CITY OF EVERMAN 2023-2024 PLAN YEAR

Medical Plan Analysis - United Healthcare

Benefits	UHC NAVIGATE BCXO	UHC DDYJ HSA	UHC BCZS	UHC BCYB
	Current / Renewal Plan			
Annual Deductible (single/family)	$1,000 / $2,000	$3,000 / $6,000	$3,000 / $6,000	$250 / $500
Out-of-pocket Maximum	$6,600 / $13,200	$4,000 / $8,000	$4,500 / $9,000	$3,000 / $6,000
Coinsurance In-Network / Out of Network	80% / 0%	100% / 70%	100% / 0%	80% / 50%
Copay	$25	100% After Deductible	$30	$20
Specialist Copay	$75	100% After Deductible	$60	$40
Preventive Care	No Charge In-Network: Deductible does NOT apply	No Charge In-Network: Deductible does NOT apply	No Charge In-Network: Deductible does NOT apply	No Charge In-Network: Deductible does NOT apply
In-Patient Hospital	80% After Deductible	100% After Deductible	100% After Deductible	80% After Deductible
Out-Patient Hospital	80% After Deductible	100% After Deductible	100% After Deductible	80% After Deductible
Emergency Room Copay	$500	100% After Deductible	$300	$250 Copay +80% After Deductible
Urgent Care Copay	$100	100% After Deductible	$75	$75
Labs / X Rays	80% After Deductible	100% After Deductible	100% After Deductible	80% After Deductible
High-Tech Imaging	80% After Deductible	100% After Deductible	100% After Deductible	80% After Deductible
Pharmacy Services				
Preferred Generic	$10 Copay	100% After Deductible	$10 Copay	$10 Copay
Non-Preferred Generic	$35 Copay	100% After Deductible	$35 Copay	$35 Copay
Preferred / Non-Preferred Brand	$85 Copay	100% After Deductible	$85 Copay	$85 Copay
Preferred / Non-Preferred Specialty	$150 Copay	100% After Deductible	$150 Copay	$150 Copay
EMPLOYEE COUNTS:				
Employee Only	0	12	0	27
Employee & Spouse	4	0	0	0
Employee & Child(ren)	8	0	1	0
Employee & Family	4	0	0	0
BILLED PREMIUM:				
Employee Only	$553.78	$662.27	$697.02	$798.62
Employee & Spouse	$1,107.56	$1,324.54	$1,394.04	$1,597.24
Employee & Child(ren)	$1,107.56	$1,324.54	$1,394.04	$1,597.24
Employee & Family	$1,661.35	$1,986.82	$2,091.07	$2,395.87
Total Monthly Premium	$19,936.12	$7,947.24	$1,394.04	$21,562.74
Total Annual Premium	$239,233.44	$95,366.88	$16,728.48	$258,752.88
TOTAL $ Change in Premium	$0.00	$0.00	$0.00	$0.00
TOTAL % Change in Premium	0.0%	0.0%	0.0%	0.0%

CITY OF EVERMAN 2023-2024 PLAN YEAR

Medical Plan Analysis - United Healthcare

	Current / Renewal Plan			
Benefits	UHC NAVIGATE BCXO	UHC DDYJ HSA	UHC BCZS	UHC BCYB
Annual Deductible (single/family)	$1,000 / $2,000	$3,000 / $6,000	$3,000 / $6,000	$250 / $500
Out-of-pocket Maximum	$6,600 / $13,200	$4,000 / $8,000	$4,500 / $9,000	$3,000 / $6,000
Coinsurance In-Network / Out of Network	80% / 0%	100% / 70%	100% / 0%	80% / 50%
Copay	$25	100% After Deductible	$30	$20
Specialist Copay	$75	100% After Deductible	$60	$40
Preventive Care	No Charge In-Network: Deductible does NOT apply	No Charge In-Network: Deductible does NOT apply	No Charge In-Network: Deductible does NOT apply	No Charge In-Network: Deductible does NOT apply
In-Patient Hospital	80% After Deductible	100% After Deductible	100% After Deductible	80% After Deductible
Out-Patient Hospital	80% After Deductible	100% After Deductible	100% After Deductible	80% After Deductible
Emergency Room Copay	$500	100% After Deductible	$300	$250 Copay +80% After Deductible
Urgent Care Copay	$100	100% After Deductible	$75	$75
Labs / X Rays	80% After Deductible	100% After Deductible	100% After Deductible	80% After Deductible
High-Tech Imaging	80% After Deductible	100% After Deductible	100% After Deductible	80% After Deductible
Pharmacy Services				
Preferred Generic	$10 Copay	100% After Deductible	$10 Copay	$10 Copay
Non-Preferred Generic	$35 Copay	100% After Deductible	$35 Copay	$35 Copay
Preferred / Non-Preferred Brand	$85 Copay	100% After Deductible	$85 Copay	$85 Copay
Preferred / Non-Preferred Specialty	$150 Copay	100% After Deductible	$150 Copay	$150 Copay
EMPLOYEE COUNTS:				
Employee Only	0	12	0	27
Employee & Spouse	4	0	0	0
Employee & Child(ren)	8	0	1	0
Employee & Family	4	0	0	0
BILLED PREMIUM:	16	12	1	27
Employee Only	$553.78	$662.27	$697.02	$798.62
Employee & Spouse	$1,107.56	$1,324.54	$1,394.04	$1,597.24
Employee & Child(ren)	$1,107.56	$1,324.54	$1,394.04	$1,597.24
Employee & Family	$1,661.35	$1,986.82	$2,091.07	$2,395.87
Total Monthly Premium	$19,936.12	$7,947.24	$1,394.04	$21,562.74
Total Annual Premium	$239,233.44	$95,366.88	$16,728.48	$258,752.88
TOTAL $ Change in Premium	$0.00	$0.00	$0.00	$0.00
TOTAL % Change in Premium	0.0%	0.0%	0.0%	0.0%

