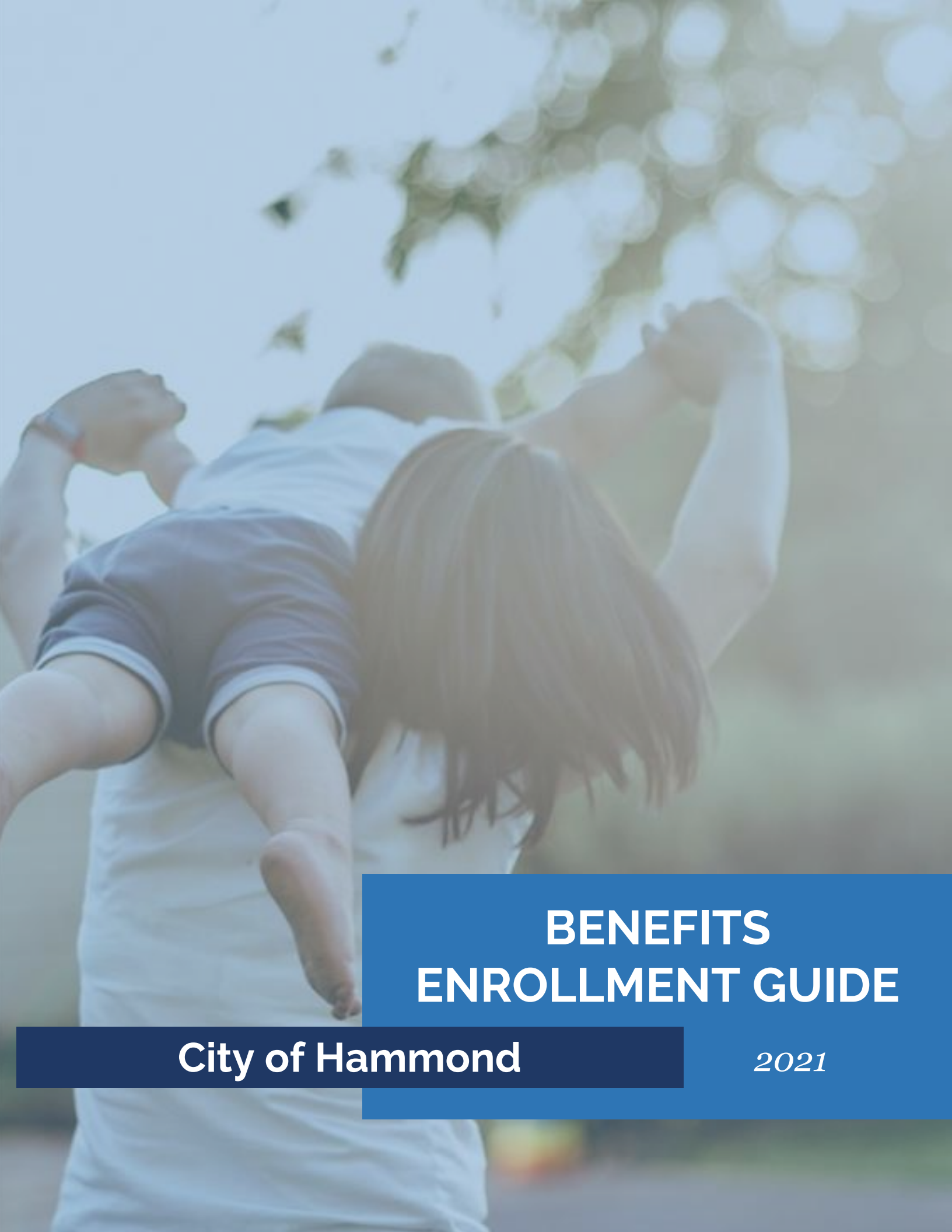


BENEFITS ENROLLMENT GUIDE

City of Hammond

2021

CONTENTS

Open Enrollment Forms Due: Wednesday, November 25th, 2020

BENEFITS OVERVIEW

BENEFITS OVERVIEW

ENROLLMENT

You can enroll in benefits or change your elections at the following times:

- 30 days prior to your initial eligibility date (as a newly hired employee)
- During the annual benefits open enrollment period
- Within 30 days of experiencing a qualifying life event

OPTIONS

We offer a comprehensive benefits package consisting of:

- Medical Insurance
- HRA Funding
- Dental Insurance
- Vision Insurance
- Basic and Voluntary Life and Accidental Death & Dismemberment Insurance
- Disability Insurance
- Accident Insurance
- Critical Illness Insurance
- LegalShield/IDShield
- Employee Assistance Program

BENEFITS OVERVIEW

ELIGIBILITY

Full-time employees working at least 30 hours per week are eligible for benefits on the first of the month following or coinciding with 30 days of employment. Many of the plans offer coverage for eligible dependents, including:

- Your legal spouse
- Your children to age 26, regardless of student, marital, or tax-dependent status (including stepchild, legally adopted child, a child placed with you for adoption, or a child for whom you are the legal guardian)
- Your dependent children over age 26 who are physically or mentally unable to care for themselves

CHANGING BENEFITS AFTER OPEN ENROLLMENT

You may pay your portion of the medical, dental, and vision plan costs, and fund the flexible spending accounts, on a pre-tax basis. Thus, due to IRS regulations, once you have made your elections for the plan year, you cannot change your benefits until the next annual open enrollment period. The only exception is if you experience a qualifying event, and election changes must be consistent with your life event.

To request a benefits change, notify your Business Office or Human Resources within 30 days of the qualifying life event. Change requests submitted after 30 days cannot be accepted. You may need to provide proof of the life event.

Qualifying life events include, but are not limited to:

- Marriage, divorce, or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects his or her benefits
- Change in your child's eligibility for benefits
- Qualified Medical Child Support Order

MEDICAL INSURANCE

MEDICAL INSURANCE

CARRIER: Blue Cross Blue Shield of Louisiana

Please refer to the official plan documents for additional information on coverage and exclusions.

