days

What are your maximum days to carryover per year?	days		days	
Waiting Period for eligibility in PTO program? (expressed in number of days)	days		days	

What is paid time off accrual for part time employees based upon? (check one)

- Hours paid ◯
- Hours worked ◯
- Budgeted FTEs/Hours scheduled ◯

Do you have a buy back policy?				
If YES, what is the maximum buy back amount? (% **or** days)	%		%	
	OR days		days	

Do you have an extended illness account?				
If YES, what are the MAX number of days for accrual?	days		days	
Report # days employee is out of work until they have access to account.	days		days	

What are the MIN hours worked per week to be eligible?	hours		hours	

Important note:

If you answered "YES" to the "Do you have a Paid Time Off program?" question at the top of this page, and checked off ALL leave categories, clicking the "Continue" button will save your information and return you to the table of contents page.

If you answered "NO" to the "Do you have a Paid Time Off program?" question, or answered "YES" and did not check off all leave categories, clicking the "Continue" button will take you to additional time off survey pages.

Save & Continue Print

Personal Leave

Year: **2025**
Facility: **Iroquois Healthcare Alliance (IHA)**

Instructions:

If you do not include Personal leave as part of a PTO program, you should complete this page.

If you DO include Personal leave as part of a PTO program, return to the main Time Off Benefits survey page, make sure you have answered YES to the "Do you have a Paid Time Off program?" question, check off the "Personal days" box, and then click the "Continue" button at the bottom of that page.

You can print out this survey page at any time by clicking on the "Print" button at the bottom of the page.

Please report all survey information as of March 1, 2025.

		Full Time		Part Time
Do you offer personal time days?				
Number of days per year?				
Maximum Personal Days Balance before stop accruing?	days		days	
What is your MAX number of days for carryover per year?	days		days	
In addition to personal time do you offer paid funeral/ bereavement leave?				
Waiting period for eligibility? (number of days)	days		days	
Do you have a buy back policy?				
If YES, what is the MAX buy back amount? (in % **or** days)	%		%	
	OR days		days	

Save & Continue Print

Paid Sick Days

Year: **2025**
Facility: **Iroquois Healthcare Alliance (IHA)**

Instructions:

If you do not include Sick leave as part of a PTO program, you should complete this page.

If you DO include Sick leave as part of a PTO program, return to the main Time Off Benefits survey page, make sure you have answered YES to the "Do you have a Paid Time Off program?" question, check off the "Sick days" box, and then click the "Continue" button at the bottom of that page.

You can print out this survey page at any time by clicking on the "Print" button at the bottom of the page.

Please report all survey information as of March 1, 2025.

		Full Time		Part Time
Do you offer paid sick days?				
Number of days per year?				
Maximum Sick Days Balance before stop accruing?				
What is your MAX number of days to carryover per year?				
First year accrual? (in days)	days		days	
Can you use sick days for family illness?				
Waiting period for eligibility?	days		days	
Do you have a buy back policy?				
If YES, what is the MAX buy back amount? (in % **or** days)	%		%	
	OR days		days	

Save & Continue Print

Holiday Leave

Year: **2025**
Facility: **Iroquois Healthcare Alliance (IHA)**

Instructions:

If you do not include Holiday leave as part of a PTO program, you should complete this page.

If you DO include Holiday leave as part of a PTO program, return to the main Time Off Benefits survey page, make sure you have ansered YES to the "Do you have a Paid Time Off program?" question, check off the "holidays" box, and then click the "Continue" button at the bottom of that page.

You can print out this survey page at any time by clicking on the "Print" button at the bottom of the page.

Please report all survey information as of March 1, 2025.

