



2016

ANNUAL ENROLLMENT

City of Hammond

Meeting Schedule

Thursday 11/19/15	5:45 am Police Station 8:30 am Fire Department Training Room 10:00 am Police Station 1:00 pm 190 Facility 3:00 pm Council Chambers
Friday 11/20/15	8:30 am Fire Department Training Room 10:00 am Council Chambers 1:00 pm 190 Facility 3:00 pm City Court and Marshall
Saturday 11/21/15	5:45 am Police Station 7:30 am Fire Department Training Room
Monday 11/23/15	8:30 am Council Chambers 10:00 am Council Chambers

Your Annual Enrollment Overview

City of Hammond knows how important it is to provide quality employee benefits to our employees and their dependents. We always strive to provide a total benefits package that meets your needs as well as the needs of the company.

The following plans renew **January 1, 2016**:

The City of Hammond pays the entire premiums for health insurance, dental insurance, life insurance, and long-term disability insurance as a benefit to its full-time employees. The City also pays for the majority of the health insurance deductible for its full-time employees.

	<u>BancorpSouth Insurance</u>	<u>Boston Mutual</u>	<u>Valic</u>	<u>Empower</u>
Medical	Long Term Disability	Whole Life	Deferred Comp	Deferred Comp
Dental	Short Term Disability			
Vision	Accident			
Basic Life and AD&D	Critical Illness			
Voluntary Life and AD&D	Cancer			

AFLAC and Colonial will no longer be offered. If you wish to keep the products you currently have you may do so.

During this Annual Enrollment Period, you may request changes to the above plans subject to completion of the proper forms and approval by the insurance carriers. These changes will become effective **January 1, 2016** subject to carrier approval.

Please take the time to read the following benefit summaries carefully. This information along with your 2016 election documentation will help you in deciding the best benefit selections for you and your family.

At other times during the year, you may request changes ONLY when there is a Family Status Change, and the proposed change is consistent with the Family Status Change event. Family Status Changes include:

- Change in legal marital status (e.g., marriage or divorce);
- Change in the number of dependents (e.g., birth, adoption or placement for adoption, death);
- Change in employment status or residency of the employee, spouse or dependent that affects eligibility;
- Change in coverage under another employer's plan.

Changes, additions or voluntary cancellations generally cannot be made during the plan year unless the employee experiences a Family Status Change. The employee **MUST contact Human Resources within 30 days of the qualifying event. Otherwise, the employee must wait until the annual enrollment period to change or cancel an election.**

Reminders

- Employees are responsible for notifying Human Resources if a dependent is no longer eligible for coverage. Failure to notify HR will affect COBRA availability and premium refunds.
- From time to time other coverage information and accident details may be requested by the carriers – please respond promptly to expedite processing of claims.

Healthcare Marketplace Notice

Why am I receiving this notice? The Affordable Care Act requires us to inform you of the healthcare Marketplace that allows you to purchase health insurance online or over the phone. Marketplace open enrollment begins November 15th for enrollment on January 1st.

Does this mean that City of Hammond will no longer offer health coverage? No. City of Hammond will continue to offer health plans with the same eligibility rules. Only full-time employees (those working 30 or more hours per week) and their dependents will be eligible.

Does the Marketplace offer anything besides a place to buy coverage? Yes, for some people, premium tax credits are available to pay for coverage depending upon whether a parent is eligible for affordable employer coverage, family size and household income.

Is it better for me to buy my coverage through the Marketplace? The decision to buy Marketplace coverage is personal and will be determined by your family's financial conditions. If you are eligible for a City of Hammond health plan, you are not likely to be eligible for a premium tax credit. If you purchase coverage through the Marketplace, you may need City of Hammond's EIN.

Can I use the City of Hammond subsidy in the Marketplace? No, if you choose to buy coverage through the Marketplace, the amount that City of Hammond pays for your coverage will be lost.

If I enroll in the City of Hammond health plan, will that coverage satisfy my obligation to have health insurance? Yes, you will not be subject to a tax for failure to maintain health coverage because the City of Hammond plan is intended to satisfy the minimum value standard.

What about my family? If your dependents do not have minimum value coverage through City of Hammond or some other source, there will be a tax due for them on the tax return of the person who claims them as dependents.

Why does it matter that the plan is minimum value? There are two reasons. If you have minimum value coverage, you won't have to pay a tax to the IRS as described above. The second reason is that if you are offered affordable, minimum value coverage, you are not eligible for a premium tax credit. This does not always mean that other members of your family are ineligible for a premium tax credit. That depends upon many factors, including marital status.

How do you know whether the plan is affordable to me? Affordability is determined on a person-by-person basis. In general, if the cost of coverage for you alone (not family or spousal coverage) exceeds 9.5% of your household income, the coverage is not affordable. We anticipate that our coverage will be affordable.

If I don't have coverage, what is the tax? The tax is the greater of \$695 per adult and \$347.50 per child under 18 (capped at \$2,085) or 2.5% of household adjusted gross income 2016.

How do I contact the Marketplace? Go to www.healthcare.gov or call 1-800-318-2596.

Medical Insurance

City of Hammond offers the Health Insurance through **United Healthcare**.

Benefits	Louisiana Choice Plus AF40 Modified	
	In-Network Benefit	Out-of-Network Benefit
Deductible Individual Family	\$2,500 \$5,000	\$5,000 \$10,000
Coinsurance	100%	80%
Out-of-Pocket Maximum Individual Family (Deductible and Copays are Included in the out of pocket)	\$2,500 \$5,000	\$10,000 \$20,000
Lifetime Maximum	Unlimited	Unlimited
Office Visit Primary Specialist	100% After Deductible 100% After Deductible	80% After Deductible 80% After Deductible
Wellness Preventive Care	100%	N/A
Emergency Room	100% After Deductible	100% After Deductible
Urgent Care	100% After Deductible	80% After Deductible
Inpatient Services	100% After Deductible	80% After Deductible
Outpatient Surgery	100% After Deductible	80% After Deductible
Prescription Drug Coverage	100% After Deductible	

Medical Insurance Cost

See chart below for 2016 payroll deductions.

Elections	Louisiana Choice Plus AF40 Modified	
	Employee Monthly Cost	Cost Per Check (24)
Employee Only	\$0.00 (City pays \$508.28)	\$0.00 (City pays \$254.14)
Employee / Spouse	\$402.56	\$201.28
Employee / Child(ren)	\$249.06	\$124.53
Family	\$468.12	\$234.06

What is the Benny Card?

It is a credit card you use to pay for your prescriptions and doctor visits adding up to your total deductible. The card not only enables the City to pay for the majority of your deductible, but it also tracks the expenses. First present your United Healthcare card. Then use your Benny Card to pay.

How can I use the card?



+



When you go to the doctor or pharmacy make sure to present your United HealthCare card. Then pay with your Benny Card.

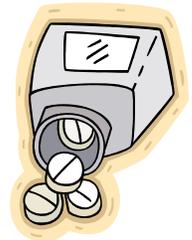
INELIGIBLE Charges on Benny Card

- Over the counter drugs
Ex.: Tylenol or sinus/allergy medications
- Medications such as:
 - smoking cessation
 - weight loss drugs, ED drugs and others

- (check with your pharmacist if you are unsure)
- Weight loss clinics, dentists and eye glasses
- Some physicals such as CDL

- **Charges from previous year(s)**

(bills from previous years can be submitted to Empire Management or BancorpSouth Insurance for manual payment on or before March 31st of the next year)



Deductible Breakdown

	<u>SINGLE</u>	<u>FAMILY</u>
Initial Funding (City Pays)	\$400	\$800
Member Paid (Out of Pocket)	\$700	\$1400
Final Funding (City Pays)	\$1400	\$2800
Total UHC Deductible	\$2500	\$5000

How much money is on my card?