Benefits	BCBSLA Blue Saver 100/80 $3000	
	In-Network Benefit	Out-of-Network Benefit
Deductible Individual Family	 $3,000 $6,000	 $6,000 $12,000
Coinsurance	100%	80%
Out-of-Pocket Maximum Individual Family	 $5,000 $10,000	 $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 for Generic 80% After Deductible for Brand Name	

Medical Insurance Cost		
See chart below for 2021 payroll deductions.		
Elections	Employee Monthly Cost	Cost Per Check (24)
Employee Only	$0.00 (City pays $652.92)	$0.00 (City pays $326.46)
Employee / Spouse	$515.79	$257.90
Employee / Child(ren)	$319.90	$159.95
Family	$600.65	$300.33

HEALTH REIMBURSEMENT ARRANGEMENT

HEALTH REIMBURSEMENT ARRANGEMENT

CARRIER: Empire Management

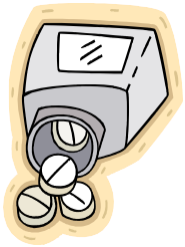
A Health Reimbursement Arrangement (HRA) is an employer-funded health spending account provided and owned by an employer. The money in it pays for qualified expenses that are determined by an employer. Employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year.

How can I use the card?

+

When you go to the doctor or pharmacy make sure to present your Blue Cross Blue Shield 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)

HEALTH REIMBURSEMENT ARRANGEMENT

Deductible Breakdown

	SINGLE	FAMILY
Initial Deductible Funding (City Pays)	$400	$800
Member Deductible Responsibility (Out of Pocket)	$700	$1400
Final Deductible Funding (City Pays)	$1900	$3800
Total BCBS Deductible	$3000	$6000
	Member may incur up to an additional $2000 if taking Brand Name RX	Member may incur up to an additional $4000 if taking Brand Name RX

HEALTH REIMBURSEMENT ARRANGEMENT

All New Members Electing Coverage Will Need to Complete New HIPAA Forms for All Covered on Plan!!!!

HIPAA Form

Individual (person whose protected health information is being disclosed)

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

Printed Name: _____ *Date of Birth: _____

Address: _____

Telephone: _____ *Email Address: _____

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

Authority to Release Protected Health Information

I hereby authorize Blue Cross Blue Shield 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:

x All Claims Information
x Health Plan Benefit Information
x 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:

HEALTH REIMBURSEMENT ARRANGEMENT

Why do we need a HIPAA 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

HEALTH REIMBURSEMENT ARRANGEMENT

Benny Card Services	Provided by: Empire Management	Provided by: BXS 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

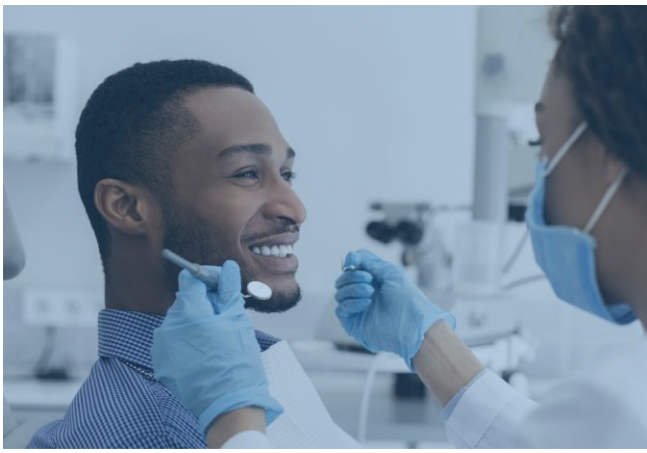
DENTAL INSURANCE

CARRIER: SunLife

You will pay less out of pocket when you choose an in-network provider.

- Be sure to ask for a pre-treatment estimate.
- Out-of-network providers can balance bill, or bill you for the difference between the provider's charge and the allowed amount.

ELECTION	DENTAL PREMIUM PER PAY PERIOD
Employee Only	$0.00
EE & Spouse	$14.06
EE & Child(ren)	$20.20
EE & (Family)	$34.37



	IN-NETWORK	OUT-OF-NETWORK
Type I, II, III (Preventive, Basic and Major Services)	$1,500 per person	$1,500 per person
Type IV Ortho Service	$2,000 lifetime child and adult	$2,000 lifetime child and adult

CALENDAR YEAR DEDUCTIBLE

	IN-NETWORK	OUT-OF-NETWORK
Type I Preventive Services	N/A	N/A
Type II, III (Basic and Major Services)	$50 individual/$150 family	$50 individual/$150 family
Type IV Ortho Services	N/A	N/A

THE PLAN PAYS THE FOLLOWING PERCENTAGE FOR PROCEDURES

	IN-NETWORK	OUT-OF-NETWORK
Type I Preventive Services	100%	100%
Type II Basic Services	80%	80%
Type III Major Services	50%	50%
Type IV Ortho Services	50%	50%

VISION INSURANCE

VISION INSURANCE

CARRIER: SunLife

You will pay less out of pocket when you choose an in-network provider.

- You must submit a claim form for out-of-network expenses.
- LASIK surgery discounts available
- Don't forget about glasses.com and contactsdirect.com!

BENEFIT	FREQUENCY	IN-NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT
Exam services			
WellVision exam®	1 per 12 months	$10 for exam	Up to $45
Routine retinal screening		No more than a $39 copay	
Laser vision correction discount	Once per eye per life-time.	Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.	N/A
Lenses			
Single lined			Up to $30
Bifocal lined			Up to $50
Trifocal	1 per 12 months	$25 (lenses and frame)	Up to $60
Lenticular			Up to $100
Necessary contacts			Up to $210
Lens enhancements			
Standard		$55 copay	N/A
Premium progressive		$95-$105 copay	N/A
Custom progressive		$150–$175 copay	N/A
Other		Average savings of 20-25%	N/A
Frames	1 per 24 months	$130 for the frame of your choice and 20% off the amount over your allowance $70 allowance at Costco®*	Up to $70
Elective contact lenses *Contact lenses are in place of lenses and frame.*	1 per 12 months	$60 for your contact lens exam (fitting and evaluation) $130 for contact lenses	Up to $105

ELECTION	VISION PREMIUM PER PAY PERIOD
Employee Only	$3.09
EE & Spouse	$6.18
EE & Child(ren)	$6.80
EE & (Family)	$9.89

GROUP LIFE and AD&D & VOLUNTARY LIFE and AD&D

GROUP LIFE and AD&D INSURANCE

CARRIER: The Standard
Benefit Amount: $30,000

LIFE and ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Basic life and AD&D insurance are automatically provided to all benefits-eligible employees at no cost. If you die as a result of an accident, your beneficiary would receive both the life and the AD&D benefit.