	Full Time	Part Time
Do you offer paid holidays?		
Number of regular or named holidays per year?		
Number of personal or floating holidays per year?		
Number of holidays premium per year?		
Holiday premium paid for per year? (Express in percentage. i.e.: time and one half = 150%)	%	%
Waiting period for eligibility? (# of days)	days	days

Save & Continue Print

Vacation Leave

Year: **2025**
Facility: **Iroquois Healthcare Alliance (IHA)**

Instructions:

If you do not include Vacation leave as part of a PTO program, you should complete this page.

If you DO include Vacation leave as part of a PTO program, return to the main Time Off Benefits survey page, make sure you have answered YES to the "Do you have a Paid Time Off program?" question, check off the "Vacation days" box, and then click the "Continue" button at the bottom of that page.

You can print out this survey page at any time by clicking on the "Print" button at the bottom of the page.

Please report all survey information as of March 1, 2025.

	Full Time	**Part Time**
Do you offer vacation time?		

Total Time Worked	**MAX Days Accrued**	
6 months		
1 year		
2 years		
3 years		
5 years		
10 years		
15 years		
20 years		
25 years		

Maximum Vacation Days Balance before stop accruing?	days		days	
What is the MAX amount of days to carry over per year?	days		days	
What is the waiting period for eligibility? (in days)	days		days	

What is vacation time accrual for **part time** employees based upon? (select one)

- Hours paid
- Hours worked
- Budgeted FTEs/ Hours scheduled

MIN hours worked per week to maintain eligibility for **part time** employees? hours

Do you have a buy back policy?		
If YES, what is the MAX buy back amount? (in % **or** days)	%	%
	OR days	days

Save & Continue Print

Flexible Benefits/Daycare Survey

Year: **2025**
Facility: **Iroquois Healthcare Alliance (IHA)**

Instructions:

Please complete the following section using the plan utilized by the **majority** of employees.

Please round dollar values to the **NEAREST DOLLAR**.

You can print out this survey at any time by clicking on the "Print" button at the bottom of this page.

Please report all survey information as of March 1, 2025.

	Full Time	Part Time
Do you have a Flexible Benefit/Cafeteria Program?		
If YES, what benefits are included? (check all that apply)		
Medical	☐	☐
Dental	☐	☐
Life	☐	☐
Long Term Disability	☐	☐
Vision	☐	☐
Dependent Care/Day Care	☐	☐
Vacation	☐	☐
What is employer's annual contribution per **individual**?	$	$
What is employer's annual contribution per **family**?	$	$
Do you have a Day Care Program?		
If YES, what type: (select one)		
On-site	○	○
Other	○	○
If YES, does the employer provide an annual subsidy?		
If YES, enter %	%	%
OR enter dollar amount	$	$

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Retirement Benefits

Year: **2025**
Facility: **Iroquois Healthcare Alliance (IHA)**

Instructions:

Please complete the following section using the plan utilized by the **majority** of employees.

Please round dollar values to the **NEAREST DOLLAR**.

You can print out this survey at any time by clicking on the "Print" button at the bottom of this page.

Please report all survey information as of March 1, 2025.

		Full Time		Part Time
Defined Benefit Plan:				
Do you have a defined benefit plan? (Y or N)				
If YES, how is the benefit calculated? (select one)				
1. Final Average		○		○
2. Career Average		○		○
3. Other		○		○
Waiting period for eligibility? (number of days)	days		days	
Time to full vesting? (number of years)	years		years	
Defined Contribution Plan:				
Do you have a defined contribution plan? (Y or N)				
If YES, which type: (select one)				
1. 401K		○		○
2. 403B		○		○
3. 401K and 403B		○		○
4. Other		○		○
Please check all that apply:				
1. **Employee** Contribution		☐		☐
2. **Employer** Match		☐		☐
MAX Employer Match, if applicable (in % **or** dollars)	%		%	
	OR $		$	
3. **Employer** Contribution (no employee contribution required)		☐		☐
MAX Employer Contribution, if applicable (in % **or** dollars)	%		%	
	OR $		$	
Waiting period for eligibility? (number of days)	days		days	
Time to full vesting? (number of years)	years		years	

Do you offer any non-qualified retirement plans? (For example, plans eligible under 457 of the Internal Revenue Code). Y or N		

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Tuition Assistance Benefits

Year: **2025**
Facility: **Iroquois Healthcare Alliance (IHA)**

Instructions:

Please complete the following section using the plan utilized by the **majority** of employees.

