HUB

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City of Glen Rose

2021 Employee Benefits Insurance Renewal

City of Glen Rose
"Dinosaur Capital of Texas"

Medical Plan Analysis

Ocotober 1, 2021 Renewal

	Dual Option Current				Dual Option Renewal				Dual Option Alternate			
	BlueCross BlueShield of Texas				BlueCross BlueShield of Texas				BlueCross BlueShield of Texas			
	S642ADT		B660ADT		S642ADT		B660ADT		S642ADT		B9E1ADT	
Benefits	HMO		HMO HSA		HMO		HMO HSA		HMO		HMO HSA	
Carrier Rating	A		A		A		A		A		A	
In-Network												
Annual Deductible (Ind / Fam)	$3,500 / $10,500		$6,750 / $13,500		$3,500 / $10,500		$6,750 / $13,500		$3,500 / $10,500		$6,350 / $12,500	
Coinsurance Percentage	70%		100%		70%		100%		70%		70%	
Out-of-Pocket Max (Ind / Fam)	$8,150 / $16,300		$6,750 / $13,500		$8,150 / $16,300		$6,750 / $13,500		$8,150 / $16,300		$6,900 / $13,800	
Is Ded included in OOP Max?	Yes		Yes		Yes		Yes		Yes		Yes	
Lifetime Maximum Benefit	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
Professional Services												
Office Visit	$50 Copay		Deductible		$50 Copay		Deductible		$50 Copay		Deductible + 30%	
Specialist Visit	$80 Copay		Deductible		$80 Copay		Deductible		$80 Copay		Deductible + 30%	
Preventive Care	100% of Allowable Amount		100% of Allowable Amount		100% of Allowable Amount		100% of Allowable Amount		100% of Allowable Amount		100% of Allowable Amount	
Physical / Manipulative Therapy	Deductible + 30% (35 visits)		Deductible(35 visits)		Deductible + 30% (35 visits)		Deductible(35 visits)		Deductible + 30% (35 visits)		Deductible + 30% (35 visits)	
Hospital Services												
Inpatient Hospital	$250 Copay + Ded + 30%		Deductible		$250 Copay + Ded + 30%		Deductible		$250 Copay + Ded + 30%		Deductible + 30%	
Outpatient Hospital	$150 Copay + Ded + 30%		Deductible		$150 Copay + Ded + 30%		Deductible		$150 Copay + Ded + 30%		Deductible + 30%	
Emergency Services												
Urgent Care	$40 Copay		Deductible		$40 Copay		Deductible		$40 Copay		Deductible + 30%	
Emergency Room - Facility	$500 Copay + Ded + 30%		Deductible		$500 Copay + Ded + 30%		Deductible		$500 Copay + Ded + 30%		Deductible + 30%	
Emergency Room - Provider & Svcs	Deductible + 30%		Deductible		Deductible + 30%		Deductible		Deductible + 30%		Deductible + 30%	
Prescription Drugs	* Preferred Pharmacy	Non Preferred Pharmacy	Preferred Pharmacy	Non Preferred Pharmacy	* Preferred Pharmacy	Non Preferred Pharmacy	Preferred Pharmacy	Non Preferred Pharmacy	* Preferred Pharmacy	Non Preferred Pharmacy	Preferred Pharmacy	Non Preferred Pharmacy
Deductible	N/A		Medical Ded Applies		N/A		Medical Ded Applies		N/A		Medical Ded Applies	
Generic	$10 Copay	$20 Copay	Deductible	Deductible	$10 Copay	$20 Copay	Deductible	Deductible	$10 Copay	$20 Copay	Ded + 30%	Ded + 30%
Preferred Brand	$50 Copay	$70 Copay	Deductible	Deductible	$50 Copay	$70 Copay	Deductible	Deductible	$50 Copay	$70 Copay	Ded + 30%	Ded + 30%
Non-Preferred Brand	$100 Copay	$120 Copay	Deductible	Deductible	$100 Copay	$120 Copay	Deductible	Deductible	$100 Copay	$120 Copay	Ded + 30%	Ded + 30%
High Technology / Specialty	$150 Copay	$250 Copay	Deductible	Deductible	$150 Copay	$250 Copay	Deductible	Deductible	$150 Copay	$250 Copay	Ded + 30%	Ded + 30%
Mail-Order	3 X Copay		Deductible		3 X Copay		Deductible		3 X Copay		Deductible + 30%	
Out-of-Network												
Annual Deductible (Ind / Fam)	N/A		N/A		N/A		N/A		N/A		N/A	
Coinsurance Percentage	N/A		N/A		N/A		N/A		N/A		N/A	
Out-of-Pocket Max (Ind / Fam)	N/A		N/A		N/A		N/A		N/A		N/A	
Provider Network												
Network Name	Blue Advantage HMO		Blue Advantage HMO		Blue Advantage HMO		Blue Advantage HMO		Blue Advantage HMO		Blue Advantage HMO	
Network Website	www.bcbstx.com		www.bcbstx.com		www.bcbstx.com		www.bcbstx.com		www.bcbstx.com		www.bcbstx.com	
Additional Notes												
Rates (Composite)	Counts	Current		Current		Renewal		Renewal				
Employee Only	1	$449.29	9	$379.44	1	$455.57	9	$391.41	1	$455.57	9	$383.13
Employee + Spouse	0	$898.58	3	$758.88	0	$911.14	3	$782.82	0	$911.14	3	$766.26
Employee + Child(ren)	0	$898.58	1	$758.88	0	$911.14	1	$782.82	0	$911.14	1	$766.26
Family	0	$1,347.87	2	$1,138.32	0	$1,366.81	2	$1,174.23	0	$1,366.81	2	$1,149.39
Estimated Monthly Premium		**$449.29**		**$8,727.12**		**$455.57**		**$9,002.43**		**$455.57**		**$8,811.99**
Estimated Annual Premium		**$5,391.48**		**$104,725.44**		**$5,466.84**		**$108,029.16**		**$5,466.84**		**$105,743.88**
Percentage Change From Current						1.4%		3.2%		1.4%		1.0%
Annual Dollar Change From Current						$75.36		$3,303.72		$75.36		$1,018.44