VOLUNTARY LIFE and AD&D INSURANCE

CARRIER: The Standard

WHAT IS VOLUNTARY LIFE INSURANCE?

Voluntary life insurance, also called group life insurance, is offered through an employer but is paid for partially or solely by employees.

WHY PURCHASE VOLUNTARY LIFE INSURANCE?

- This type of life insurance has limited underwriting required. This allows for people with health conditions or lifestyles that might otherwise disqualify them to qualify for life insurance.
- The group rates are lower than what you could purchase on your own.
- You may purchase a policy for your spouse and children.

REMINDER

Review your beneficiary designations

VOLUNTARY LIFE INSURANCE

Rate Tables (Semi-Monthly)

How Much Can I Apply For?

The coverage amount for your spouse cannot exceed 100 percent of your Additional Life coverage. The coverage amount for your child(ren) cannot exceed 100 percent of your Additional Life coverage.

For You:	**$10,000** - **$500,000** in increments of **$10,000**
For Your Spouse:	**$5,000**-**$100,000** in increments of **$5,000**
For Your Child(ren):	**$10,000**

What is the Guarantee Issue Maximum?

Depending on your eligibility, this is the maximum amount of coverage you may apply for during initial enrollment without answering health questions.

For You:	Up to **$100,000**
For Your Spouse:	Up to **$25,000**

Age (as of January 1)	Your Rate* (Per $1,000 of Total Coverage)	Your Spouse's Rate** (Per $1,000 of Total Coverage)
<30	$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	$0.810	$0.810
65–69	$3.025	$3.025
70–74	$7.117	$7.117
75+	$7.277	$7.277

*Includes a monthly AD&D rate of $0.029 per $1,000 of AD&D benefit.
**Includes a monthly AD&D rate of $0.029 per $1,000 of AD&D benefit for your spouse.

VOLUNTARY LIFE INSURANCE

Rate Tables (Semi-Monthly)

Employee Life with AD&D Semi-Monthly Premiums Group Additional Life and AD&D Insurance

