Group Name: City of Hammond
Compare Plans Report - Medical
Effective: 01/01/2025

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		Current / Renewal BCBSLA Blue Saver 100/80 $3000		Option 1 BCBSLA Blue Saver 80/60 $4000	Option 4 UnitedHealthcare EBTB BX-INT
Grandfathered Status		Non-Grandfathered		Non-Grandfathered	Non-Grandfathered
General Plan Information		In-Network		In-Network	In-Network
Annual Deductible/Individual		$3,000		$4,000	$3,300
Annual Deductible/Family		$6,000		$8,000	$6,600
Coinsurance *(After Deductible)*		100%		80%	50%
Primary Care Office Visit		100% after Deductible		80% after Deductible	50% after Deductible
Specialist Office Visit		100% after Deductible		80% after Deductible	50% after Deductible
Annual Out-of-Pocket Limit/Individual		$5,000		$6,350	$4,000
Annual Out-of-Pocket Limit/Family		$10,000		$12,700	$8,000
Included in Out-of-Pocket Limits		Yes		Yes	Yes
Lifetime Plan Maximum		Unlimited		Unlimited	Unlimited
Preventive Services					
Well-Child and Adult Exams		Covered		Covered	Covered
Outpatient Services					
Surgery Facility		100% after Deductible		80% after Deductible	50% after Deductible
Professional Services		100% after Deductible		80% after Deductible	50% after Deductible
Emergency Room		100% after Deductible		80% after Deductible	50% after Deductible
Urgent Care Facility		100% after Deductible		80% after Deductible	50% after Deductible
Lab & Low Tech Imaging		100% after Deductible		80% after Deductible	50% after Deductible
High Tech Imaging		100% after Deductible		80% after Deductible	50% after Deductible
Rehab (Speech, Phys, & Occ Therapy)		100% after Deductible		80% after Deductible	50% after Deductible
Inpatient Services					
Inpatient Hospitalization		100% after Deductible		80% after Deductible	50% after Deductible
Professional Services		100% after Deductible		80% after Deductible	50% after Deductible
Prescription Drug Benefits					
Deductible		Included in Medical		Included in Medical	Included in Medical
Tier 1		100% after Deductible		80% after Deductible	$10
Tier 2		NA		NA	NA
Tier 3		80% after Deductible		60% after Deductible	$35
Tier 4		80% after Deductible		60% after Deductible	$70
Tier 5		80% after Deductible		60% after Deductible	UHC
Rates	**368**	**Current**	**Renewal**	**Option 1**	**Option 4**
Employee Only	**240**	$671.20	$789.33	$651.59	$857.69
Employee + Spouse	**40**	$1,201.43	$1,412.88	$1,166.33	$1,535.24
Employee + Child(ren)	**34**	$1,000.06	$1,176.07	$970.85	$1,277.92
Family	**54**	$1,288.67	$1,515.48	$1,251.03	$1,646.73
Total Employee Premium		$247,001.60	$290,473.44	$239,785.12	$315,629.92
Total Dependent Premium		$65,733.82	$77,303.26	$63,814.20	$83,997.98
Total Monthly Premium		***$312,735.42***	***$367,776.70***	***$303,599.32***	***$399,627.90***
Total Annual Premium		***$3,752,825.04***	***$4,413,320.40***	***$3,643,191.84***	***$4,795,534.80***
Percentage Rate Change			***18%***	***-2.92%***	***27.78%***
Annual Savings/Increase ($)			***$660,495.36***	***-$109,633.20***	***$1,042,709.76***
Notes:					

DISCLAIMER: Rates are subject to change if there are census variances prior to renewal or benefit change date. 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.

Group Name: City of Hammond
Compare Plans Report - Dental
Effective: 01/01/2025

Carrier Network		Current / Renewal BCBS LA Advantage PLUS 2.0	
Rate Guarantee		12 Months	
Participation		Assumes Current	
Rates	373		
EE	251	$28.61	$29.75
EE & Spouse	40	$57.67	$59.98
EE & Child(ren)	32	$70.37	$73.18
EE & (Family)	50	$99.66	$103.65
Total Monthly Premium		$16,722.75	$17,390.71
Total Annual Premium		$200,673.00	$208,688.52
Percentage Rate Change			3.99%
General Plan Information		In-Network	
Annual Deductible		$50	
Annual Family Deductible		$150	
Annual Plan Maximum		$1,500	
Annual Maximum Carryover		NA	
Lifetime Orthodontia Plan Max		$2,000	
UCR Percentile		*90th Percentile*	
Diagnostic and Preventive Svc		100%	
Basic Services		80%	
Waiting Period New Hires		*NA*	
Major Services		50%	
Waiting Period New Hires		*NA*	
Endodontic Treatment		80%	
Periodontic Treatment		80%	
Implant Coverage		50%	
Orthodontia Services		50%	
Waiting Period New Hires		*NA*	

The rates outlined above are intended as a rate comparison only. Rates are based on census

Group Name: City of Hammond
Compare Plans Report - Vision
Effective: 01/01/2025

Carrier Network		Current / Renewal MetLife MetLife		Option 2 BCBSLA Plan 2	
Rate Guarantee		12 Months		24 Months	
Participation		Assumes Current		100%	
Rates					
EE	187	$6.13	$6.13	$5.94	
EE & Spouse	38	$12.26	$12.26	$11.64	
EE & Child(ren)	20	$13.50	$13.50	$12.16	
EE & (Family)	38	$19.63	$19.63	$18.10	
Total Monthly Premium		$2,628.13	$2,628.13	$2,484.10	
Total Annual Premium		$31,537.56	$31,537.56	$29,809.20	
Percentage Rate Increase			0.00%	-5.48%	
		In - Network	Out-of-Network	In - Network	Out-of-Network
Plan Copays					
Examination		$10	$45	$0	$30
Materials		$25	See Below	$15	See Below
Benefit Frequencies					
Examination		*12 months*		*12 months*	
Lenses		*12 months*		*12 months*	
Frames		*24 months*		*24 months*	
Contacts		*12 months*		*12 months*	
Lens Benefits					
Single Vision Lens		Covered	$30	Covered	$25
Bifocal Lens		Covered	$50	Covered	$35
Trifocal Lens		Covered	$65	Covered	$45
Lenticular		Covered	$100	Covered	$60
Contact Lens Benefits					
Medically Necessary		Covered	$210	Covered	$225
Elective		$130	$105	$130	$75
Frame Benefits					
		$130	**$70**	**$150**	**$30**
Network Lasik Discounts		Discounted		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 - Basic Life AD&D
Effective: 01/01/2025

Carrier	Current / Renewal MetLife	
Rate Guarantee	12 Months	
Participation Requirements	100%	100%
Per Covered Benefit	$1,000	$1,000
Volume	$9,534,000	$9,534,000
Life Rate	$0.111	$0.132
AD & D Rate	$0.037	$0.037
Total Rate	$0.148	$0.169
Total Monthly Premium	$1,411.03	$1,611.25
Total Annual Premium	$16,932.38	$19,334.95
Percentage Rate Change	-	18.92%
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	