Single
\$400

Family
\$800

What do I do when the card is out of money?

Employee pays their portion of the deductible out of pocket, which is:

Single
\$700

Family
\$1400

What do I do next?

Call Empire
Management
985-340-2880

or

Call
BancorpSouth
Insurance
985.340.4092

The remainder of the deductible will be loaded onto your card.

Single
\$1400

Family
\$2800

HIPPA Form

Individual (person whose protected health information is being disclosed)

Group Name: _____ Dept: _____ * **REQUIRED TO SET UP UHC ACCOUNT**

Printed Name: _____ * **Date of Birth:** _____

Address: _____

Telephone: _____ * **Email Address:** _____

* **Member Number:** _____ * **Group number:** _____ (may be obtained from Your United Healthcare card)

Authority to Release Protected Health Information

I hereby authorize United Healthcare to release the protected health information identified in this authorization form to Empire Management Group.

Protected Health Information To Be Disclosed – Covering Dates of Service

From (date) effective date of policy to (date) termination date of policy

Please check type of information to be released:

<input checked="" type="checkbox"/> All Claims Information
<input checked="" type="checkbox"/> Health Plan Benefit Information
<input checked="" type="checkbox"/> All Protected Health Information

Other, (specify) _____

Purpose of the Requested Disclosure of Protected Health Information

I am authorizing the disclosure of my Protected Health Information for the following purposes (e.g. a purpose may be "at the request of the individual"): substantiate claims related to Health Reimbursement account

Drug and/or Alcohol Abuse, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to its release. **Check One:** **Yes** **No**

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. **Check One:** **Yes** **No**

Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to Empire Management Group 110 West Morris Avenue, Hammond, LA 70403. Unless revoked, this authorization will expire on the following date, or after the following time period or event: termination of above referenced policy.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment will not be denied if I do not sign this form. However, if health care services are being provided to me for the purpose of providing information to a third-party (e.g. fitness-for-work test), I understand that services may be denied if I do not authorize the release of information related to such health care services to the third-party. I can inspect or copy the protected health information to be used or disclosed. **I hereby hold Empire Management Group harmless for complying with this Authorization.**

Signature: _____ Date: _____

Description of relationship if Personal Representative of Individual:

Why do we need a HIPPA form?

This form allows Empire Management Group to access your online account with the insurance carrier. We match your Explanation of Benefits to your Benny Card charges. This process is called substantiation and is required by the IRS. If you do not wish to have Empire Management access your account, you can send the EOB for each Benny Card charge to Empire Management manually. Please contact Empire Management at 985-340-2880 and we can discuss this process.

For a charge to be eligible to be paid by the Benny Card, it must be:

1. A covered service, medication or medical equipment under your medical plan
2. Part of your deductible, co-pay or co-insurance under your medical plan
3. A charge for the employee or any covered dependent on the medical plan only
4. A medical expense incurred in the current calendar year

<h1>Benny Card Services</h1>	Provided by: Empire Management	Provided by: BancorpSouth Insurance
Check to see if the Benny Card is eligible to be funded the additional money provided by the City of Hammond		
Submit expenses for reimbursement when the Benny Card could not be used or for expenses from the prior year		
Verify if the total deductible has been Met by the employee with the medical insurance carrier		
Notify employee if a provider has overcharged them and a refund is due		
Check to see why the Benny Card was declined by a provider and assist in remediating the problem		
Order Benny Card for an employee		
Check the employee's Benny Card balance		
Notify the employee if a claim has not processed with the insurance carrier or was not filed with the carrier		
Provider customer service with any other issues Related to the Benny Card		

*******The approval of Benny Card charges is required by the Internal Revenue Service. In order for a Benny Card charge to be an eligible expense, it must be:**

1. A covered service, medication or medical equipment under your medical insurance plan
2. Part of your deductible, co-pay or co-insurance under your medical plan
3. A charge for the employee or any covered dependents on the medical plan only
4. A medical expense incurred in the current calendar year (contact our office for assistance paying medical bills incurred in the prior year)

Dental Insurance

City of Hammond offers the Employer Paid Dental Insurance through MetLife.

Plan Design for: City of Hammond Original Plan Effective Date: January 1, 2016

Network: PDP Plus

The Preferred Dentist Program was designed to help you get the dental care you need and help lower your costs. You get benefits for a wide range of covered services — both in and out of the network. The goal is to deliver affordable protection for a healthier smile and a healthier you.

Coverage Type:	In-Network ¹ % of Negotiated Fee ²	Out-of-Network ¹ % of R&C Fee ⁴
Type A - Preventive	100%	100%
Type B - Basic Restorative	80%	80%
Type C - Major Restorative	50%	50%
Type D - Orthodontia	50%	50%
Deductible³		
Individual	\$50	\$50
Family	\$150	\$150
Annual Maximum Benefit:		
Per Individual	\$1500	\$1500
Orthodontia Lifetime Maximum - Ortho applies to Adult and Child		
	Up to dependent age limit	
	\$2000 per Person	\$2000 per Person
Dependent Age:	Eligible for benefits until the day that he or she turns 26.	
<p>1. "In-Network Benefits" means benefits provided under this plan for covered dental services that are provided by a MetLife PDP dentist. "Out-of-Network Benefits" means benefits provided under this plan for covered dental services that are not provided by a MetLife PDP dentist.</p> <p>2. PDP Fee refers to the fees that MetLife PDP dentists have agreed to accept as payment in full.</p> <p>3. Applies to Type B and C services only.</p> <p>4. Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:</p> <ul style="list-style-type: none"> <input type="checkbox"/> the dentist's actual charge (the 'Actual Charge'), <input type="checkbox"/> the dentist's usual charge for the same or similar services (the 'Usual Charge') or <input type="checkbox"/> the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 90th percentile. Services must be necessary in terms of generally accepted dental standards. 		

Dental (MetLife)		
	Employee Monthly Cost	Cost Per Check (24)
Employee	\$0.00 (City pays \$24.06)	\$0.00 (City pays \$12.03)
Employee + Spouse	\$24.46	\$12.23
Employee + Child(ren)	\$35.14	\$17.57
Employee + Family	\$59.78	\$29.89

Selected Covered Services and Frequency Limitations*

Type A - Preventive

How Many/How Often:

Oral Examinations	2 in 12 months
Full Mouth X-rays	1 in 60 months
Biting X-rays (Adult/Child)	1 in 12 months
Prophylaxis - Cleanings	2 in 12 months
Topical Fluoride Applications	2 in 12 months - Children to age 14
Space Maintainers	1 per lifetime per tooth area - Children up to age 14

Type B - Basic Restorative

How Many/How Often:

Problem Focused Examinations	2 in 12 months
Sealants	1 in 36 months - Children to age 14
Amalgam and Composite Fillings	1 in 24 months.
Endodontics Root Canal	1 per tooth per lifetime
Periodontal Surgery	1 in 60 months per quadrant
Periodontal Scaling & Root Planing	1 in 36 months per quadrant
Periodontal Maintenance	2 in 1 year, includes 2 cleanings
Oral Surgery (Simple Extractions)	
Oral Surgery (Surgical Extractions)	
Other Oral Surgery	
Emergency Palliative Treatment	

Type C - Major Restorative

How Many/How Often:

Crowns/Inlays/Onlays	1 per tooth in 10 years
Prefabricated Crowns	1 per tooth in 24 months
Repairs	1 in 24 months
Bridges	1 in 10 years
Dentures	1 in 10 years
General Anesthesia	
Consultations	1 in 12 months
Implant Services	1 service per tooth in 10 years - 1 repair per 12 months
TMJ	Major Service as part of Annual Maximum.