Coverage Amount	Employee's Age as of January 1											
	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74*	75-79*	80+*
$10,000	0.55	0.65	0.75	1.20	1.90	3.35	5.60	4.05	15.13	23.13	18.19	12.73
$20,000	1.10	1.30	1.50	2.40	3.80	6.70	11.20	8.10	30.25	46.26	36.39	25.47
$30,000	1.65	1.95	2.25	3.60	5.70	10.05	16.80	12.15	45.38	69.39	54.58	38.20
$40,000	2.20	2.60	3.00	4.80	7.60	13.40	22.40	16.20	60.50	92.52	72.77	50.94
$50,000	2.75	3.25	3.75	6.00	9.50	16.75	28.00	20.25	75.63	115.65	90.96	63.67
$60,000	3.30	3.90	4.50	7.20	11.40	20.10	33.60	24.30	90.75	138.78	109.16	76.41
$70,000	3.85	4.55	5.25	8.40	13.30	23.45	39.20	28.35	105.88	161.91	127.35	89.14
$80,000	4.40	5.20	6.00	9.60	15.20	26.80	44.80	32.40	121.00	185.04	145.54	101.88
$90,000	4.95	5.85	6.75	10.80	17.10	30.15	50.40	36.45	136.13	208.17	163.73	114.61
$100,000	5.50	6.50	7.50	12.00	19.00	33.50	56.00	40.50	151.25	231.30	181.93	127.35
$110,000	6.05	7.15	8.25	13.20	20.90	36.85	61.60	44.55	166.38	254.43	200.12	140.08
$120,000	6.60	7.80	9.00	14.40	22.80	40.20	67.20	48.60	181.50	277.56	218.31	152.82
$130,000	7.15	8.45	9.75	15.60	24.70	43.55	72.80	52.65	196.63	300.69	236.50	165.55
$140,000	7.70	9.10	10.50	16.80	26.60	46.90	78.40	56.70	211.75	323.82	254.70	178.29
$150,000	8.25	9.75	11.25	18.00	28.50	50.25	84.00	60.75	226.88	346.95	272.89	191.02
$160,000	8.80	10.40	12.00	19.20	30.40	53.60	89.60	64.80	242.00	370.08	291.08	203.76
$170,000	9.35	11.05	12.75	20.40	32.30	56.95	95.20	68.85	257.13	393.21	309.27	216.49
$180,000	9.90	11.70	13.50	21.60	34.20	60.30	100.80	72.90	272.25	416.34	327.47	229.23
$190,000	10.45	12.35	14.25	22.80	36.10	63.65	106.40	76.95	287.38	439.47	345.66	241.96
$200,000	11.00	13.00	15.00	24.00	38.00	67.00	112.00	81.00	302.50	462.61	363.85	254.70
$210,000	11.55	13.65	15.75	25.20	39.90	70.35	117.60	85.05	317.63	485.74	382.04	267.43
$220,000	12.10	14.30	16.50	26.40	41.80	73.70	123.20	89.10	332.75	508.87	400.24	280.16
$230,000	12.65	14.95	17.25	27.60	43.70	77.05	128.80	93.15	347.88	532.00	418.43	292.90
$240,000	13.20	15.60	18.00	28.80	45.60	80.40	134.40	97.20	363.00	555.13	436.62	305.63
$250,000	13.75	16.25	18.75	30.00	47.50	83.75	140.00	101.25	378.13	578.26	454.81	318.37
$260,000	14.30	16.90	19.50	31.20	49.40	87.10	145.60	105.30	393.25	601.39	473.01	331.10
$270,000	14.85	17.55	20.25	32.40	51.30	90.45	151.20	109.35	408.38	624.52	491.20	343.84
$280,000	15.40	18.20	21.00	33.60	53.20	93.80	156.80	113.40	423.50	647.65	509.39	356.57
$290,000	15.95	18.85	21.75	34.80	55.10	97.15	162.40	117.45	438.63	670.78	527.58	369.31
$300,000	16.50	19.50	22.50	36.00	57.00	100.50	168.00	121.50	453.75	693.91	545.78	382.04
$310,000	17.05	20.15	23.25	37.20	58.90	103.85	173.60	125.55	468.88	717.04	563.97	394.78
$320,000	17.60	20.80	24.00	38.40	60.80	107.20	179.20	129.60	484.00	740.17	582.16	407.51
$330,000	18.15	21.45	24.75	39.60	62.70	110.55	184.80	133.65	499.13	763.30	600.35	420.25
$340,000	18.70	22.10	25.50	40.80	64.60	113.90	190.40	137.70	514.25	786.43	618.55	432.98
$350,000	19.25	22.75	26.25	42.00	66.50	117.25	196.00	141.75	529.38	809.56	636.74	445.72
$360,000	19.80	23.40	27.00	43.20	68.40	120.60	201.60	145.80	544.50	832.69	654.93	458.45
$370,000	20.35	24.05	27.75	44.40	70.30	123.95	207.20	149.85	559.63	855.82	673.12	471.19
$380,000	20.90	24.70	28.50	45.60	72.20	127.30	212.80	153.90	574.75	878.95	691.32	483.92
$390,000	21.45	25.35	29.25	46.80	74.10	130.65	218.40	157.95	589.88	902.08	709.51	496.66
$400,000	22.00	26.00	30.00	48.00	76.00	134.00	224.00	162.00	605.00	925.21	727.70	509.39
$410,000	22.55	26.65	30.75	49.20	77.90	137.35	229.60	166.05	620.13	948.34	745.89	522.12
$420,000	23.10	27.30	31.50	50.40	79.80	140.70	235.20	170.10	635.25	971.47	764.09	534.86
$430,000	23.65	27.95	32.25	51.60	81.70	144.05	240.80	174.15	650.38	994.60	782.28	547.59
$440,000	24.20	28.60	33.00	52.80	83.60	147.40	246.40	178.20	665.50	1,017.73	800.47	560.33
$450,000	24.75	29.25	33.75	54.00	85.50	150.75	252.00	182.25	680.63	1,040.86	818.66	573.06
$460,000	25.30	29.90	34.50	55.20	87.40	154.10	257.60	186.30	695.75	1,063.99	836.86	585.80
$470,000	25.85	30.55	35.25	56.40	89.30	157.45	263.20	190.35	710.88	1,087.12	855.05	598.53
$480,000	26.40	31.20	36.00	57.60	91.20	160.80	268.80	194.40	726.00	1,110.25	873.24	611.27
$490,000	26.95	31.85	36.75	58.80	93.10	164.15	274.40	198.45	741.13	1,133.38	891.43	624.00
$500,000	27.50	32.50	37.50	60.00	95.00	167.50	280.00	202.50	756.25	1,156.51	909.63	636.74

* Coverage amounts for ages 70 and over reduce due to age reduction (see Life Insurance Age Reductions section).

VOLUNTARY LIFE INSURANCE

Rate Tables (Semi-Monthly)

Spouse Life with AD&D Semi-Monthly Premiums

Group Additional Life and AD&D Insurance

Coverage Amount	Employee's Age as of January 1											
	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74*	75-79*	80+*
$5,000	0.28	0.33	0.38	0.60	0.95	1.68	2.80	2.03	7.56	11.57	9.10	6.37
$10,000	0.55	0.65	0.75	1.20	1.90	3.35	5.60	4.05	15.13	23.13	18.19	12.73
$15,000	0.83	0.98	1.13	1.80	2.85	5.03	8.40	6.08	22.69	34.70	27.29	19.10
$20,000	1.10	1.30	1.50	2.40	3.80	6.70	11.20	8.10	30.25	46.26	36.39	25.47
$25,000	1.38	1.63	1.88	3.00	4.75	8.38	14.00	10.13	37.81	57.83	45.48	31.84
$30,000	1.65	1.95	2.25	3.60	5.70	10.05	16.80	12.15	45.38	69.39	54.58	38.20
$35,000	1.93	2.28	2.63	4.20	6.65	11.73	19.60	14.18	52.94	80.96	63.67	44.57
$40,000	2.20	2.60	3.00	4.80	7.60	13.40	22.40	16.20	60.50	92.52	72.77	50.94
$45,000	2.48	2.93	3.38	5.40	8.55	15.08	25.20	18.23	68.06	104.09	81.87	57.31
$50,000	2.75	3.25	3.75	6.00	9.50	16.75	28.00	20.25	75.63	115.65	90.96	63.67
$55,000	3.03	3.58	4.13	6.60	10.45	18.43	30.80	22.28	83.19	127.22	100.06	70.04
$60,000	3.30	3.90	4.50	7.20	11.40	20.10	33.60	24.30	90.75	138.78	109.16	76.41
$65,000	3.58	4.23	4.88	7.80	12.35	21.78	36.40	26.33	98.31	150.35	118.25	82.78
$70,000	3.85	4.55	5.25	8.40	13.30	23.45	39.20	28.35	105.88	161.91	127.35	89.14
$75,000	4.13	4.88	5.63	9.00	14.25	25.13	42.00	30.38	113.44	173.48	136.44	95.51
$80,000	4.40	5.20	6.00	9.60	15.20	26.80	44.80	32.40	121.00	185.04	145.54	101.88
$85,000	4.68	5.53	6.38	10.20	16.15	28.48	47.60	34.43	128.56	196.61	154.64	108.25
$90,000	4.95	5.85	6.75	10.80	17.10	30.15	50.40	36.45	136.13	208.17	163.73	114.61
$95,000	5.23	6.18	7.13	11.40	18.05	31.83	53.20	38.48	143.69	219.74	172.83	120.98
$100,000	5.50	6.50	7.50	12.00	19.00	33.50	56.00	40.50	151.25	231.30	181.93	127.35

* Coverage amounts for ages 70 and over reduce due to age reduction (see Life Insurance Age Reductions section).