CITY OF EVERMAN 2023-2024 PLAN YEAR

Medical Plan Analysis - United Healthcare

Benefits	FINAL RENEWAL ALL DISCOUNTS UHC NAVIGATE BCXO	UHC DDYJ HSA	UHC BCZS	UHC BCYB
Annual Deductible (single/family)	$1,000 / $2,000	$3,000 / $6,000	$3,000 / $6,000	$250 / $500
Out-of-pocket Maximum	$6,600 / $13,200	$4,000 / $8,000	$4,500 / $9,000	$3,000 / $6,000
Coinsurance In-Network / Out of Network	80% / 0%	100% / 70%	100% / 0%	80% / 50%
Copay	$25	100% After Deductible	$30	$20
Specialist Copay	$75	100% After Deductible	$60	$40
Preventive Care	No Charge In-Network: Deductible does NOT apply	No Charge In-Network: Deductible does NOT apply	No Charge In-Network: Deductible does NOT apply	No Charge In-Network: Deductible does NOT apply
In-Patient Hospital	80% After Deductible	100% After Deductible	100% After Deductible	80% After Deductible
Out-Patient Hospital	80% After Deductible	100% After Deductible	100% After Deductible	80% After Deductible
Emergency Room Copay	$500	100% After Deductible	$300	$250 Copay +80% After Deductible
Urgent Care Copay	$100	100% After Deductible	$75	$75
Labs / X Rays	80% After Deductible	100% After Deductible	100% After Deductible	80% After Deductible
High-Tech Imaging	80% After Deductible	100% After Deductible	100% After Deductible	80% After Deductible
Pharmacy Services				
Preferred Generic	$10 Copay	100% After Deductible	$10 Copay	$10 Copay
Non-Preferred Generic	$35 Copay	100% After Deductible	$35 Copay	$35 Copay
Preferred / Non-Preferred Brand	$85 Copay	100% After Deductible	$85 Copay	$85 Copay
Preferred / Non-Preferred Specialty	$150 Copay	100% After Deductible	$150 Copay	$150 Copay
EMPLOYEE COUNTS:				
Employee Only	0	12	0	27
Employee & Spouse	4	0	0	0
Employee & Child(ren)	8	0	1	0
Employee & Family	4	0	0	0
BILLED PREMIUM:	16	12	1	27
Employee Only	$539.94	$645.71	$679.59	$778.65
Employee & Spouse	$1,079.88	$1,291.42	$1,359.18	$1,557.30
Employee & Child(ren)	$1,079.88	$1,291.42	$1,359.18	$1,557.30
Employee & Family	$1,619.83	$1,937.14	$2,038.78	$2,335.96
Total Monthly Premium	$19,437.88	$7,748.52	$1,359.18	$21,023.55
Total Annual Premium	$233,254.56	$92,982.24	$16,310.16	$252,282.60
TOTAL $ Change in Premium	$5,978.88	$2,384.64	$418.32	$6,470.28
TOTAL % Change in Premium	-2.5%	-2.5%	-2.5%	-2.5%