Please round dollar values to the **NEAREST DOLLAR**.

You can print out this survey at any time by clicking on the "Print" button at the bottom of this page.

Please report all survey information as of March 1, 2025.

		Full Time		Part Time
Do you have a tuition assistance benefit? (Y or N)				
Percentage paid	%		%	
Maximum dollars paid per year per employee	$		$	
Maximum credits per year				
Maximum courses per year				
Waiting period for eligibility (express in number of days)	days		days	
Required to work after utilizing benefit (days)	days		days	
Do you offer upfront payment for specialized professional education (i.e., nursing)? (Y or N)				
If so, number of days required to work after utilizing benefit.	days		days	
Must education be job related? (Y or N)				
Is prior approval required to receive tuition assistance? (Y or N)				

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Other Benefits

Year: **2025**
Facility: **Iroquois Healthcare Alliance (IHA)**

Instructions:

If your facility offers other benefits to full and/or part time employees, indicate either yes or no, and then check off all other benefits offered.

You can print out this survey at any time by clicking on the "Print" button at the bottom of this page.

Please report all survey information as of March 1, 2025.

(Select all that apply below)	Full Time	Part Time	(Select all that apply below)	Full Time	Part Time
Business Travel Accident	☐	☐	Subsidized Eating Facilities	☐	☐
Long Term Care	☐	☐	Pre-retirement Counseling	☐	☐
Wellness Program	☐	☐	Gambling Assistance	☐	☐
Onsite Fitness Facilities	☐	☐	Legal Counseling	☐	☐
Subsidized offsite fitness Facilities	☐	☐	Child/Elder Care Assistance	☐	☐
Parental Family Leave	☐	☐	Flextime	☐	☐
Employee Assistance Program	☐	☐	Business Casual Policy	☐	☐
Free/Subsidized Parking	☐	☐	Funeral Leave	☐	☐
Telecommuting	☐	☐	Jury Leave	☐	☐
Satellite Workplace	☐	☐	Adoption Benefits	☐	☐
Job Sharing	☐	☐	Work at Home Policy	☐	☐
College Scholarships	☐	☐	Discount Purchasing	☐	☐
Financial Planning Assistance	☐	☐	Other	☐	☐

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Benefits as Percent of Payroll

Year: **2025**
Facility: **Iroquois Healthcare Alliance (IHA)**

Instructions:

Please enter the percentage cost of benefits against the total payroll costs (formula: total cost of benefits ï¿½ total payroll) Enter a WHOLE % number only.

Then, check off all benefits you included in this percentage.

You can print out this survey at any time by clicking on the "Print" button at the bottom of this page.

Please report all survey information as of March 1, 2025.

What is the cost of benefits as a percentage of total payroll?
(whole number only) %

What benefits are included? (check **all** that apply)

- [ ] Long Term Disability
- [ ] Short Term Disability
- [ ] Life Insurance
- [ ] Medical Insurance
- [ ] Dental Insurance
- [ ] Flexible Spending Account
- [ ] Defined Contribution Plan
- [ ] Defined Benefit Plan
- [ ] Worker's Compensation
- [ ] Unemployment
- [ ] FICA
- [ ] Tuition Assistance
- [ ] Employee Assistance Program (EAP)
- [ ] Recognition Programs
- [ ] Parties (Christmas, picnics, etc.)
- [ ] Pharmacy Discount
- [ ] Cafeteria Discount
- [ ] Entertainment (ie, Disney accounts,etc)
- [ ] Severance Program
- [ ] Outplacement services
- [ ] Other

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