Child Life with AD&D Semi-Monthly Premiums

Coverage Amount	Premium
$10,000	1.30

DISABILITY INSURANCE

EMPLOYER PAID LONG-TERM DISABILITY INSURANCE

CARRIER: The Standard

EMPLOYER PAID LONG-TERM DISABILITY INSURANCE

LTD insurance is designed to help you meet your financial needs if your disability extends beyond the short-term disability period. City of Hammond pays 100% of the premium amount for this benefit.

- **Benefit** – 60% of base monthly salary up to $6,000 per month
- **Elimination Period:** 90 days from the date of disability
- **Benefit Durations:** Up to age 65

SHORT-TERM DISABILITY INSURANCE

CARRIER: The Standard

SHORT-TERM DISABILITY INSURANCE

Short-Term Disability (STD) insurance is designed to help you meet your financial needs if you become unable to work due to a non-work related illness or injury. This is a voluntary plan; employees are responsible for 100% of the cost. Premiums are calculated as a percentage of your annual base salary.

- **Benefit** – 60% of base weekly salary up to $1,200 per week
- **Elimination Period:** 14 days from the date of injury/14 days from the date of illness
- **Benefit Durations:** 90 days

Your Age (as of January 1)	Rate per $10 of weekly benefit
<30	$0.519
30–34	$0.566
35–39	$0.444
40–44	$0.417
45–49	$0.508
50–54	$0.600
55–59	$0.834
60+	$1.015

ACCIDENT INSURANCE

VOLUNTARY ACCIDENT INSURANCE

Carrier: Boston Mutual

Accident insurance supplements your existing medical insurance in case you are have an accident; medical insurance alone may not be enough to cover your expenses. The plan pays a cash benefit during the term of your coverage following a covered accident and could help cover:

- Out-of-pocket expenses such as copays and deductibles
- Transportation
- Lodging costs
- Emergency room expenses

KEY FEATURES

Coverage: 24 Hour Gold - Custom Plan

SEMI-MONTHLY PREMIUMS

Premiums are unisex, unismoke, are paid by the employee and are payroll deducted. Rates are based on the Certificate Effective Date

Employee	Employee & Spouse	Employee & Children	Employee, Spouse & Children
$5.84	$10.62	$13.16	$17.94

POLICY BENEFITS

All benefits are limited to one benefit per covered accident, per insured, and are paid independently of one another unless specifically noted otherwise.

HOSPITAL CARE

Hospital Admission: Within 6 months after the covered accident. Amount will be doubled if placed in a Hospital Intensive Care Unit within the first 24 hours of admission.	$2,000
Hospital Confinement: Per day up to 365 days. Within 6 months after the covered accident.	$500
Hospital Intensive Care Unit Confinement: Per day up to 30 days. Within 30 days after the covered accident.	$1,000
Lodging: Per day up to 30 days per covered accident for companion. Hospital must be more than 100 miles round trip from the residence of the insured.	$200
Rehabilitation Unit: Per day up to 30 days. When confined in a rehab unit following hospitalization.	$150
Transportation: Up to 3 round trips per covered accident. Insured must travel more than 100 miles round trip for treatment	$600

VOLUNTARY ACCIDENT INSURANCE

EMERGENCY CARE	
Ambulance	
• *Air: Within 48 hours after the covered accident.*	$1,000
• *Ground: Within 90 days after the covered accident.*	$200
Appliance: Within 90 days after the covered accident. For personal locomotion or mobility.	$100
Blood, Plasma, Platelets: Within 90 days after the covered accident.	$200
Physician Office/Urgent Care - Initial Visit: Within 60 days of a covered accident.	$50
Surgery	
•*Outpatient Surgery Facility Service: Torn Knee Cartilage, Ruptured Disc, Tendon/Ligament/Rotator Cuff.*	$200
• *Abdominal or Thoracic with repair: Within 72 hours of a covered accident.*	$1,000
• *Abdominal or Thoracic without repair: Within 72 hours of a covered accident.*	$100
• *Hernia: Diagnosed within 30 days and repaired within 90 days of the covered accident.*	$100
EMERGENCY ROOM	
Emergency Room Treatment: Within 72 hours after a covered accident.	$200
DIAGNOSTIC IMAGING	
Medical Imaging: For CT scan, MRI or EEG as the result of a covered accident.	$200
X-Rays: Payable for diagnosis and treatment of injuries received as the result of a covered accident.	$50
CONTINUING CARE	
Epidural Pain Management: Within 6 months after the covered accident. Payable once per 12 month period.	$100
Physician Follow-Up Care: Within 180 days of the covered accident. Payable twice per covered accident.	$100
Spinal Manipulation: Payable for 1 visit per day, up to a maximum of 5 visits per 12 month period, regardless of the number of covered accidents.	$30
Therapy Services – Occupational, Physical & Speech: Maximum of 10 visits per covered accident and completed within 2 years after the covered accident.	$30
SPECIFIC LOSS	
Burns: Treated by a physician within 72 hours after the covered accident.	
• *2nd degree burns which cover at least 36% of the body*	$1,500
• *3rd degree burns which cover at least 9 square inches of the body but less than 35 square inches*	$3,000
• *3rd degree burns which cover 35 or more square inches of the body*	$20,000
• *Skin Grafts: 25% of the applicable burn benefit*	
Concussion: Diagnosed by a physician within 72 hours after the covered accident.	$300
Emergency Dental Work	
• *Broken teeth repaired with crown(s)*	$300
• *Broken teeth resulting in extraction(s)*	$100
Eye Injury: Within 90 days after the covered accident.	$500