CITY OF EVERMAN 2023-2024 PLAN YEAR

Dental Plan Analysis

	Current Plan	Renewal Plan	Plan Option 9
Benefits	Mutual of Omaha	Mutual of Omaha	UHC 2.0% Med Discount
Annual Deductible (single/family)	$50 / $150	$50 / $150	$50 / $150
Preventive Care	100%	100%	100%
Basic Services	80%	80%	80%
Major Services	50%	50%	50%
Endodontics / Periodontics	80%	80%	80%
Orthodontics	50%	50%	50%
Annual Max Per Member	$2,000	$2,000	$2,000
Adult / Child Orthodontics	Child Only to age 19	Child Only to age 19	Child Only to age 19
Orthodontics Lifetime Max	$1,500	$1,500	$1,500
Out of Network Benefits	90th %	90th %	90th %
Waiting Period	None	None	None
EMPLOYEE COUNTS:			
Employee Only	36	36	36
Employee & 1 Dependent	7	7	7
Employee & 2 or More Dependents	12	12	12
BILLED PREMIUM:			
Employee Only	$29.68	$30.57	$32.71
Employee & 1 Dependent	$66.68	$68.68	$65.41
Employee & 2 or More Dependents	$102.72	$105.80	$89.36
			$129.62
Total Monthly Premium	$2,767.88	$2,850.88	$2,707.75
Total Annual Premium	$33,214.56	$34,210.56	$32,493.00
TOTAL $ Change in Premium	$33,214.56	$996.00	-$721.56
TOTAL % Change in Premium		3.0%	#REF!
Employee Cost Semi-Montly			
Employee Only	$0.00	$0.00	$0.00
Employee Spouse	$18.50	$19.06	$17.42
Employee Child(ren)	$36.52	$37.62	$29.40

CITY OF EVERMAN 2023-2024 PLAN YEAR

Vision Plan Analysis

	Current Plan / Renewal	Plan Option 6
Benefits	Superior	UHC .05% Med Discount
Network	Superior	Spectra
Benefit Frequency	12 / 12 / 24	12 / 12 / 24
Exam Copay	$10	$10
Materials Copay	$25	$25
Frame Allowance	$100	100%
Contacts Allowance	$125	$125
Contact Fitting Fee Allowance	Up to $65	Up to $60
Progressive Lenses - Standard		See Lens Options
Progressive Lenses - Tier 1		
Progressive Lenses - Tier 2		
Progressive Lenses- Tier 3		
Progressive Lenses - Tier 4		
Rate Guarantee	Thru 10/1/2024	12 months
EMPLOYEE COUNTS:		
Employee Only	38	38
Employee & Spouse	12	12
Employee & Child(ren)	6	6
Employee & Family	8	8
BILLED PREMIUM:		
Employee Only	$5.41	$6.10
Employee & Spouse	$9.73	$11.58
Employee & Child(ren)	$10.33	$13.58
Employee & Family	$15.46	$19.12
Total Monthly Premium	$508.00	$605.20
Total Annual Premium	$6,096.00	$7,262.40
TOTAL $ Change in Premium		$1,166.40
TOTAL % Change in Premium		19.1%
Employee Cost Semi-Monthly		
Employee Only	$0.00	$0.00
Employee Spouse	$2.16	#REF!
Employee Child(ren)	$2.46	#REF!
Employee Family	$5.03	#REF!

CITY OF EVERMAN 2023-2024 PLAN YEAR

Life / AD&D Plan Analysi

Rates	Current / Renewal Plan Mutual of Omaha
Life Rate per $1,000	$0.160
AD&D Rate per $1,000	$0.020
Combined Life/AD&D Rate per $1,000	$0.180
Total Monthly Volume	$4,661,900
Total Monthly Premium	$839.14
Total Annual Premium	**$10,069.70**
Benefits	
Class 1 Description:	
Life Amount	2x Salary
AD&D Amount	2x Salary
Age Reduction Schedule	
First Reduction	65% at age 65
Second Reduction	50% at age 70
Conversion	Included
Waiver of Premium	Included
Elimination Period	9 months
Maximum Age Duration	To Age 65
Accelerated Benefit	80% of Benefit
Maximum Benefit	$240,000
Enhanced Product Services	
Travel Assistance Services	
Employee Assistance Program	
Beneficiary Resources Services	
Temporary Layoff / Leave	

Declined to Quote: Boston Mutual, Guardian, Hartford, Sun Life (uncompetitive)

CITY OF EVERMAN 2023-2024 PLAN YEAR

Voluntary Life / AD&D Plan Analy

Rates	Current Plan Mutual of Omaha
Employee:	$10,000 Increments
Maximum Amount	$300,000
Guaranteed Issue (GI)	$100,000
Portability	With EOI
Conversion	Included
Waiver of Premium	To age 65 if disabled prior to 60
Accelerated Life Benefit	80% of benefit to $240,000 maximum
Spouse:	$5,000 Increments
Maximum	$150,000
Not to Exceed	100% of Employee Benefit
Guaranteed Issue (GI)	$25,000
Dependen Children:	$10,000 Flat Amount
Maximum	$10,000
Guaranteed Issue (GI)	$10,000
	One Family Rate
Age Brackets	Rate per $1,000 *
< 25	$0.088
25 - 29	$0.088
30 - 34	$0.088
35 - 39	$0.124
40 - 44	$0.185
45 - 49	$0.309
50 - 54	$0.512
55 - 59	$0.865
60 - 64	$1.280
65 - 69	$2.136
70-74	$3.751
75-79	$6.284
80-84	$9.964
85-89	$15.030
90-100	$21.712
AD&D Benefit Amount	Same as Life Amount
Spouse Rate	Based on Employees Age
Dependent Life/AD&D Rate	$3.00 for $10,000

