

City of Hammond

Group Plan Analysis

2016

	Current UHC Option1 433 w/ J9 \$1900- Dual Plan		Renewal UHC Option2 43Z w/ J9 \$2000- Dual Plan		Plan Proposed Eff 1/1/16 UHC AF9N w/ Tf-INT \$2500- Single Option	
Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible						
Individual	\$1,900	\$3,800	\$2,000	\$4,000	\$2,500	\$5,000
Family	\$3,800	\$7,600	\$6,000	\$8,000	\$5,000	\$10,000
Coinsurance	100%	80/20	80/20	60/40	100%	80/20
Out-of-Pocket Maximum						
Individual	\$4,100	\$8,200	\$6,000	\$12,000	\$2,500	\$10,000
Family	\$8,200	\$16,400	\$12,000	\$24,000	\$5,000	\$20,000
Deductible Included/Excluded?	Included	Included	Included	Included	Included	Included
Office Visit						
Primary Care Physician	100% After Ded	80% After Ded	\$40 Copay Same As Primary Care	60% After Ded	100% After Ded	80% After Ded
Specialist	100% After Ded	80% After Ded		60% After Ded	100% After Ded	80% After Ded
Preventive Care	100% After Ded	80% After Ded	100% Allowable	60% After Ded	100% After Ded	80% After Ded
In-Patient Services	100% After Ded	80% After Ded	80% After Ded	60% After Ded	100% After Ded	80% After Ded
Hospital	100% After Ded	80% After Ded	80% After Ded	60% After Ded	100% After Ded	80% After Ded
Professional Services	100% After Ded	80% After Ded	80% After Ded	60% After Ded	100% After Ded	80% After Ded
Out-Patient Surgery	100% After Ded	80% After Ded	80% After Ded	60% After Ded	100% After Ded	80% After Ded
Maternity Benefit						
Office Visit	100% After Ded	80% After Ded	Same As Primary Care	60% After Ded	100% After Ded	80% After Ded
Inpatient Services	100% After Ded	80% After Ded	80% After Ded	60% After Ded	100% After Ded	80% After Ded
Emergency Room	100% After Ded	80% After Ded	80% After Ded	60% After Ded	100% After Ded	80% After Ded
Prescription Drugs						
Deductible						
Generic	\$7	Same As Network	\$7	Participating Pharmacies Only	100% After Ded 100% After Ded	Same As Network Same As Network
Preferred Brand	\$30	Same As Network	\$30			
Non-Preferred Brand	\$50		\$50			
Multi-Source						
Injectables						
Creditable/Non-Creditable		Creditable		Creditable	Creditable	Creditable
	Count	433 w/ J9 \$1900- Dual Plan	43Z w/ J9 \$2000- Dual Plan	43Z w/ J9 \$2000- Dual Plan	AF9N w/ Tf-INT \$2500- Single Option	
Employee Only	256	\$605.91	\$556.55	\$696.80	\$640.03	\$508.28
Employee Spouse	14	\$1,085.79	\$997.34	\$1,248.66	\$1,146.94	\$910.84
Employee Child(ren)	13	\$902.81	\$829.26	\$1,038.24	\$953.65	\$757.34
Employee Family	38	\$1,163.95	\$1,069.13	\$1,338.55	\$1,229.49	\$976.40
Estimated Monthly Premium		\$225,237.97		\$259,024.85		\$189,820.06
Estimated Annual Premium		\$2,702,855.64		\$3,108,298.20		\$2,277,840.72
Percentage Change From Current				15.00%		-15.72%
Annual Dollar Change From Current				\$405,442.56		(\$425,014.92)
COH		\$605.91	\$556.55	\$696.80	\$640.03	\$508.28
EE		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
ES		\$479.88	\$440.79	\$551.86	\$506.91	\$402.56
EC		\$296.90	\$272.71	\$341.44	\$313.62	\$249.06
EF		\$558.04	\$512.58	\$641.75	\$589.46	\$468.12