Type D – Orthodontia

<ul style="list-style-type: none"> <input type="checkbox"/> Adult and Child Coverage. Dependent children up to age 26. Age limitations may vary by state. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern. <input type="checkbox"/> All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia. <input type="checkbox"/> Benefits for the initial placement will not exceed 20% of the Lifetime Maximum Benefit Amount for Orthodontia. Periodic follow-up visits will be payable on a monthly basis during the scheduled course of the orthodontic treatment. Allowable expenses for the initial placement, periodic follow-up visits and procedures performed in connection with the orthodontic treatment, are all subject to the Orthodontia coinsurance level and Lifetime Maximum Benefit Amount as defined in the Plan Summary. <input type="checkbox"/> Orthodontic benefits end at cancellation of coverage

***Alternate Benefits:** Your dental plan provides that if there are two or more professionally acceptable dental treatment alternatives for a dental condition, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you receive a more costly treatment alternative, your dentist may charge you or your dependent for the difference between the cost of the service that was performed and the least costly treatment alternative.

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern.

Like most group dental insurance policies, MetLife group policies contain certain exclusions, limitations and waiting periods and terms for keeping them in force. The certificate of insurance sets forth all plan terms and provisions, including all exclusions and limitations.

Voluntary Vision Insurance

City of Hammond offers the Voluntary Vision Insurance through MetLife.

With your Vision Preferred Provider Organization Plan, you can:

- Go to any licensed vision specialist and receive coverage. Just remember your benefit dollars go further when you stay in network.
- Choose from a large network of ophthalmologists, optometrists and opticians, from private practices to retailers like Costco® Optical and Vision works.
- Take advantage of our service agreement with Walmart and Sam's Club—they check your eligibility and process claims even though they are out of network.

In-network value added features:

Additional lens enhancements:¹
Average 20-25% savings on all other lens enhancements.

Savings on glasses and sunglasses:
Get 20% savings on additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements. At times, other promotional offers may also be available.

Laser vision correction:²
Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. This offer is only available at MetLife participating locations.

In-network benefits

There are no claims for you to file when you go to a participating vision specialist. Simply pay your copay and, if applicable, any amount over your allowance at the time of service.

	Frequency
Eye exam	Once every 12 months
<input type="checkbox"/> Eye health exam, dilation, prescription and refraction for glasses: Covered in full after \$10 copay.	
<input type="checkbox"/> Retinal imaging: ¹ Up to a \$39 copay on routine retinal screening when performed by a private practice provider.	

Frame	Once every 24 months
<input type="checkbox"/> Allowance: \$130 after \$25 eyewear copay.	
<input type="checkbox"/> Costco: \$70 allowance after \$25 eyewear copay. You will receive an additional 20% savings on the amount that you pay over your allowance. This offer is available from all participating locations except Costco. ¹	

Standard corrective lenses	Once every 12 months
<input type="checkbox"/> Single vision, lined bifocal, lined trifocal, lenticular: Covered in full after \$25 eyewear copay	

Standard lens enhancements¹	Once every 12 months
<input type="checkbox"/> Polycarbonate (child up to age 18) and Ultraviolet (UV) coating: Covered in full after \$25 eyewear copay.	

<input type="checkbox"/> Progressive, Polycarbonate (adult), Photochromic, Anti-reflective, Scratch-resistant coatings and Tints: Your cost will be limited to a copay that MetLife has negotiated for you. These copays can be viewed after enrollment at www.metlife.com/mybenefits .	
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

Contact lenses instead of eye glasses	Once every 12 months
<input type="checkbox"/> Contact fitting and evaluation: ¹ Covered in full with a maximum copay of \$60 .	
<input type="checkbox"/> Elective lenses: \$130 allowance.	
<input type="checkbox"/> Necessary lenses: Covered in full after eyewear copay.	

We're here to help

Find a participating vision specialist:

www.metlife.com/mybenefits or call [1-855-MET-EYE1 (1-855-638-3931)]

Get a claim form:

www.metlife.com/mybenefits

General questions:

www.metlife.com/mybenefits or call [1-855-MET-EYE1 (1-855-638-3931)]

Vision (MetLife)		
	Employee Monthly Cost	Cost Per Check (24)
Employee	\$4.44	\$2.22
Employee + Spouse	\$8.88	\$4.44
Employee + Child(ren)	\$7.46	\$3.73
Employee + Family	\$12.46	\$6.23

Out-of-network reimbursement

You pay for services and then submit a claim for reimbursement. The same benefit frequencies for **In-network benefits** apply. Once you enroll, visit www.metlife.com/mybenefits for detailed out-of-network benefits information.

<input type="checkbox"/> Eye exam: up to \$45	<input type="checkbox"/> Single vision lenses: up to \$30	<input type="checkbox"/> Lined trifocal lenses: up to \$65
<input type="checkbox"/> Frames: up to \$70	<input type="checkbox"/> Lined bifocal lenses: up to \$50	<input type="checkbox"/> Progressive lenses: up to \$50
<input type="checkbox"/> Contact lenses:	<input type="checkbox"/> Lenticular lenses: up to \$100	
- Elective up to \$105		
- Necessary up to \$210		

Exclusions and Limitations of Benefits

This plan does not cover the following services, materials and treatments.

Services and Eyewear

- Services and/or materials not specifically included in the Vision Plan Benefits Overview (Schedule of Benefits).
- Any portion of a charge above the Maximum Benefit Allowance or reimbursement indicated in the Schedule of Benefits.
- Any eye examination or corrective eyewear required as a condition of employment.
- Services and supplies received by you or your Dependent before the Vision Insurance starts.
- Missed appointments.
- Services or materials resulting from or in the course of a Covered Person's regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
- Local, state and/or federal taxes, except where MetLife is required by law to pay.
- Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or

1 All lens enhancements are available at participating private practices. Maximum copays and pricing are subject to change without notice. Please check with your provider for details and copays applicable to your lens choice. Please contact your local Costco to confirm the availability of lens enhancements and pricing prior to receiving services. Additional discounts may not be available in certain states.

2 Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. Additional savings on laser vision care is only available at participating locations.

committing or attempting to commit a felony.

- Services and materials obtained while outside the United States, except for emergency vision care.
- Services, procedures, or materials for which a charge would not have been made in the absence of insurance.
- Services: (a) for which the employer of the person receiving such services is not required to pay; or (b) received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
- Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Vision Insurance under the Group Policy be paid first. Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government. The term does not include any plan, program, or coverage provided by a government as an employer or Medicare.
- Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter).
- Two pairs of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost, stolen, or damaged (within the 12 month benefit period from date of purchase.)

Important: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

M130D-10/25

Benefits are underwritten by Metropolitan Life Insurance Company, New York, NY.