VOLUNTARY ACCIDENT INSURANCE

Gunshot Wound: Treated in a hospital or by a physician as the result of a covered accident.	$2,000
Laceration: Repaired by a physician within 72 hours after the covered accident.	
• *Treated without stitches, staples or glue*	$50
• *Total of all lacerations is not more than 3 inches long and repaired by stitches*	$100
• *Total of all lacerations is greater than 3 inches but not more than 5 inches and repaired by stitches*	$400
• *Total of all lacerations is over 5 inches and repaired by stitches*	$800
Organized Sports: Pays an additional 25% of the total benefit paid for the covered accident up to this amount. Payable once per 12 month period per insured.	$1,000
Prosthetic Device/Artificial Limb: Within 1 year of the covered accident.	
• *One*	$1,000
• *More than one*	$2,000
Ruptured Disc: Treated by a physician within 60 days and repaired through surgery within 1 year after the covered accident.	$1,000
Tendon, Ligament, Rotator Cuff: Within 1 year of the covered accident.	
• *Repair of one*	$1,200
• *Repair of more than one*	$1,800
• *Exploratory without repair*	$300
Torn Knee Cartilage: Treated by a physician within 60 days and repaired through surgery within 1 year after the covered accident.	
• *Surgery with Repair*	$1,500
• *Exploratory surgery*	$300

MAJOR INJURY

Accidental Death: Within 90 days from the date of a covered accident.	
• *Employee*	$100,000
• *Spouse*	$100,000
• *Children*	$20,000
Accidental Death / Common Carrier: Within 90 days after the covered accident.	
• *Employee*	$200,000
• *Spouse*	$200,000
• *Children*	$40,000
Coma: Unconscious for 30 consecutive days if as a result of a covered accident.	$10,000
Dismemberment: Within 90 days after the covered accident.	
• *Loss of both hands, or both feet or the sight of both eyes or any combination of two or more listed*	$20,000
• *Loss of one hand, or one foot or sight of one eye*	$10,000
• *Loss of two or more fingers or two or more toes or any combination of two or more fingers and toes*	$2,400
• *Loss of one finger or one toe*	$1,200

VOLUNTARY ACCIDENT INSURANCE

Catastrophic Accident: Payable after a 365 day elimination period.		
• *Employee (reduced by 50% at age 70)*		$100,000
• *Spouse (reduced by 50% at age 70)*		$100,000
• *Children*		$20,000
DISLOCATIONS: Diagnosed by a physician within 90 days after the covered accident.	Closed	Open
Dislocation (with Anesthesia)		
• *Hip*	$4,000	$8,000
• *Knee (except Patella)*	$2,000	$4,000
• *Ankle – Bones or Bones of Foot (not Toes)*	$1,600	$3,200
• *Collarbone (Sternoclavicular)*	$1,000	$2,000
• *Lower Jaw*	$600	$1,200
• *Shoulder (Glenohumeral)*	$600	$1,200
• *Elbow*	$600	$1,200
• *Wrist*	$600	$1,200
• *Bone or Bones of the Hand (not Fingers)*	$600	$1,200
• *Collarbone (Acromioclavicular and separation)*	$200	$400
• *One Toe or Finger*	$200	$400
• *Closed without Anesthesia: 25% of the closed with anesthesia benefit*		

VOLUNTARY ACCIDENT INSURANCE

FRACTURES: Diagnosed by a physician within 90 days after the covered accident.	Closed	Open
• *Skull - depressed fracture (except Bones of Face or Nose)*	$5,000	$10,000
• *Skull - simple non-depressed fracture (except Bones of Face or Nose)*	$2,000	$4,000
• *Hip, Thigh (Femur)*	$3,000	$6,000
• *Vertebrae, Body of (except Vertebral processes)*	$1,600	$3,200
• *Pelvis (includes Ilium, Ischium, Pubis, Acetabulum except Coccyx)*	$1,600	$3,200
• *Leg*	$1,600	$3,200
• *Bones of Face or Nose (except Mandible or Maxilla)*	$700	$1,400
• *Upper Jaw - Maxilla (except Alveolar process)*	$700	$1,400
• *Upper Arm between Elbow and Shoulder*	$700	$1,400
• *Lower Jaw - Mandible (except Alveolar process)*	$600	$1,200
• *Shoulder blade or Collarbone (Scapula, Clavicle, Sternum)*	$600	$1,200
• *Vertebral Processes*	$600	$1,200
• *Forearm, Hand, Wrist (except fingers)*	$600	$1,200
• *Kneecap (Patella)*	$600	$1,200
• *Foot (except toes)*	$600	$1,200
• *Ankle*	$600	$1,200
• *Rib*	$500	$1,000
• *Coccyx*	$400	$800
• *Finger, Toe*	$100	$200
• *Chips; 25% of closed benefit*		

HEALTH SCREENING BENEFIT RIDER (WPS-ACC HS Rider 07/15)

We will pay $50 for any one or more of the following health screening tests listed below performed by a Physician more than 30 days after the rider effective date. Benefit is payable once per calendar year per insured person.

1. Biopsy for Skin Cancer
2. Blood test for triglycerides
3. Bone marrow testing
4. CA 125 (blood test for ovarian cancer)
5. CA 15-3 (blood test for breast cancer)
6. CEA (blood test for colon cancer)
7. Chest X-ray
8. Colonoscopy
9. Electrocardiogram (EKG)
10. Fasting blood glucose test
11. Flexible sigmoidoscopy
12. Hemocult stool analysis
13. Lipid Panel (total cholesterol count)
14. Mammography/Breast Ultrasound
15. Oral Cancer screening using ViziLite, OraTest or other similar test
16. Pap smear (including ThinPrep Pap Test)
17. PSA (blood test for prostate cancer)
18. Serum Protein Electrophoresis (blood test for myeloma)
19. Stress test on a bicycle or treadmill
20. Thermography

CRITICAL ILLNESS INSURANCE

VOLUNTARY CRITICAL ILLNESS INSURANCE

CARRIER: Boston Mutual

Critical illness insurance supplements your existing medical insurance in case you are diagnosed with a covered condition, like a heart attack or stroke; medical insurance alone may not be enough to cover your expenses. The plan pays a cash benefit during the term of your coverage following a covered diagnosis.