City of Hammond

Group Plan Analysis

2016

	Current Plan 1 UHC Option1 433 w/ J9 \$1900		Renewal UHC Option1 433 w/ J9 \$1900		Plan 1 Option 1 Blue Cross Blue Shield of LA Blue Saver \$1900 100%		Plan 1 Option 2 Blue Cross Blue Shield of LA Blue Saver \$3000 100%		Plan 1 Option 3 Humana NPOS 16 COINS/ 100/70 \$2000	
Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible										
Individual	\$1,900	\$3,800	\$1,900	\$3,800	\$1,900	\$3,800	\$3,000	\$6,000	\$2,000	\$6,000
Family	\$3,800	\$7,600	\$3,800	\$7,600	\$3,800	\$7,600	\$600	\$12,000	\$4,000	\$12,000
Coinsurance	100%	80/20	100%	80/20	100%	80/20	100%	80/20	100%	70/30
Out-of-Pocket Maximum										
Individual	\$4,100	\$8,200	\$4,100	\$8,200	\$4,100	\$8,200	\$5,000	\$10,000	\$4,000	\$12,000
Family	\$8,200	\$16,400	\$8,200	\$16,400	\$8,200	\$16,400	\$10,000	\$20,000	\$8,000	\$24,000
Deductible Included/Excluded?	Included	Included	Included	Included	Included	Included	Included	Included	Included	Included
Office Visit										
Primary Care Physician	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	70% After Ded
Specialist	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	70% After Ded
Preventive Care	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	70% After Ded
In-Patient Services	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	70% After Ded
Hospital	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	70% After Ded
Professional Services	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	70% After Ded
Out-Patient Surgery	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	70% After Ded
Maternity Benefit										
Office Visit	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	70% After Ded
Inpatient Services	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	70% After Ded
Emergency Room	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	80% After Ded	100% After Ded	70% After Ded
Prescription Drugs										
Deductible										
Generic	\$7	Same As Network	\$7	Same As Network	100% After Ded	Same As Network	100% After Ded	Same As Network	\$10	Same As Network
Preferred Brand	\$30	Same As Network	\$30	Same As Network	80% After Ded	Same As Network	80% After Ded	Same As Network	\$30	Same As Network
Non-Preferred Brand	\$50		\$50						\$50	
Multi-Source										
Injectables										
Creditable/Non-Creditable	Creditable		Creditable		Creditable		Creditable		Creditable	
Count	433 w/ J9 \$1900		433 w/ J9 \$1900		Blue Saver \$1900 100%		Blue Saver \$3000 100%		NPOS 16 COINS/ 100/70 \$2000	
Employee Only	242	\$605.91		\$696.80		\$695.63		\$532.06		\$883.06
Employee Spouse	13	\$1,085.79		\$1,248.66		\$1,245.10		\$1,064.12		\$1,580.67
Employee Child(ren)	12	\$902.81		\$1,038.24		\$1,106.00		\$984.31		\$1,315.76
Employee Family	36	\$1,163.95		\$1,338.55		\$1,669.50		\$1,516.37		\$1,695.47
Estimated Monthly Premium		\$213,481.41		\$245,504.86		\$257,902.76		\$208,993.12		\$311,075.27
Estimated Annual Premium		\$2,561,776.92		\$2,946,058.32		\$3,094,833.12		\$2,507,917.44		\$3,732,903.24
Percentage Change From Current				15.00%		20.81%		-2.10%		45.72%
Annual Dollar Change From Current				\$384,281.40		\$533,056.20		(\$53,859.48)		\$1,171,126.32

COH	\$605.91	\$696.80	\$695.63	\$532.06	\$883.06
EE	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
ES	\$479.88	\$551.86	\$549.47	\$532.06	\$697.61
EC	\$296.90	\$341.44	\$410.37	\$452.25	\$432.70
EF	\$558.04	\$641.75	\$973.87	\$984.31	\$812.41