Certain claims and network administration services are provided through Vision Service Plan. In certain states, availability of MetLife's group vision benefits is subject to regulatory approval. Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details.

Contact lens insurance policies and service agreements.

Refitting of contact lenses after the initial (90-day) fitting period.

Contact lens modification, polishing, and cleaning.

Treatments

Orthoptics or vision training and any associated supplemental testing.

Medical and surgical treatment of the eye(s).

Medications

Prescription and non-prescription medication

Employer Paid Life Insurance

City of Hammond offers the Employer Paid Life Insurance through **AllState**.
The City pays \$6.00 per month per employee for this coverage

Basic Life	\$30,000
Accidental Death & Dismemberment	\$30,000

Employer Paid Long Term Disability Insurance

City of Hammond offers the Employer Paid Long Term Disability Insurance through **Metlife**.
The City pays for this coverage. The amount of coverage and cost is different for each employee based on their salary.

Monthly Benefit	60% of Predisability Earnings
Maximum Monthly Benefit	\$6,000
Elimination Period	90 Days
Benefit Duration	RBD w/ SSNRA

Voluntary Life Insurance

City of Hammond offers the Voluntary Life Insurance through **AllState**.

Voluntary Life

Voluntary Life Benefit	Increments of \$10,000 to a maximum to \$300,000, minimum of \$10,000
Guarantee Issue	\$100,000
Voluntary Life Cost	See Rate Table

Voluntary Spouse Life

Voluntary Spouse Life Benefit <small>**if you elect Additional Life for yourself, you may elect for your spouse*</small>	Increments of \$5,000 to a maximum to \$150,000, minimum of \$5,000
Spouse Guarantee Issue	\$25,000
Voluntary Spouse Cost	See Rate Table

Voluntary Child(ren) Life

Voluntary Child(ren) Life Benefit <small>**if you elect Additional Life for yourself, you may elect for your child(ren)*</small>	\$10,000
Child(ren) Guarantee Issue	\$10,000
Voluntary Child Cost	See Rate Table

**VOLUNTARY GROUP LIFE SEMI-MONTHLY PREMIUMS FOR ELIGIBLE EMPLOYEES
CITY OF HAMMOND**

Amounts above these **GUARANTEE ISSUE** limits are subject to **Evidence of Insurability:**

Employees to age 60:	\$100,000	Spouses to age 60:	\$25,000
Employees age 60 - 69:	\$20,000	Spouses age 60 - 69:	\$10,000
Employees age 70+:	\$5,000	Spouses age 70+:	\$2,500

Spouse benefits are limited to 50% of the employee's amount subject to the GI limits above
Employee must be covered for Spouse or Dependents to also be covered
Employee is limited to coverage of 5 x Annual Salary subject to GI limits above

GROUP VOLUNTARY LIFE ESTIMATED PREMIUM ILLUSTRATION FOR ALL ELIGIBLE EMPLOYEES

SEMI-MONTHLY PREMIUMS (Applicable for Male/Female Eligible Employees and, separately, for their Dependent Spouses)										
Annual Salary	Maximum Employee Life	Employees								
		Ages 20 - 29	Ages 30 - 34	Ages 35 - 39	Ages 40 - 44	Ages 45 - 49	Ages 50 - 54	Ages 55 - 59	Ages 60 - 64	Ages 65 - 69
\$2,000	\$10,000	\$0.550	\$0.650	\$0.750	\$1.200	\$1.900	\$3.350	\$5.600	\$9.050	\$15.125
\$4,000	\$20,000	\$1.100	\$1.300	\$1.500	\$2.400	\$3.800	\$6.700	\$11.200	\$18.100	\$30.250
\$6,000	\$30,000	\$1.650	\$1.950	\$2.250	\$3.600	\$5.700	\$10.050	\$16.800	\$27.150	\$45.375
\$8,000	\$40,000	\$2.200	\$2.600	\$3.000	\$4.800	\$7.600	\$13.400	\$22.400	\$36.200	\$60.500
\$10,000	\$50,000	\$2.750	\$3.250	\$3.750	\$6.000	\$9.500	\$16.750	\$28.000	\$45.250	\$75.625
\$12,000	\$60,000	\$3.300	\$3.900	\$4.500	\$7.200	\$11.400	\$20.100	\$33.600	\$54.300	\$90.750
\$14,000	\$70,000	\$3.850	\$4.550	\$5.250	\$8.400	\$13.300	\$23.450	\$39.200	\$63.350	\$105.875
\$16,000	\$80,000	\$4.400	\$5.200	\$6.000	\$9.600	\$15.200	\$26.800	\$44.800	\$72.400	\$121.000
\$18,000	\$90,000	\$4.950	\$5.850	\$6.750	\$10.800	\$17.100	\$30.150	\$50.400	\$81.450	\$136.125
\$20,000	\$100,000	\$5.500	\$6.500	\$7.500	\$12.000	\$19.000	\$33.500	\$56.000	\$90.500	\$151.250
\$22,000	\$110,000	\$6.050	\$7.150	\$8.250	\$13.200	\$20.900	\$36.850	\$61.600	\$99.550	\$166.375
\$24,000	\$120,000	\$6.600	\$7.800	\$9.000	\$14.400	\$22.800	\$40.200	\$67.200	\$108.600	\$181.500
\$26,000	\$130,000	\$7.150	\$8.450	\$9.750	\$15.600	\$24.700	\$43.550	\$72.800	\$117.650	\$196.625
\$28,000	\$140,000	\$7.700	\$9.100	\$10.500	\$16.800	\$26.600	\$46.900	\$78.400	\$126.700	\$211.750
\$30,000	\$150,000	\$8.250	\$9.750	\$11.250	\$18.000	\$28.500	\$50.250	\$84.000	\$135.750	\$226.875
\$32,000	\$160,000	\$8.800	\$10.400	\$12.000	\$19.200	\$30.400	\$53.600	\$89.600	\$144.800	\$242.000
\$34,000	\$170,000	\$9.350	\$11.050	\$12.750	\$20.400	\$32.300	\$56.950	\$95.200	\$153.850	\$257.125
\$36,000	\$180,000	\$9.900	\$11.700	\$13.500	\$21.600	\$34.200	\$60.300	\$100.800	\$162.900	\$272.250
\$38,000	\$190,000	\$10.450	\$12.350	\$14.250	\$22.800	\$36.100	\$63.650	\$106.400	\$171.950	\$287.375
\$40,000	\$200,000	\$11.000	\$13.000	\$15.000	\$24.000	\$38.000	\$67.000	\$112.000	\$181.000	\$302.500

Coverage for Dependent Children age 1 to 19 years (to age 25 if a full-time student)	\$10,000
For Dependent Children age 14 days to 1 year (benefit is 10% of age 1-19 child)	\$1,000
Life Semi-Monthly Premium:	\$0.50

Voluntary Short Term Disability Insurance

City of Hammond offers the Voluntary Short Term Disability Insurance through AllState.

	<i>Plan 1</i>	<i>Plan 2</i>
<i>Monthly Benefit</i>	<i>\$400 up to 60% of income</i>	<i>\$400 up to 60% of income</i>
<i>Maximum Monthly Benefit</i>	<i>\$5,000</i>	<i>\$5,000</i>
<i>Elimination Period</i>	<i>7/7</i>	<i>14/14</i>
<i>Benefit Duration</i>	<i>3 Months</i>	<i>3 Months</i>

American Heritage Life Insurance Company
 Group Disability Insurance Policy Illustration
 This Rate Generator does not validate income rules for any States.