- Critical illness insurance may not cover all types of cancer, but it does cover heart and vascular conditions, cancer-related conditions, and major organ failure

Covered Specified Critical Illnesses	Percent of Benefit Amount
Cancer	100%
Carcinoma in situ	30%
Skin Cancer	$300 one-time *(lifetime)*
Heart Attack *(Myocardial Infarction)*	100%
Coronary Artery Bypass Surgery	30%
Angioplasty & Stent Insertion	30%
Stroke *(Apoplexy or Cerebral Vascular Accident)*	100%
Coma	100%
Paralysis	100%
Severe Burns	100%
Major Organ Transplant	100%
Alzheimer's Disease	100%
ALS *(Lou Gehrig's Disease)*	100%
Loss of Sight/Speech/Hearing	100%
End Stage Renal Disease	100%
Benign Brain Tumor	100%

VOLUNTARY CRITICAL ILLNESS INSURANCE

Rate Tables (Semi-Monthly)

RATES INCLUDE THE FOLLOWING: **Specified Critical Illness including Cancer, Pre-Existing Condition Exclusion, Age 70 Reduction and the $50 Health Screening Benefit Rider. Spouse is eligible to apply for up to 100% of the employee amount. Includes 25% benefit for eligible children.**

Employee Non-Tobacco Rates

Face Purchase – *Semi-Monthly Premiums*

Issue Ages	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$2.25	$3.60	$4.95	$6.30	$7.65	$9.00	$10.35	$11.70	$13.05	$14.40
30-39	$3.35	$5.80	$8.25	$10.70	$13.15	$15.60	$18.05	$20.50	$22.95	$25.40
40-49	$5.40	$9.90	$14.40	$18.90	$23.40	$27.90	$32.40	$36.90	$41.40	$45.90
50-59	$8.55	$16.20	$23.85	$31.50	$39.15	$46.80	$54.45	$62.10	$69.75	$77.40
60-69	$13.90	$26.90	$39.90	$52.90	$65.90	$78.90	$91.90	$104.90	$117.90	$130.90
* 70+	$26.90	$52.90	$78.90	$104.90	$130.90	NA	NA	NA	NA	NA

Employee Tobacco Rates

Face Purchase – *Semi-Monthly Premiums*

Issue Ages	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$2.75	$4.60	$6.45	$8.30	$10.15	$12.00	$13.85	$15.70	$17.55	$19.40
30-39	$4.75	$8.60	$12.45	$16.30	$20.15	$24.00	$27.85	$31.70	$35.55	$39.40
40-49	$8.75	$16.60	$24.45	$32.30	$40.15	$48.00	$55.85	$63.70	$71.55	$79.40
50-59	$15.05	$29.20	$43.35	$57.50	$71.65	$85.80	$99.95	$114.10	$128.25	$142.40
60-69	$25.90	$50.90	$75.90	$100.90	$125.90	$150.90	$175.90	$200.90	$225.90	$250.89
* 70+	$50.90	$100.90	$150.90	$200.90	$250.89	NA	NA	NA	NA	NA

*** Benefit amounts for individuals who are age 70 and over and applying for coverage have already been reduced by 50%.**

Spouse Non-Tobacco Rates *BASED ON SPOUSE AGE*

Face Purchase – *Semi-Monthly Premiums*

Issue Ages	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$2.25	$3.60	$4.95	$6.30	$7.65	$9.00	$10.35	$11.70	$13.05	$14.40
30-39	$3.35	$5.80	$8.25	$10.70	$13.15	$15.60	$18.05	$20.50	$22.95	$25.40
40-49	$5.40	$9.90	$14.40	$18.90	$23.40	$27.90	$32.40	$36.90	$41.40	$45.90
50-59	$8.55	$16.20	$23.85	$31.50	$39.15	$46.80	$54.45	$62.10	$69.75	$77.40
60-69	$13.90	$26.90	$39.90	$52.90	$65.90	$78.90	$91.90	$104.90	$117.90	$130.90

Face Purchase – *Semi-Monthly Premiums*

Issue Ages	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$2.75	$4.60	$6.45	$8.30	$10.15	$12.00	$13.85	$15.70	$17.55	$19.40
30-39	$4.75	$8.60	$12.45	$16.30	$20.15	$24.00	$27.85	$31.70	$35.55	$39.40
40-49	$8.75	$16.60	$24.45	$32.30	$40.15	$48.00	$55.85	$63.70	$71.55	$79.40
50-59	$15.05	$29.20	$43.35	$57.50	$71.65	$85.80	$99.95	$114.10	$128.25	$142.40
60-69	$25.90	$50.90	$75.90	$100.90	$125.90	$150.90	$175.90	$200.90	$225.90	$250.89

Health Screening Benefits

We will pay a $50 benefit if an insured has any one of the covered screening tests after the 30 day waiting period. *(Waiting period does not apply in Kansas, Indiana and Missouri.)* This benefit is paid only once per calendar year, regardless of the number of tests. This benefit is paid regardless of the results of the test. Payment of this benefit will not reduce the amount payable for the diagnosis of a critical illness. There is no limit to the number of years the insured can receive the health screening benefit; it will be paid as long as the policy remains inforce. This benefit is payable for the covered employee *(and spouse if spouse coverage is included)*. This benefit is not paid for dependent children. The covered health screening tests include:

Health Screening Test is defined as:

1. Stress test on a bicycle or treadmill
2. Fasting blood glucose test
3. Blood test for triglycerides
4. Lipid Panel *(total cholesterol count)*
5. Bone marrow testing
6. CA 15-3 *(blood test for breast cancer)*
7. CA 125 *(blood test for ovarian cancer)*
8. CEA *(blood test for colon cancer)*
9. Chest X-ray
10. Electrocardiogram (EKG)
11. Colonoscopy
12. Flexible sigmoidoscopy
13. Hemocult stool analysis
14. Mammography/Breast Ultrasound
15. Pap smear *(including ThinPrep Pap Test)*
16. PSA *(blood test for prostate cancer)*
17. Serum Protein Electrophoresis *(blood test for myeloma)*
18. Thermography
19. Oral Cancer screening using ViziLite OraTest or other similar test
20. Biopsy for Skin Cancer

LEGALSHIELD
/IDSHIELD

LEGALSHIELD/IDSHIELD

CARRIER: LegalShield/IDShield

HAVE YOU EVER?