City of Hammond

Group Plan Analysis

2016

	Current Plan 2 UHC 43Z w/ J9 \$2000		Renewal Plan 2 UHC 43Z w/ J9 \$2000		Plan 2 Option 1 Blue Cross Blue Shield of LA Premier Blue Copay 80/60 \$2000A		Plan 2 Option 2 Humana NPOS 16 Copay F 80/50 \$2000	
Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible								
Individual	\$2,000	\$4,000	\$2,000	\$4,000	\$2,000	\$4,000	\$2,000	\$6,000
Family	\$6,000	\$8,000	\$6,000	\$8,000	\$6,000	\$12,000	\$4,000	\$12,000
Coinsurance	80/20	60/40	80/20	60/40	80/20	60/40	80/20	50/50
Out-of-Pocket Maximum								
Individual	\$6,000	\$12,000	\$6,000	\$12,000	\$5,750	\$11,500	\$6,500	\$13,500
Family	\$12,000	\$24,000	\$12,000	\$24,000	\$11,500	\$23,000	\$19,500	\$39,000
Deductible Included/Excluded?	Included	Included	Included	Included	Included	Included	Included	Included
Office Visit								
Primary Care Physician	\$40 Copay Same As Primary Care	60% After Ded	\$40 Copay Same As Primary Care	60% After Ded	\$40 Copay	60% After Ded	\$25 Copay	50% After Ded
Specialist	\$55 Copay	60% After Ded	\$55 Copay	60% After Ded	\$55 Copay	60% After Ded	\$40 Copay	50% After Ded
Preventive Care	100% Allowable	60% After Ded	100% Allowable	60% After Ded	100% Allowable	60% After Ded	100% Allowable	50% After Ded
In-Patient Services	80% After Ded	60% After Ded	80% After Ded	60% After Ded	80% After Ded	60% After Ded	80% After Ded	50% After Ded
Hospital	80% After Ded	60% After Ded	80% After Ded	60% After Ded	80% After Ded	60% After Ded	80% After Ded	50% After Ded
Professional Services	80% After Ded	60% After Ded	80% After Ded	60% After Ded	80% After Ded	60% After Ded	80% After Ded	50% After Ded
Out-Patient Surgery	80% After Ded	60% After Ded	80% After Ded	60% After Ded	80% After Ded	60% After Ded	80% After Ded	50% After Ded
Maternity Benefit								
Office Visit	Same As Primary Care	60% After Ded	Same As Primary Care	60% After Ded	Same As Primary Care	60% After Ded	Same As Primary Care	50% After Ded
Inpatient Services	80% After Ded	60% After Ded	80% After Ded	60% After Ded	80% After Ded	60% After Ded	80% After Ded	50% After Ded
Emergency Room	80% After Ded	60% After Ded	80% After Ded	60% After Ded	\$150 Copay	60% After Ded	\$150 Copay	50% After Ded
Prescription Drugs								
Deductible		Participating Pharmacies Only		Participating Pharmacies Only		Participating Pharmacies Only		Participating Pharmacies Only
Generic	\$7		\$7		\$7		\$10	
Preferred Brand	\$30		\$30		\$30		\$30	
Non-Preferred Brand	\$50		\$50		\$70		\$50	
Multi-Source								
Injectables								
Creditable/Non-Creditable		Creditable		Creditable		Creditable		Creditable
Count	43Z w/ J9 \$2000		43Z w/ J9 \$2000		Premier Blue Copay 80/60 \$2000A		NPOS 16 Copay F 80/50 \$2000	
Employee Only	14	\$556.55		\$640.03		\$661.72		\$853.13
Employee Spouse	1	\$997.34		\$1,146.94		\$1,184.48		\$1,527.10
Employee Child(ren)	1	\$829.26		\$953.65		\$1,052.14		\$1,271.16
Employee Family	2	\$1,069.13		\$1,229.49		\$1,588.13		\$1,638.01
Estimated Monthly Premium		\$11,756.56		\$13,519.99		\$14,676.96		\$18,018.10
Estimated Annual Premium		\$141,078.72		\$162,239.88		\$176,123.52		\$216,217.20
Percentage Change From Current				15.00%		24.84%		53.26%
Annual Dollar Change From Current				\$21,161.16		\$35,044.80		\$75,138.48

COH	\$556.55	\$640.03	\$661.72	\$853.13
EE	\$0.00	\$0.00	\$0.00	\$0.00
ES	\$440.79	\$506.91	\$522.76	\$673.97
EC	\$272.71	\$313.62	\$390.42	\$418.03
EF	\$512.58	\$589.46	\$926.41	\$784.88