This illustration and rates expire 2/9/2016
Issue State: Louisiana

Industry Class: Preferred Plus
Premium Mode: Semi-Monthly

Benefit Period	3	3	3	3	3
Elimination Period Acc/Sick	7/7	7/7	7/7	7/7	7/7
Issue Age	18-49	50-59	60-64	65-69	70 +
Portable?	YES	YES	YES	YES	YES

Monthly Benefit

\$ 400.00	\$ 6.68	\$ 8.12	\$ 10.96	\$ 11.98	\$ 12.61
\$ 500.00	\$ 8.35	\$ 10.15	\$ 13.70	\$ 14.97	\$ 15.77
\$ 600.00	\$ 10.02	\$ 12.17	\$ 16.44	\$ 17.96	\$ 18.92
\$ 700.00	\$ 11.70	\$ 14.20	\$ 19.18	\$ 20.96	\$ 22.07
\$ 800.00	\$ 13.37	\$ 16.23	\$ 21.92	\$ 23.95	\$ 25.23
\$ 900.00	\$ 15.04	\$ 18.26	\$ 24.66	\$ 26.94	\$ 28.38
\$ 1,000.00	\$ 16.71	\$ 20.29	\$ 27.40	\$ 29.94	\$ 31.53
\$ 1,100.00	\$ 18.38	\$ 22.32	\$ 30.14	\$ 32.93	\$ 34.68
\$ 1,200.00	\$ 20.05	\$ 24.35	\$ 32.88	\$ 35.92	\$ 37.84
\$ 1,300.00	\$ 21.72	\$ 26.38	\$ 35.62	\$ 38.92	\$ 40.99
\$ 1,400.00	\$ 23.39	\$ 28.40	\$ 38.36	\$ 41.91	\$ 44.14
\$ 1,500.00	\$ 25.06	\$ 30.43	\$ 41.10	\$ 44.90	\$ 47.30
\$ 1,600.00	\$ 26.73	\$ 32.46	\$ 43.84	\$ 47.90	\$ 50.45
\$ 1,700.00	\$ 28.40	\$ 34.49	\$ 46.58	\$ 50.89	\$ 53.60
\$ 1,800.00	\$ 30.07	\$ 36.52	\$ 49.31	\$ 53.88	\$ 56.75
\$ 1,900.00	\$ 31.74	\$ 38.55	\$ 52.05	\$ 56.88	\$ 59.91
\$ 2,000.00	\$ 33.41	\$ 40.58	\$ 54.79	\$ 59.87	\$ 63.06
\$ 2,100.00	\$ 35.08	\$ 42.61	\$ 57.53	\$ 62.86	\$ 66.21
\$ 2,200.00	\$ 36.75	\$ 44.63	\$ 60.27	\$ 65.86	\$ 69.37
\$ 2,300.00	\$ 38.42	\$ 46.66	\$ 63.01	\$ 68.85	\$ 72.52
\$ 2,400.00	\$ 40.09	\$ 48.69	\$ 65.75	\$ 71.84	\$ 75.67
\$ 2,500.00	\$ 41.76	\$ 50.72	\$ 68.49	\$ 74.84	\$ 78.83
\$ 2,600.00	\$ 43.43	\$ 52.75	\$ 71.23	\$ 77.83	\$ 81.98
\$ 2,700.00	\$ 45.10	\$ 54.78	\$ 73.97	\$ 80.82	\$ 85.13
\$ 2,800.00	\$ 46.77	\$ 56.81	\$ 76.71	\$ 83.82	\$ 88.28
\$ 2,900.00	\$ 48.44	\$ 58.84	\$ 79.45	\$ 86.81	\$ 91.44
\$ 3,000.00	\$ 50.11	\$ 60.86	\$ 82.19	\$ 89.80	\$ 94.59
\$ 3,100.00	\$ 51.79	\$ 62.89	\$ 84.93	\$ 92.80	\$ 97.74
\$ 3,200.00	\$ 53.46	\$ 64.92	\$ 87.67	\$ 95.79	\$ 100.90
\$ 3,300.00	\$ 55.13	\$ 66.95	\$ 90.41	\$ 98.78	\$ 104.05
\$ 3,400.00	\$ 56.80	\$ 68.98	\$ 93.15	\$ 101.78	\$ 107.20
\$ 3,500.00	\$ 58.47	\$ 71.01	\$ 95.89	\$ 104.77	\$ 110.35
\$ 3,600.00	\$ 60.14	\$ 73.04	\$ 98.63	\$ 107.76	\$ 113.51
\$ 3,700.00	\$ 61.81	\$ 75.07	\$ 101.37	\$ 110.76	\$ 116.66
\$ 3,800.00	\$ 63.48	\$ 77.09	\$ 104.11	\$ 113.75	\$ 119.81
\$ 3,900.00	\$ 65.15	\$ 79.12	\$ 106.85	\$ 116.74	\$ 122.97
\$ 4,000.00	\$ 66.82	\$ 81.15	\$ 109.59	\$ 119.74	\$ 126.12
\$ 4,100.00	\$ 68.49	\$ 83.18	\$ 112.33	\$ 122.73	\$ 129.27
\$ 4,200.00	\$ 70.16	\$ 85.21	\$ 115.06	\$ 125.72	\$ 132.42
\$ 4,300.00	\$ 71.83	\$ 87.24	\$ 117.80	\$ 128.72	\$ 135.58
\$ 4,400.00	\$ 73.50	\$ 89.27	\$ 120.54	\$ 131.71	\$ 138.73
\$ 4,500.00	\$ 75.17	\$ 91.30	\$ 123.28	\$ 134.70	\$ 141.88
\$ 4,600.00	\$ 76.84	\$ 93.32	\$ 126.02	\$ 137.70	\$ 145.04
\$ 4,700.00	\$ 78.51	\$ 95.35	\$ 128.76	\$ 140.69	\$ 148.19
\$ 4,800.00	\$ 80.18	\$ 97.38	\$ 131.50	\$ 143.68	\$ 151.34
\$ 4,900.00	\$ 81.85	\$ 99.41	\$ 134.24	\$ 146.68	\$ 154.50
\$ 5,000.00	\$ 83.52	\$ 101.44	\$ 136.98	\$ 149.67	\$ 157.65

Allstate Benefits is the marketing name for American Heritage Life Insurance Company, a subsidiary of the Allstate Corporation, Home Office: Northbrook, Illinois. All products are underwritten by American Heritage Life Insurance Company, Home Office: Jacksonville, Florida. This illustration highlights some features of the policy and riders, but is not the insurance contract. Only the actual policy and certificate provisions control. The policy and riders set forth, in detail, the rights and obligations of both the insured and the insurance company. ©2011 Allstate Insurance Company.

The Maximum Monthly Benefit that can be applied for must be reduced by the Monthly Benefits of all other existing coverage.

This illustration is incomplete without Brochure SCSET

This quote is incomplete and cannot be used without the accompanying illustration pages that provide a complete description of all benefits, limitations and exclusions.

American Heritage Life Insurance Company
 Group Disability Insurance Policy Illustration
 This Rate Generator does not validate income rules for any States.