- ☐ Needed your Will prepared or updated
- ☐ Been overcharged for a repair or paid an unfair bill
- ☐ Had trouble with a warranty or defective product
- ☐ Signed a contract
- ☐ Received a moving traffic violation
- ☐ Had concerns regarding child support
- ☐ Worried about being a victim of Identity theft
- ☐ Been concerned about your child's identity
- ☐ Lost your wallet
- ☐ Worried about entering personal information on-line
- ☐ Feared the security of your medical information
- ☐ Been pursued by a collection agency

WHAT IS LEGALSHIELD?

LegalShield was founded in 1972, with the mission to make equal justice under law a reality for all North Americans. The 3.5 million individuals enrolled as LegalShield members throughout the United States and Canada can talk to a lawyer on any personal legal matter, no matter how trivial or traumatic, all without worrying about high hourly costs. LegalShield has provided identity theft protection since 2003 with Kroll Advisory Solutions, the world's leading company in ID Theft consulting and restoration. We have safeguarded over 1million members, provided more than 200,000 identity consultations, and helped restore nearly 10,000 individual identities.

THE LEGALSHIELD® MEMBERSHIP INCLUDES:

- ✓ Personal Legal advice on unlimited issues
- ✓ Letters/ calls made on your behalf
- ✓ Contracts & documents reviewed (up to 15 pages)
- ✓ Residential Loan Document Assistance
- ✓ Lawyers prepare your Will, your Living Will and your Health Care Power of Attorney
- ✓ Moving Traffic Violations (available 15 days after enrollment)
- ✓ IRS Audit Assistance
- ✓ Trial Defense (if named defendant/ respondent in a covered civil action suit)
- ✓ Uncontested Divorce, Separation, Adoption and/or Name Change Representation (available 90 days after enrollment)
- ✓ 25% Preferred Member Discount (Bankruptcy, Criminal Charges, DUI, Other Matters, etc.)
- ✓ 24/7 Emergency Access for covered situations

LegalShield legal plans cover the member; member's spouse; never married dependent children under 26 living at home; dependent children under age 18 for whom the member is legal guardian; never married, dependent children up to age 26 if a full-time college student; and physically or mentally disabled dependent children. An individual rate is available for those enrollees who are not married, do not have a domestic partner and do not have minor children or dependents. No family benefits are available to individual plan members. Ask your Independent Associate for details.

THE IDSHIELD℠ MEMBERSHIP INCLUDES:

Privacy Monitoring
Monitoring your name, SSN, date of birth, email address (up to 10), phone numbers (up to 10), driver license & passport numbers, and medical ID numbers (up to 10) provides you with comprehensive identity protection service that leaves nothing to chance.

Security Monitoring
SSN, credit cards (up to 10), and bank account (up to 10) monitoring, sex offender search, financial activity alerts and quarterly credit score tracking keep you secure from every angle. With the family plan, Minor Identity Protection is included and provides monitoring for up to 8 children under the age of 18.

Consultation
Your identity protection plan includes 24/7/365 live support for covered emergencies, unlimited counseling, identity alerts, data breach notifications and lost wallet protection.

Full Service Restoration
Complete identity recovery services by Kroll Licensed Private Investigators and our $5 million service guarantee ensure that if your identity is stolen, it will be restored to its pre-theft status.

IDShield plans are available at individual or family rates. A family rate covers the member, member's spouse and up to 8 dependents up to the age of 18

Payroll Deduction Semi-Monthly	Individual	Family
LegalShield	$8.48	$9.48
IDShield	$4.48	$9.48
Combined	$12.96	$16.95

For more information, please call your independent associate:

This is a general overview and is for illustrative purposes only. Plans and services vary from state to state. See a plan contract for your state of residence for complete terms, coverage, amounts, conditions and exclusions.

EMPLOYEE ASSISTANCE PROGRAM

EMPLOYEE ASSISTANCE PROGRAM

CARRIER: EAP of Louisiana

All employees, regardless of enrollment in other benefits, have 24/7 access to confidential support, guidance, and resources.

SERVICES INCLUDE:

- Work/life services for assistance with relationships, financial issues, child care, elder care, and adoption
- 24/7 toll-free phone and web access
- To access services, call 800-749-3277

WHOLE LIFE INSURANCE

BOSTON MUTUAL
Francis Clements
225-755-1288
francis@clementsinsgroup.com

IMPORTANT CONTACTS

BENEFIT	CARRIER/CONTACT	PHONE	WEBSITE/EMAIL
Medical Insurance	Blue Cross Blue Shield of Louisiana	800-495-2583	www.bcbsla.com
Health Reimbursement Arrangement	Empire Management	985-340-2880	empmgt@bellsouth.net
Dental and Vision Insurance	SunLife	800-786-5433	www.sunlife.com
Life and AD&D, Disability	The Standard	888-937-4783	www.standard.com
Accident, Critical Illness, and Whole Life	Boston Mutual	225-755-1288	francis@clementsinsgroup.com
LegalShield/IDShield	Austen Powell	985-386-8542	apowell@powellins.net
Employee Assistance Program	EAP of Louisiana	800-749-3277	
City of Hammond	Rhonda Huskey	985-277-5628	huskey_rj@Hammond.org

BXS INSURANCE
A SUBSIDIARY OF BANCORPSOUTH BANK

YOUR BXS INSURANCE ACCOUNT REPRESENTATIVE:

Mickie Thompson
888-240-5899
Mickie.Thompson@bxsi.com