City of Hammond

Group Plan Analysis

2015

256 Singles

65 Family

Benny Card (HRA)

Maximum Exposure	\$ 463,200.00
Total Funded	\$ 245,000.00
Projected Fund Use	\$ 162,120.00
Projected % of Fund Use	35.00%

2015 Funding Method

Employee
COH Funds \$400
Employee \$700
COH Funds \$800
Family
COH Funds \$800
Employee \$1,400
COH Funds \$1,600

*** Funding as of 11/10/15

Benny Card (HRA)

Maximum Exposure	\$ 694,800.00
Total Funding Estimated	\$ 416,880.00
Projected Fund Use	\$ 243,180.00
Projected % of Fund Use	35.00%

Proposed 2016 Funding Method

Employee
COH Funds \$400
Employee \$700
COH Funds \$1400
Family
COH Funds \$800
Employee \$1,400
COH Funds \$2,800

City of Hammond
Compare Plans Report - Basic Life AD&D
1/1/2016



Carrier	Current/ Renewal Standard	Option 5 Allstate	Option 1 Metlife	Option 2 Metlife	Option 3 Cigna
Rate Guarantee	1 Year	2 Year	2 Year	2 Year	2 Year
Participation Requirements	100%	100%	100%	100%	100%
Per Covered Benefit	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000
Volume	\$7,615,000	\$9,138,000	\$7,615,000	\$9,138,000	\$7,615,000
Life Rate	\$0.210	\$0.170	\$0.167	\$0.167	\$0.190
AD & D Rate	\$0.030	\$0.030	\$0.034	\$0.034	\$0.030
Total Rate	\$0.240	\$0.200	\$0.201	\$0.201	\$0.220
Total Monthly Premium	\$1,827.60	\$1,827.60	\$1,530.62	\$1,836.74	\$1,675.30
Total Annual Premium	\$21,931.20	\$21,931.20	\$18,367.38	\$22,040.86	\$20,103.60
Percentage Rate Change	-	0.00%	-16%	1%	-8%
General Plan Information					
Life Benefit	\$25,000	\$30,000	\$25,000	\$30,000	\$25,000
AD & D Benefit	\$25,000	\$30,000	\$25,000	\$30,000	\$25,000
Max Benefit Amount	\$25,000	\$30,000	\$25,000	\$30,000	\$25,000
Age Reduction Schedule	65% at age 65; 50% at age 70; 35% at age 75	65% at age 65; 50% at age 70; 35% at age 75	65% at age 65; 50% at age 70; 35% at age 75	65% at age 65; 50% at age 70; 35% at age 75	65% at age 65; 50% at age 70; 35% at age 75; 35% at age 80; 35% at age 85; 35% at age 90 and 35% at age 90

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.

City of Hammond
Compare Plans Report - Dental
1/1/2016



Carrier Network		Current Assurant	Renewal Assurant	Option 3 Metlife	Option 1 Assurant	Option 2 Metlife	Option 4 Cigna	Option 5 Cigna	Option 6 Allstate
Rate Guarantee		1 Year	1 Year	2 Year	1 Year	2 Year	2 Year	2 Year	2 Year
Participation		100%	100%	100%	100%	100%	100%	100%	100%
Rates	306								
EE	191	\$26.57	\$23.38	\$24.05	\$25.95	\$22.71	\$22.32	\$24.10	\$24.28
EE & Spouse	40	\$53.58	\$47.15	\$48.51	\$52.32	\$45.80	\$45.02	\$48.62	\$48.94
EE & Child(ren)	29	\$65.61	\$57.74	\$59.39	\$62.44	\$56.09	\$55.12	\$59.53	\$59.93
EE & (Family)	46	\$92.62	\$81.51	\$83.84	\$88.78	\$79.17	\$77.82	\$84.05	\$84.61
Total Monthly Premium		\$13,381.28	\$11,775.50	\$12,112.90	\$12,943.89	\$11,438.04	\$11,242.12	\$12,140.57	\$12,225.11
Total Annual Premium		\$160,575.36	\$141,306.00	\$145,354.80	\$155,326.68	\$137,256.48	\$134,905.44	\$145,686.84	\$146,701.32
Percentage Rate Change			-12%	-9%	-3%	-15%	-16%	-9%	-9%
General Plan Information		In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network
Annual Deductible		\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50
Annual Family Deductible		\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150
Annual Plan Maximum		\$1,000	\$1,000	\$1,500	\$1,500	\$1,000	\$1,000	\$1,500	\$1,000
Lifetime Orthodontia Plan Max		\$1,500	\$1,500	\$2,000	\$2,000	\$1,500	\$1,500	\$2,000	\$1,500
UCR Percentile		90	90	90%	90%	90%	90	90	90
Diagnostic and Preventative Svc		100%	100%	100%	100%	100%	100%	100%	100%
Basic Services		80%	80%	80%	80%	80%	80%	80%	80%
Major Services		50%	50%	50%	50%	50%	80%	80%	80%
Endodontic Treatment		80%	80%	80%	80%	80%	80%	80%	80%
Periodontic Treatment		80%	80%	80%	80%	80%	80%	80%	80%
Implant Coverage				50%	50%	50%	50%	50%	50%
Orthodontia Services		50%	50%	50%	50%	50%	50%	50%	50%