This illustration and rates expire 2/9/2016
Issue State: Louisiana

Industry Class: Preferred Plus
Premium Mode: Semi-Monthly

Benefit Period	3	3	3	3	3
Elimination Period Acc/Sick	14/14	14/14	14/14	14/14	14/14
Issue Age	18-49	50-59	60-64	65-69	70 +
Portable?	YES	YES	YES	YES	YES

Monthly Benefit

\$ 400.00	\$ 4.88	\$ 6.02	\$ 7.90	\$ 8.36	\$ 9.26
\$ 500.00	\$ 6.09	\$ 7.53	\$ 9.87	\$ 10.45	\$ 11.58
\$ 600.00	\$ 7.31	\$ 9.03	\$ 11.84	\$ 12.54	\$ 13.89
\$ 700.00	\$ 8.53	\$ 10.54	\$ 13.82	\$ 14.63	\$ 16.21
\$ 800.00	\$ 9.75	\$ 12.04	\$ 15.79	\$ 16.72	\$ 18.53
\$ 900.00	\$ 10.97	\$ 13.55	\$ 17.77	\$ 18.80	\$ 20.84
\$ 1,000.00	\$ 12.19	\$ 15.05	\$ 19.74	\$ 20.89	\$ 23.16
\$ 1,100.00	\$ 13.40	\$ 16.56	\$ 21.71	\$ 22.98	\$ 25.47
\$ 1,200.00	\$ 14.62	\$ 18.06	\$ 23.69	\$ 25.07	\$ 27.79
\$ 1,300.00	\$ 15.84	\$ 19.57	\$ 25.66	\$ 27.16	\$ 30.10
\$ 1,400.00	\$ 17.06	\$ 21.07	\$ 27.63	\$ 29.25	\$ 32.42
\$ 1,500.00	\$ 18.28	\$ 22.58	\$ 29.61	\$ 31.34	\$ 34.73
\$ 1,600.00	\$ 19.50	\$ 24.08	\$ 31.58	\$ 33.43	\$ 37.05
\$ 1,700.00	\$ 20.71	\$ 25.59	\$ 33.56	\$ 35.52	\$ 39.36
\$ 1,800.00	\$ 21.93	\$ 27.09	\$ 35.53	\$ 37.61	\$ 41.68
\$ 1,900.00	\$ 23.15	\$ 28.60	\$ 37.50	\$ 39.70	\$ 44.00
\$ 2,000.00	\$ 24.37	\$ 30.10	\$ 39.48	\$ 41.79	\$ 46.31
\$ 2,100.00	\$ 25.59	\$ 31.61	\$ 41.45	\$ 43.87	\$ 48.63
\$ 2,200.00	\$ 26.81	\$ 33.11	\$ 43.42	\$ 45.96	\$ 50.94
\$ 2,300.00	\$ 28.02	\$ 34.62	\$ 45.40	\$ 48.05	\$ 53.26
\$ 2,400.00	\$ 29.24	\$ 36.12	\$ 47.37	\$ 50.14	\$ 55.57
\$ 2,500.00	\$ 30.46	\$ 37.63	\$ 49.35	\$ 52.23	\$ 57.89
\$ 2,600.00	\$ 31.68	\$ 39.13	\$ 51.32	\$ 54.32	\$ 60.20
\$ 2,700.00	\$ 32.90	\$ 40.64	\$ 53.29	\$ 56.41	\$ 62.52
\$ 2,800.00	\$ 34.12	\$ 42.14	\$ 55.27	\$ 58.50	\$ 64.83
\$ 2,900.00	\$ 35.33	\$ 43.65	\$ 57.24	\$ 60.59	\$ 67.15
\$ 3,000.00	\$ 36.55	\$ 45.15	\$ 59.21	\$ 62.68	\$ 69.46
\$ 3,100.00	\$ 37.77	\$ 46.66	\$ 61.19	\$ 64.77	\$ 71.78
\$ 3,200.00	\$ 38.99	\$ 48.16	\$ 63.16	\$ 66.86	\$ 74.10
\$ 3,300.00	\$ 40.21	\$ 49.67	\$ 65.14	\$ 68.94	\$ 76.41
\$ 3,400.00	\$ 41.43	\$ 51.17	\$ 67.11	\$ 71.03	\$ 78.73
\$ 3,500.00	\$ 42.64	\$ 52.68	\$ 69.08	\$ 73.12	\$ 81.04
\$ 3,600.00	\$ 43.86	\$ 54.18	\$ 71.06	\$ 75.21	\$ 83.36
\$ 3,700.00	\$ 45.08	\$ 55.69	\$ 73.03	\$ 77.30	\$ 85.67
\$ 3,800.00	\$ 46.30	\$ 57.19	\$ 75.00	\$ 79.39	\$ 87.99
\$ 3,900.00	\$ 47.52	\$ 58.70	\$ 76.98	\$ 81.48	\$ 90.30
\$ 4,000.00	\$ 48.74	\$ 60.20	\$ 78.95	\$ 83.57	\$ 92.62
\$ 4,100.00	\$ 49.95	\$ 61.71	\$ 80.93	\$ 85.66	\$ 94.93
\$ 4,200.00	\$ 51.17	\$ 63.21	\$ 82.90	\$ 87.75	\$ 97.25
\$ 4,300.00	\$ 52.39	\$ 64.72	\$ 84.87	\$ 89.84	\$ 99.57
\$ 4,400.00	\$ 53.61	\$ 66.22	\$ 86.85	\$ 91.93	\$ 101.88
\$ 4,500.00	\$ 54.83	\$ 67.73	\$ 88.82	\$ 94.01	\$ 104.20
\$ 4,600.00	\$ 56.05	\$ 69.23	\$ 90.79	\$ 96.10	\$ 106.51
\$ 4,700.00	\$ 57.26	\$ 70.74	\$ 92.77	\$ 98.19	\$ 108.83
\$ 4,800.00	\$ 58.48	\$ 72.24	\$ 94.74	\$ 100.28	\$ 111.14
\$ 4,900.00	\$ 59.70	\$ 73.75	\$ 96.72	\$ 102.37	\$ 113.46
\$ 5,000.00	\$ 60.92	\$ 75.25	\$ 98.69	\$ 104.46	\$ 115.77

Allstate Benefits is the marketing name for American Heritage Life Insurance Company, a subsidiary of the Allstate Corporation, Home Office: Northbrook, Illinois. All products are underwritten by American Heritage Life Insurance Company, Home Office: Jacksonville, Florida. This illustration highlights some features of the policy and riders, but is not the insurance contract. Only the actual policy and certificate provisions control. The policy and riders set forth, in detail, the rights and obligations of both the insured and the insurance company. ©2011 Allstate Insurance Company.

The Maximum Monthly Benefit that can be applied for must be reduced by the Monthly Benefits of all other existing coverage.

This illustration is incomplete without Brochure SCSET

This quote is incomplete and cannot be used without the accompanying illustration pages that provide a complete description of all benefits, limitations and exclusions.

Voluntary Accident Insurance

City of Hammond offers the Voluntary Accident Insurance through AllState.

