Group Name: City of Hammond
Compare Plans Report - Current/Renewal Medical
Effective:01/01/2024

	Base Plan BCBSLA Blue Saver 100/80 $3000		
Grandfather Status	**Non-Grandfathered**		
General Plan Information	**In-Network**		
Annual Deductible/Individual	$3,000		
Annual Deductible/Family	$6,000		
Coinsurance	100%		
Primary Care Visit	100% after Deductible		
Outpatient Specialist Visit	100% after Deductible		
Annual Out-of-Pocket Limit/Individual	$5,000		
Annual Out-of-Pocket Limit/Family	$10,000		
Included in Out-of-Pocket Limits	Yes		
Lifetime Plan Maximum	Unlimited		
Preventive Services			
Well-Child and Adult Exams	Covered		
Hospital Services			
Surgery Facility	100% after Deductible		
Professional Services	100% after Deductible		
Emergency Room	100% after Deductible		
Urgent Care Facility	100% after Deductible		
Lab & Low Tech Imaging	100% after Deductible		
High Tech Imaging	100% after Deductible		
Rehab (Speech, Phys, & Occ Therapy)	100% after Deductible		
Inpatient Services			
Inpatient Hospitalization	100% after Deductible		
Professional Services	100% after Deductible		
Prescription Drug Benefits			
Deductible	Included in Medical		
Tier 1	100% after Deductible		
Tier 2	NA		
Tier 3	80% after Deductible		
Tier 4	NA		
Tier 5	NA		
Rates		**Current**	**Renewal**
Employee Only	**286**	$671.20	$671.20
Employee + Spouse	**22**	$1,201.43	$1,201.43
Employee + Child(ren)	**23**	$1,000.06	$1,000.06
Family	**34**	$1,288.67	$1,288.67
Total Premium Per Plan	**365**	***$285,210.82***	***$285,210.82***
Percentage Rate Change Per Plan		**-**	***0.0%***
Total Percentage Rate Change	**0.0%**		
Total Current Monthly Premium	**$285,210.82**		
Total Renewal Monthly Premium	**$285,210.82**		
Monthly Increase/Savings ($)	***$0.00***		
Annual Increase/Savings ($)	***$0.00***		

The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this information conflicts in any way with the contract, the contract will prevail.

CITY OF HAMMOND
Group Plan Analysis

2023 Benny Card (HRA)

Maximum Exposure	$1,156,900.00
Total Funded	$733,665.15
Actual Funds Used	$423,234.85
% of Fund Used as of 11/13/2023	36.6%

2023 Funding Method

Employee
COH Funds $2,300
Employee $700
Family
COH Funds $4,600
Employee $1,400

2024 Benny Card (HRA)

Maximum Exposure	$1,156,900.00
Total Funding Estimated	$694,140
Projected Fund Use	$462,760
% of Fund Used as of 11/13/2023	40.0%

Proposed 2024 Funding Method

Employee
COH Funds $2,300
Employee $700
Family
COH Funds $4,600
Employee $1,400

Group Name: City of Hammond
Compare Plans Report - Dental
Effective:01/01/2024

CADENCE Insurance

Carrier Network		Current / Renewal MetLife -		Option 1 BCBSLA AdvantagePLUS 2.0
Rate Guarantee		12 Months		12 Months
Participation		100% and atleast 10 eligible		70% of eligible
Rates	360			
EE	237	$27.68	$31.00	$28.61
EE & Spouse	45	$55.80	$62.50	$57.67
EE & Child(ren)	34	$68.08	$76.25	$70.37
EE & (Family)	44	$96.42	$107.99	$99.66
Total Monthly Premium		$15,628.36	$17,503.56	$16,153.34
Total Annual Premium		$187,540.32	$210,042.72	$193,840.08
Percentage Rate Change			12.00%	3.36%
General Plan Information		In-Network		In-Network
Annual Deductible		$50		$50
Annual Family Deductible		$150		$150
Annual Plan Maximum		$1,500		$1,500
Annual Maximum Carryover		NA		NA
Lifetime Orthodontia Plan Max		$2,000		$2,000
UCR Percentile		*90th Percentile*		*90th Percentile*
Diagnostic and Preventive Svc		100%		100%
Basic Services		80%		80%
Waiting Period New Hires		*NA*		*NA*
Major Services		50%		50%
Waiting Period New Hires		*NA*		*NA*
Endodontic Treatment		80%		80%
Periodontic Treatment		80%		80%
Implant Coverage		50%		50%
Orthodontia Services		50%		50%
Waiting Period New Hires		*NA*		*NA*

The rates outlined above are intended as a rate comparison only. Rates are based on census information received. Final rates are subject to actual enrollment, plan design(s) selected, and underwriting approval.