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City of Hammond
Compare Plans Report - Vision



1/1/2016

Carrier Network		Current/ Renewal Alwayscare		Option 1 Metlife VSP Choice		Option 2 Assurant VSP Choice	
Rate Guarantee		1 Year		2 Year		2 Year	
Participation				76%		76%	
Rates							
EE	148	\$4.56		\$4.44		\$4.40	
EE & Spouse	3	\$9.12		\$8.88		\$8.80	
EE & Child(ren)	42	\$7.66		\$7.45		\$7.39	
EE & (Family)	34	\$12.80		\$12.46		\$12.35	
Total Monthly Premium		\$1,459.16		\$1,420.30		\$1,407.88	
Total Annual Premium		\$17,509.92		\$17,043.60		\$16,894.56	
Percentage Rate Increase				-3%		-1%	
		In - Network	Out-of-Network	In - Network	Out-of-Network	In - Network	Out-of-Network
Plan Copays							
Examination		\$10	up to \$35	\$10	\$45 allowance	\$10	\$45 allowance
Materials		\$25		\$25		\$25	
Benefit Frequencies							
Examination		<i>12 months</i>		<i>12 months</i>		<i>12 months</i>	
Lenses		<i>12 months</i>		<i>12 months</i>		<i>12 months</i>	
Frames		<i>24 months</i>		<i>24 months</i>		<i>24 months</i>	
Contacts		<i>12 months</i>		<i>12 months</i>		<i>12 months</i>	
Lens Benefits							
Single Vision Lens		Covered by Copay	up to \$25	Covered by Copay	\$30 allowance	Covered by Copay	\$55 allowance
Bifocal Lens		Covered by Copay	up to \$40	Covered by Copay	\$50 allowance	Covered by Copay	\$75 allowance
Trifocal Lens		Covered by Copay	up to \$50	Covered by Copay	\$65 allowance	Covered by Copay	\$95 allowance
Lenticular		\$80 Allowance	up to \$50	Covered by Copay	\$100 allowance	Covered by Copay	\$125 allowance
Basic Progressive		\$70 Allowance	up to \$40	up to \$55 copay	\$50 allowance	up to \$55 copay	
Contact Lens Benefits							
Medically Necessary		up to \$210	up to \$210	Covered in full after eyewear copay	\$210 allowance	Covered in full after eyewear copay	\$210 allowance
Elective		up to \$120	up too \$100	up to \$130	\$105 allowance	up to \$130	\$105 allowance
Frame Benefits							
		\$120 allowance (\$94 at Wal-Mart, Sam's Club, and Costco)	up to \$50	\$130 allowance (\$70 allowance at Costco)	\$70 allowance	\$130 allowance (\$70 allowance at Costco)	\$57 allowance
Network Lasik Discounts		yes		yes		yes	

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.