	OPTION 1	OPTION 2
BASE COVERAGE		
Initial Hospital Confinement	\$1,250	\$1,250
Daily Hospital Confinement	\$250	\$250
Intensive Care	\$500	\$500
DISLOCATION/FRACTURE RIDER		
Dislocation/Fracture Rider	\$5,000	\$6,000
ACCIDENT TREATMENT & URGENT CARE RIDER		
Ground Ambulance	\$200	\$250
Air Ambulance	\$600	\$750
Accident Physicians Treatment	\$100	\$125
X-ray	\$200	\$250
Urgent Care	\$100	\$125
ACCIDENTAL DEATH, DISMEMBERMENT AND FUNCTIONAL LOSS RIDER		
Accidental Death	\$50,000	\$60,000
Common Carrier Accidental Death	\$125,000	\$150,000
Dismemberment	\$50,000	\$60,000
Functional Loss	\$50,000	\$60,000
EMERGENCY ROOM SERVICES RIDER		
Emergency Room Services Rider	\$200	\$250
OUTPATIENT PHYSICIAN'S BENEFIT RIDER		
Outpatient Physician's Benefit Rider	\$50.00	\$62.50

		OPTION 1	OPTION 2
BENEFIT ENHANCEMENT RIDER			
Accident Follow-Up Treatment		\$100	\$125
Lacerations		\$100	\$125
Burns	< 15% of body	\$200	\$250
	≥ 15% of body	\$1,000	\$1,250
Skin Graft (% of Burns Benefit)		50% of burn benefit	50% of burn benefit
Brain Injury Diagnosis		\$600	\$750
Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI) Benefit		\$100	\$125
Paralysis Benefit	Paraplegia	\$15,000	\$18,750
	Quadriplegia	\$30,000	\$37,500
Coma with Respiratory Assistance		\$20,000	\$25,000
Open Abdominal or Thoracic Surgery		\$2,000	\$2,500
Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery Benefit			
	With Repair	\$1,000	\$1,250
	Without Repair	\$300	\$375
Ruptured Disc Surgery		\$1,000	\$1,250
Eye Surgery		\$200	\$250
General Anesthesia		\$200	\$250
Blood and Plasma		\$600	\$750
Appliance		\$250	\$312.50
Medical Supplies		\$10	\$12.50
Medicine		\$10	\$12.50
Prosthesis	One device	\$1,000	\$1,250
	Two or more	\$2,000	\$2,500
Physical, Occupational, or Speech Therapy		\$60	\$75
Rehabilitation Unit		\$200	\$250
Non-Local Transportation		\$500	\$625
Family Member Lodging		\$200	\$250
Post-Accident Transportation		\$400	\$500
Broken Tooth		\$200	\$250
Residence/Vehicle Modification		\$1,000	\$1,250
Pain Management (Epidural Injection)		\$100	\$125
Miscellaneous Outpatient Surgery		\$200	\$250

Voluntary Accident (Allstate) Option 1

	Employee Monthly Cost	Cost Per Check (24)
Employee	\$15.06	\$7.53
Employee + Spouse	\$26.04	\$13.02
Employee + Child(ren)	\$32.38	\$16.19
Employee + Family	\$41.24	\$20.62

Voluntary Accident (Allstate) Option 2

	Employee Monthly Cost	Cost Per Check (24)
Employee	\$18.16	\$9.08
Employee + Spouse	\$31.40	\$15.70
Employee + Child(ren)	\$39.04	\$19.52
Employee + Family	\$49.98	\$24.99

Voluntary Critical Illness Insurance

City of Hammond offers the Voluntary Critical Illness Insurance through AllState.

INITIAL CRITICAL ILLNESS BENEFITS*	OPTION 1	OPTION 2	OPTION 3	OPTION 4
Heart Attack (100%)	\$10,000	\$10,000	\$20,000	\$20,000
Stroke (100%)	\$10,000	\$10,000	\$20,000	\$20,000
Coronary Artery Bypass Surgery (25%)	\$2,500	\$2,500	\$5,000	\$5,000
Major Organ Transplant (100%)	\$10,000	\$10,000	\$20,000	\$20,000
End Stage Renal Failure (100%)	\$10,000	\$10,000	\$20,000	\$20,000
Waiver of Premium (employee only)	Yes	Yes	Yes	Yes
CANCER CRITICAL ILLNESS BENEFITS*				
Invasive Cancer (100%)	\$10,000	\$0	\$20,000	\$0
Carcinoma in Situ (25%)	\$2,500	\$0	\$5,000	\$0
SUPPLEMENTAL CRITICAL ILLNESS BENEFITS*				
Benign Brain Tumor (100%)	\$10,000	\$10,000	\$20,000	\$20,000
Coma (100%)	\$10,000	\$10,000	\$20,000	\$20,000
Complete Blindness (100%)	\$10,000	\$10,000	\$20,000	\$20,000
Complete Loss of Hearing (100%)	\$10,000	\$10,000	\$20,000	\$20,000
Paralysis (100%)	\$10,000	\$10,000	\$20,000	\$20,000
Advanced Alzheimer's Disease (25%)	\$2,500	\$2,500	\$5,000	\$5,000
Advanced Parkinson's Disease (25%)	\$2,500	\$2,500	\$5,000	\$5,000
ADDITIONAL BENEFITS				
Second Event Initial Critical Illness Benefit	Yes	Yes	Yes	Yes
Wellness Benefit (per year)	\$50	\$50	\$50	\$50
ADDITIONAL FEATURES				
Remove Pre-existing Condition Limitation	Yes	Yes	Yes	Yes
Continuation of Insurance Coverage to Age 70	Yes	Yes	Yes	Yes

* Insured employees are eligible for 100% of the benefit amounts listed; covered dependents are eligible for 50% of the employee benefit amount.

Voluntary Critical Illness (AllState)

Option 1 – Cost Per Check (24)

Issue Age	\$10,000 non-tobacco		tobacco	
	EE, EE & CH	EE & SP, Family	EE, EE & CH	EE & SP, Family
18-29	\$2.55	\$4.14	\$3.71	\$5.88
30-39	\$4.49	\$7.05	\$6.93	\$10.71
40-49	\$8.18	\$12.57	\$14.37	\$21.87
50-59	\$14.42	\$21.95	\$24.24	\$36.67
60-63	\$23.36	\$35.36	\$39.90	\$60.16
64+	\$30.62	\$46.24	\$52.83	\$79.56

Option 2 – Cost Per Check (24)

Issue Age	\$10,000 non-tobacco		tobacco	
	EE, EE & CH	EE & SP, Family	EE, EE & CH	EE & SP, Family
18-29	\$1.37	\$2.37	\$1.77	\$2.97
30-39	\$2.42	\$3.94	\$3.42	\$5.44
40-49	\$4.07	\$6.41	\$6.64	\$10.27
50-59	\$7.23	\$11.16	\$11.49	\$17.54
60-63	\$12.21	\$18.63	\$19.94	\$30.22
64+	\$17.11	\$25.98	\$28.37	\$42.87

Option 3 – Cost Per Check (24)

Issue Age	\$20,000 non-tobacco		tobacco	
	EE, EE & CH	EE & SP, Family	EE, EE & CH	EE & SP, Family
18-29	\$4.48	\$7.03	\$6.81	\$10.52
30-39	\$8.36	\$12.85	\$13.23	\$20.16
40-49	\$15.74	\$23.91	\$28.12	\$42.49
50-59	\$28.23	\$42.65	\$47.85	\$72.09
60-63	\$46.10	\$69.46	\$79.17	\$119.06
64+	\$60.62	\$91.24	\$105.03	\$157.86

Option 4 – Cost Per Check (24)