Rate Guarantee thru 10/2025

Declined to Quote: Boston Mutual, Guardian, Hartford, Sun Life (uncompetitive)

CITY OF EVERMAN - 2023-2024 PLAN YEAR

LONG-TERM DISABILITY PLAN ANALYSIS

	Plan Option 1
Rates	Mutual of Omaha
Rate per $100	$0.250
Volume of Covered Payroll	$197,916
Total Monthly Premium	**$494.79**
Total Annual Premium	**$5,937.48**
Benefits	
Class 1 Description:	All Eligible Employees
Benefit Percentage	60% of monthly earnings
Maximum Monthly Amount	$5,000
Elimination Period	90 Days
Maximum Benefit Duration	RBD to SSNRA
Own Occupation	24 Months
Partial Disability Earnings Test:	Included
During Own Occ. Period	99%
During Any Occ. Period	60%
Limitations:	
Mental/Nervous (M/N)	24 Months
Substance Abuse (SA)	24 Months
Are limitations per occurrence or lifetime?	Lifetime
Pre-existing condition exclusion	3 / 12
Rates Guarantee	2 Years

SHORT-TERM DISABILITY PLAN ANALYSIS

	Plan Option 1
Rates	Mutual of Omaha
Rate per $10	$0.180
Volume of Weekly Benefit	$27,404
Total Monthly Premium	**$493.27**
Total Annual Premium	**$5,919.26**
Benefits	
Class 1 Description:	All Eligible Employees
Benefit Percentage	60%
Maximum Weekly Amount	$1,500
Elimination Period - Accident	14 Days
Elimination Period - Sickness	14 Days
Maximum Benefit Duration	11 Weeks
Rates Guaranteed Through	2 Years

Declined to Quote: Boston Mutual, Guardian, Hartford, Sun Life (uncompetitive)

CITY OF EVERMAN HEALTHCARE COST HISTORY 2019-2023

	CITY IS SMALL GROUP 2-50 EES		CITY GROWS TO MIDDLE MARKET 51-99 EES			
	JANUARY 2019	**2020**	**Oct-21**	**Oct-22**	**Oct-23**	5 Year Average
Enrolled Employees	**46**	**47**	**47**	**47**	**56**	
Loss Ratio Time of Renewal				**52%**	**65%**	
Current Annual Cost	**$563,493**	**$470,496**	**$538,599**	**$531,523**	**$610,081**	
Initial Renewal Increase	13.0%	11.7%	12.8%	6.7%	8.0%	10%
Initial Renewal Premium	$636,747	$525,684	$608,617	$567,058	$658,887	
Total Percentage Premium Change current Plans after Bidding	**13.0%**	**11.7%**	**0.0%**	**0.0%**	**-2.5%**	4%
Negotiated Renewal	**$636,747**	**$525,684**	**$608,617**	**$531,523**	**$594,829**	
Value of Negotiation if current plan was renewed	$0	$0	$0	$35,535	$64,058	$19,919
Cost Selected Provider	$466,395	$525,684	$468,611	$531,523	$594,829	
Admin Credit	$0		$0	$0	$0	
Premium/Cost Change	-$97,098	$55,188	-$69,988	$0	-$15,252	$ (25,430)
Premium Change Recommended Provider	**-17.23%**	**11.73%**	**-12.99%**	**0.00%**	**-2.50%**	**-2.6%**
Selected Provider	BCBS PPO	BCBS PPO	UHC PPO	UHC PPO	UHC PPO	
City Base Plan	80/60 $250 Ded	80/60 $250 Ded	80/60 $250 Ded	80/60 $250 Ded	80/60 $250 Ded	
Employee	$844	$969	$799	$799	$778	
Employee Spouse	$1,689	$1,938	$1,597	$1,597	$1,537	
Employee Child(ren)	$1,689	$1,938	$1,597	$1,597	$1,537	
Employee Family	$2,534	$2,907	$2,396	$2,396	$2,335	

** Begiinning in 2011 3.45% of total premium cost are direclty related to Health Insurer Fee & Reinsurance as mandated by Healthcare Reform (ACA)