City of Hammond
Compare Plans Report - LTD
1/1/2016



Carrier	Option 1 Metlife	Option 2 Cigna
Participation Requirements	100%	100%
Rate Guarantee	2 Years	2 Year
Per Covered Payroll	\$100	\$100
Volume	\$994,626	\$994,646
Rate	\$0.586	\$0.720
Total Monthly Premium	\$5,828.51	\$7,161.45
Total Annual Premium	\$69,942.10	\$85,937.41
General Plan Information		
Benefit Percentage	60%	60%
Monthly Benefit Maximum	\$6,000	\$10,000
Benefit Duration	RBD w/ SSNRA	RBD w/ SSNRA
Elimination Period	90 days	90
Definition of Disability	Due to a Sickness, or as a direct result of accidental injury. See Policy	Due to a Sickness, or as a direct result of accidental injury. See Policy
Own Occupation	Any Occupation	Any Occupation
Social Security Integration	Family Social Security	Family Social Security
Mental Nervous Limitation	24 Months	24 Months
Substance Abuse Limitation	24 Months	24 Months
Pre-Existing Condition Limitations	3/12	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.

City of Hammond
Compare Plans Report - Voluntary Life
1/1/2016



Carrier	Current/ Renewal Standard	Option 3 Allstate	Option 1 Metlife	Option 2 Cigna
Rate Guarantee	1 Year	2 Year	2 Year	2 Year
Participation Requirements				
Volume	Determined Upon Enrollment	Determined Upon Enrollment	Determined Upon Enrollment	Determined Upon Enrollment
Average Age Rate ()				
General Plan Information				
Employee Life Benefit	Increments of \$10,000 to a maximum of \$300,000, minimum of \$10,000	Increments of \$10,000 to a maximum of \$300,000, minimum of \$10,000	Increments of \$10,000 to a maximum of \$300,000, minimum of \$10,000	Increments of \$10,000 to a maximum of \$300,000, minimum of \$10,000
Spouse Life Benefit	Increments of \$5,000 to a maximum of \$150,000, minimum of \$5,000	Increments of \$5,000 to a maximum of \$150,000, minimum of \$5,000	Increments of \$5,000 to a maximum of \$150,000, minimum of \$5,000	Increments of \$5,000 to a maximum of \$150,000, minimum of \$5,000
Child(ren) Life Benefit	\$10,000	\$10,000	\$10,000	\$10,000
Guaranteed Issue Maximum				
Employee	\$100,000	\$100,000	\$100,000	\$100,000
Spouse	\$25,000	\$25,000	\$25,000	\$25,000
Child(ren)	\$10,000	\$10,000	\$10,000	\$10,000
AD&D Benefit	N/A	Available	Available	Available
Age Reduction Schedule	65% at age 65; 50% at age 70; 35% at age 75	65% at age 65; 50% at age 70; 35% at age 75	No Age Reduction	65% at age 65; 50% at age 70; 35% at age 75; 35% at age 80; 35% at age 85; 35% at age 90 and 35% at age 90

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.

Employee Rates

	- Current/Renewal		Allstate - Option 3
<u>Age</u>		<u>Rate</u>	<u>Rate</u>
<20		\$0.110	\$0.110
20-24		\$0.110	\$0.110
25-29		\$0.110	\$0.110
30-34		\$0.130	\$0.130
35-39		\$0.150	\$0.150
40-44		\$0.240	\$0.240
45-49		\$0.380	\$0.380
50-54		\$0.670	\$0.670
55-59		\$1.120	\$1.120
60-64		\$1.810	\$1.810
65-69		\$3.025	\$3.025
70-74		\$7.117	\$7.117
75-79		\$7.117	\$7.117
80-84		\$7.117	\$7.117
85-89		\$7.117	\$7.117
90-100		\$7.117	\$7.117
AD&D (Per \$1,000)		N/A	N/A
Spouse Rates		Spouse Age	
<20		\$0.110	\$0.110
20-24		\$0.110	\$0.110
25-29		\$0.110	\$0.110
30-34		\$0.130	\$0.130
35-39		\$0.150	\$0.150
40-44		\$0.240	\$0.240
45-49		\$0.380	\$0.380
50-54		\$0.670	\$0.670
55-59		\$1.120	\$1.120
60-64		\$1.810	\$1.810
65-69		\$3.025	\$3.025
70-74		\$7.117	\$7.117
75-79		\$7.117	\$7.117
80-84		\$7.117	\$7.117
85-89		\$7.117	\$7.117
90-100		\$7.117	\$7.117
AD&D (Per \$1,000)		N/A	N/A
Child(ren) Rates		\$1.00/\$10,000 (Per Family Unit)	\$1.00/\$1,000 (Per Family Unit)
AD&D		N/A	N/A