Issue Age	\$20,000 non-tobacco		tobacco	
	EE, EE & CH	EE & SP, Family	EE, EE & CH	EE & SP, Family
18-29	\$2.12	\$3.49	\$2.92	\$4.69
30-39	\$4.21	\$6.63	\$6.22	\$9.64
40-49	\$7.51	\$11.58	\$12.65	\$19.29
50-59	\$13.85	\$21.08	\$22.34	\$33.83
60-63	\$23.80	\$36.01	\$39.25	\$59.19
64+	\$33.59	\$50.70	\$56.12	\$84.49

Please note:

EE- Employee Only Coverage
 EE& CH- Employee and Child(ren) Coverage
 EE & SP- Employee and Spouse Coverage
 Family- Family Coverage

Voluntary Cancer (Allstate) Option 1

	Employee Monthly Cost	Cost Per Check (24)
Employee	\$16.88	\$8.44
Employee + Spouse	\$26.58	\$13.29
Employee + Child(ren)	\$23.22	\$11.61
Employee + Family	\$32.92	\$16.46

Voluntary Cancer (Allstate) Option 2

	Employee Monthly Cost	Cost Per Check (24)
Employee	\$26.24	\$13.12
Employee + Spouse	\$40.98	\$20.49
Employee + Child(ren)	\$36.84	\$18.42
Employee + Family	\$51.56	\$25.78

Voluntary Cancer (Allstate) Option 3

	Employee Monthly Cost	Cost Per Check (24)
Employee	\$32.40	\$16.20
Employee + Spouse	\$51.00	\$25.50
Employee + Child(ren)	\$45.98	\$22.99
Employee + Family	\$64.54	\$32.27

Carrier Contact Information

We created this simple directory for you. It provides you with important information on your employee benefits and contact information for human resources. For more information on the plans, please contact Henry Powell's office with BancorpSouth Insurance at 1-888-240-5899.

BancorpSouth Insurance Services, Inc.	
Account Manager:	<i>Mickie Thompson</i>
Phone Number:	<i>888-240-5899</i>
Email:	<i>mickie.thompson@bksi.com</i>
Empire Management	
Contact:	<i>Wende Powell</i>
Phone Number:	<i>985-340-2880</i>
Email:	<i>empmgmt@bellsouth.net</i>
City of Hammond Human Resources	
Contact:	<i>Jaquetta McGee</i>
Phone Number:	<i>985-277-5629</i>
Email:	<i>mcgee_jr@hammond.org</i>
Medical Insurance (United Healthcare)	
Phone Number:	<i>866-633-2446</i>
Website:	<i>www.myuhc.com</i>
HRA Card (Consumer Choice Plans)	
Phone Number:	<i>985-340-2880</i>
Website	<i>http://www.consumerchoiceplans.com</i>
Dental, Vision, Long Term Disability Insurance (Metlife)	
Phone Number:	<i>Dental 800-942-0854 / Vision 855-638-3931/ LTD 866-729-9200</i>
Website:	<i>www.metlife.com</i>
Life, Short Term Disability, Accident, Critical Illness, Cancer Insurance (AllState)	
Phone Number:	<i>800-521-3535</i>
Website	<i>www.allstatebenefits.com</i>
Whole Life (Boston Mutual)	
Provider Name:	<i>Boston Mutual</i>
Contact and Phone Number:	<i>Frances Clements 225-755-1288</i>
Email:	<i>francis@clementinsgroup.com</i>
Deferred Comp (VALIC)	
Contact Name:	<i>Colombo Baldini</i>
Phone Number:	<i>225-201-1009</i>
Email:	<i>Colombo.baldini@valic.com</i>
Deferred Comp (Empower Retirement)	
Contact:	<i>C. David Arriaza</i>
Phone Number:	<i>800-937-7604 ext. 35502</i>
Email:	<i>Cesar.arriaza@empower-retirement.com</i>

IMPORTANT NOTICES- PLEASE READ

LIFETIME LIMIT NO LONGER APPLIES

The lifetime limit on the dollar value of benefits under the medical plan no longer applies with respect to “essential health benefits,” as defined under the Affordable Care Act.

NOTICE ABOUT SPECIAL ENROLLMENT RIGHTS

A federal law called the Health Insurance Portability and Accountability Act (HIPAA) requires that we provide you this notice explaining your group health plan’s procedures for your special enrollment rights.

- **Your Special Enrollment Rights-** If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Please refer to the Summary Plan Description or contact your Benefits Administrator with any questions.

PATIENT PROTECTION

You do not need prior authorization from United Healthcare or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact [United Healthcare](#) at [866-633-2446](tel:866-633-2446) and www.myuhc.com.

MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. For Louisiana, go to <http://bhsfweb.dhh.louisiana.gov/LaCHIP> or call 1-877-252-2447. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

WOMEN’S HEALTH AND CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individual receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles, coinsurance, and co-payments (if any) applicable to other medical and surgical benefits provided under this plan. Information on the plans specific deductible, coinsurance, or co-payment amounts is found in the Schedule of Benefits document that is issued with your health benefit booklet.

Rate Recap Sheet

Medical (United Healthcare)		
	Employee Monthly Cost	Cost Per Check (24)
Employee	\$0.00 (City pays \$508.28)	\$0.00 (City pays \$254.14)
Employee + Spouse	\$402.56	\$201.28
Employee + Child(ren)	\$249.06	\$124.53
Employee + Family	\$468.12	\$234.06
Dental (Metlife)		
	Employee Monthly Cost	Cost Per Check (24)
Employee	\$0.00 (City pays \$24.06)	\$0.00 (City pays \$12.03)
Employee + Spouse	\$24.46	\$12.23
Employee + Child(ren)	\$35.14	\$17.57
Employee + Family	\$59.78	\$29.89
Vision (Metlife)		
	Employee Monthly Cost	Cost Per Check (24)
Employee	\$4.44	\$2.22
Employee + Spouse	\$8.88	\$4.44
Employee + Child(ren)	\$7.46	\$3.73
Employee + Family	\$12.46	\$6.23

Coverage	Election	Deduction Per Check (24)
Medical		
Dental		
Vision		
Employer Paid Life	\$30,000	\$0.00 (City pays \$3.00)
Employer Paid Long Term Disability	60% of Income	\$0.00 (City pays)
Voluntary Life		
Voluntary Spouse Life		
Voluntary Child Life		
Voluntary Short Term Disability		
Voluntary Accident		
Voluntary Critical Illness		
Voluntary Cancer		
Boston Mutual – Whole Life		
Colonial Life		
AFLAC		
VALIC- Deferred Compensation		
Great West- Deferred Compensation		
	Total	

The terms "you" and "your" as used in this Annual Enrollment Overview refer to an employee of **City of Hammond** who meets all the eligibility and participation requirements under the **City of Hammond United Healthcare Plan** (the "Plan"). Receipt of this document does not guarantee that the recipient is a participant under the Plan and/or otherwise eligible for benefits under the Plan.

City of Hammond reserves the right to make changes or to terminate any benefit plan or plans at any time, without prior notice to or consent from any employee or participant. If there is any inconsistency between this document and the official plan documents and contracts, the official plan documents and contracts will control.

The information contained in this Annual Enrollment Overview may have been supplied by third parties. Although BancorpSouth Insurance/Wright and Percy Insurance has no reason to doubt the accuracy of information used to prepare this document, we make no representation and give no warranty as to the accuracy, currency or completeness of any information contained in this document or its relevance to the recipient.