Group Name: City of Hammond
Compare Plans Report - Vision
Effective: 01/01/2024

CADENCE Insurance

Carrier		Current / Renewal MetLife	
Rate Guarantee		**12 Months**	
Rates	**272**		
EE	**180**	$6.13	$6.13
EE & Spouse	**40**	$12.26	$12.26
EE & Child(ren)	**20**	$13.50	$13.50
EE & (Family)	**32**	$19.63	$19.63
Total Monthly Premium		**$2,491.96**	**$2,491.96**
Total Annual Premium		**$29,903.52**	**$29,903.52**
Percentage Rate Increase			**0.00%**
		In - Network	**Out-of-Network**
Plan Copays			
Examination		$10	$45 allowance
Materials		$25	See below
Benefit Frequencies			
Examination		*12 months*	
Lenses		*12 months*	
Frames		*24 months*	
Contacts		*12 months*	
Lens Benefits			
Single Vision Lens		$25	$30 allowance
Bifocal Lens		$25	$50 allowance
Trifocal Lens		$25	$65 allowance
Lenticular		$25	$100 allowance
Contact Lens Benefits			
Medically Necessary		Covered	$210 allowance
Elective		$130 allowance	$105 allowance
Frame Benefits			
		$130 allowance	**$70 allowance**
Network Lasik Discounts		DISCOUNTED	

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Group Name: City of Hammond
Compare Plans Report - Basic Life AD&D
Effective:01/01/2024

CADENCE Insurance

Carrier	Current / Renewal MetLife	
Rate Guarantee	12 Months	
Participation Requirements	100%	100%
Per Covered Benefit	$1,000	$1,000
Volume	$9,429,000	$9,429,000
Life Rate	$0.111	$0.111
AD & D Rate	$0.037	$0.037
Total Rate	$0.148	$0.148
Total Monthly Premium	$1,395.49	$1,395.49
Total Annual Premium	$16,745.90	$16,745.90
Percentage Rate Change	-	0.00%
General Plan Information		
Life Benefit	$30,000	
AD & D Benefit	100% of the Basic Life Benefit	
Guarantee Issue	$30,000	
Age Reduction Schedule	Reduction of 35% at age 65, 50% at age 70	

The rates outlined above are intended as a rate comparison only. Rates are based on census information received. Final rates are subject to actual enrollment, plan design(s) selected, and underwriting approval.

Group Name: City of Hammond
Compare Plans Report - Voluntary Life
Effective:01/01/2024

CADENCE Insurance

Carrier	Current / Renewal MetLife	
Rate Guarantee	12 Months	
Volume	$11,870,000	
Total Monthly Premium	$4,131.23	$4,131.23
Total Annual Premium	$49,574.76	$49,574.76
Percentage Rate Change	-	0.00%
General Plan Information		
Employee Life Benefit	Lesser of 5 times pay or $500,000	
Spouse Life Benefit	$100,000, not to exceed 50% of employee's	
Child(ren) Life Benefit	$10,000	
Guaranteed Issue Maximum		
Employee	$100,000	
Spouse	$25,000	
Child(ren)	$10,000	
AD&D Benefit	100% of the Supplemental Term Life Benefit	
Age Reduction Schedule	No Age Reduction	

The rates outlined above are intended as a rate comparison only. Rates are based on census information received. Final rates are subject to actual enrollment, plan design(s) selected, and underwriting approval.

Group Name: City of Hammond
Compare Plans Report - Voluntary STD
Effective:01/01/2024

CADENCE Insurance

Carrier	Current / Renewal MetLife	
Rate Guarantee	12 Months	
Per Covered Benefit	$10	
Monthly Benefit	$13,750.00	
Total Monthly Premium	$736.17	$736.17
Total Annual Premium	$8,834.04	$8,834.04
Percentage Rate Change	-	0.00%
General Plan Information		
Definition of Disability	Due to a sickness, or as a direct result of accidental injury: the employee is receiving Appropriate Care and Treatment and complying with the requirements of such treatment, and is unable to earn more than 80% of their predisability earnings at their Own Occupation for any employer.	
Pre-Existing Limitation	3/12	
Elimination Period Accident Sickness	 14 Days 14 Days	
Benefit Percentage	60%	
Weekly Benefit Maximum	$1,200	
Benefit Duration	11 weeks	

The rates outlined above are intended as a rate comparison only. Rates are based on census information received. Final rates are subject to actual enrollment, plan design(s) selected, and underwriting approval.

Group Name: City of Hammond
Compare Plans Report - LTD
Effective:01/01/2024

CADENCE Insurance

Carrier	Current / Renewal MetLife	
Rate Guarantee	12 Months	
Per Covered Payroll	$100	$100
Volume	$1,798,305	$1,798,305
Rate	$0.488	$0.488
Total Monthly Premium	$8,775.73	$8,775.73
Total Annual Premium	$105,308.74	$105,308.74
Percentage Rate Change	-	0.00%
General Plan Information		
Benefit Percentage	60%	
Monthly Benefit Maximum	$6,000	
Benefit Duration	To Age 65	
Elimination Period	90 Days	
Definition of Disability	The employee is receiving Appropriate Care and Treatment and complying with the requirements of such treatment, and during the elimination period and the next 24 months is unable to earn more than 80% of predisability earnings at their Own Occupation.	
Own Occupation	24 Months	
Social Security Integration	Family Social Security	
Mental Nervous Limitation	24 Months	
Substance Abuse Limitation	24 Months	
Pre-Existing Condition Limitations	3/12	

The rates outlined above are intended as a rate comparison only. Rates are based on census information received. Final rates are subject to actual enrollment, plan design(s) selected, and underwriting approval.