City of Hammond
Compare Plans Report - Voluntary STD
1/1/2016



Carrier	Current AFLAC/Colonial	Option 4 Allstate	Option 5 Allstate	Option 1 Metlife	Option 2 Metlife	Option 3 Cigna
Participation Requirements				30%	30%	
Rate Guarantee		2 Year	2 Year	1 Year	1 Year	2 Year
Per Covered Benefit	\$10	\$10	\$10	\$10	\$10	\$10
Volume	Determined Upon Enrollment	Determined Upon Enrollment	Determined Upon Enrollment	Determined Upon Enrollment	Determined Upon Enrollment	Determined Upon Enrollment
General Plan Information						
Definition of Disability		Due to a Sickness, or as a direct result of accidental injury. See Policy	Due to a Sickness, or as a direct result of accidental injury. See Policy	Due to a Sickness, or as a direct result of accidental injury. See Policy	Due to a Sickness, or as a direct result of accidental injury. See Policy	Due to a Sickness, or as a direct result of accidental injury. See Policy
Pre-Existing Limitation		3/12	3/12	3/12	3/12	3/12
Elimination Period						
Accident				14/14	0/7	14/14
Sickness		7/7	14/14			
Benefit Percentage		\$400 Month up to 60%	\$400 Month up to 60%	60%	60%	60%
Weekly Benefit Maximum		\$1200 or 60% of Earnings	\$1200 or 60% of Earnings	\$1000 or 60% of Earnings	\$1000 or 60% of Earnings	\$1200 or 60% of Earnings
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
Compare Plans Report -Accident
1/1/2016



Carrier	Current AFLAC	Option 6 Allstate- Middle Plan	Option 7 Allstate- High Plan	Option 1 Metlife- Low Plan	Option 2 Metlife- High Plan	Option 3 Cigna- Low	Option 4 Cigna- High	Option 5 Allstate- Low Plan
EO	\$26.30	\$15.06	\$18.16	\$11.84	\$22.77	\$7.34	\$13.64	\$10.58
ES	\$35.36	\$26.03	\$31.40	\$18.38	\$35.30	\$12.20	\$22.70	\$18.31
EC	\$39.31	\$32.37	\$39.03	\$21.44	\$41.13	\$16.91	\$31.51	\$22.45
EF	\$50.31	\$41.23	\$49.97	\$28.57	\$54.81	\$21.77	\$40.57	\$29.14

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

Group Name
Compare Plans Report - Critical Illness
1/1/2016



Carrier	Current HM	Option 3 Allstate	Option 1 Metlife	Option 2 Cigna
Illness				
<i>Myocardial Infarction (Heart Attack)</i>	100%	100%	100%	100%
<i>Coronary Artery Bypass</i>	25%	25%		25%
<i>Stroke</i>	100%	100%	100%	100%
<i>Invasive Cancer</i>	100%	100%	100%	100%
<i>Carcinoma in Situ</i>	25%	25%	100%	25%
<i>Skin Cancer</i>	10%	N/A	100%	100%
<i>Heart Transplant</i>	100%	100%	100%	N/A
<i>Major Organ Transplant</i>	100%	100%	100%	100%
<i>End-Stage Renal Disease (Kidney Failure)</i>	100%	100%	100%	100%
<i>Loss of Sight, Speech or Hearing</i>	100%	N/A	N/A	N/A
<i>Coma</i>	100%	N/A	N/A	N/A
<i>Alzheimer's Disease</i>	N/A	N/A	100%	N/A
<i>Lou Gehrig's disease</i>	N/A	N/A	25%	100%
<i>Paralysis</i>	100%	N/A	N/A	100%

The rates outlined above are intended as a rate comparison only. Rates are based on census information recieved. Final rates are subject to