	CURRENT	RENEWAL	ALTERNATE
Combined Estimated Monthly Premium	**$9,176.41**	**$9,458.00**	**$9,267.56**
Combined Estimated Annual Premium	**$110,116.92**	**$113,496.00**	**$111,210.72**
		3.1%	1.0%
		$3,379.08	$1,093.80

City of Glen Rose
"Dinosaur Capital of Texas"

Medical Plan Analysis

Ocotober 1, 2021 Renewal

	Dual Option Current — BlueCross BlueShield of Texas		Dual Option 1 — United Healthcare	
	S642ADT	B660ADT	CED2	B660ADT
Benefits	HMO	HMO HSA	HMO	HMO HSA
Carrier Rating	A	A	A	A
In-Network				
Annual Deductible (Ind / Fam)	$3,500 / $10,500	$6,750 / $13,500	$2,500 / $5,000	$6,850 / $13,700
Coinsurance Percentage	70%	100%	80%	100%
Out-of-Pocket Max (Ind / Fam)	$8,150 / $16,300	$6,750 / $13,500	$8,500 / $17,000	$6,850 / $13,700
Is Ded included in OOP Max?	Yes	Yes	Yes	Yes
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Professional Services				
Office Visit	$50 Copay	Deductible	$0	Deductible
Specialist Visit	$80 Copay	Deductible	$70 Copay	Deductible
Preventive Care	100% of Allowable Amount	100% of Allowable Amount	100% of Allowable Amount	100% of Allowable Amount
Physical / Manipulative Therapy	Deductible + 30% (35 visits)	Deductible(35 visits)	Deductible + 20% (35 visits)	Deductible(35 visits)
Hospital Services				
Inpatient Hospital	$250 Copay + Ded + 30%	Deductible	Deductible + 20%	Deductible
Outpatient Hospital	$150 Copay + Ded + 30%	Deductible	Deductible + 20%	Deductible
Emergency Services				
Urgent Care	$40 Copay	Deductible	$50 Copay	Deductible
Emergency Room - Facility	$500 Copay + Ded + 30%	Deductible	$250 Copay + Ded + 20%	Deductible
Emergency Room - Provider & Svcs	Deductible + 30%	Deductible	Deductible + 20%	Deductible
Prescription Drugs	* Preferred Pharmacy / Non Preferred Pharmacy	Preferred Pharmacy / Non Preferred Pharmacy		
Deductible	N/A	Medical Ded Applies	N/A	Medical Ded Applies
Generic	$10 Copay / $20 Copay	Deductible / Deductible	$10 Copay	Deductible
Preferred Brand	$50 Copay / $70 Copay	Deductible / Deductible	$40 Copay	Deductible
Non-Preferred Brand	$100 Copay / $120 Copay	Deductible / Deductible	$125 Copay	Deductible
High Technology / Specialty	$150 Copay / $250 Copay	Deductible / Deductible	$300 Copay	Deductible
Mail-Order	3 X Copay	Deductible	3 X Copay	Deductible
Out-of-Network				
Annual Deductible (Ind / Fam)	N/A	N/A	N/A	N/A
Coinsurance Percentage	N/A	N/A	N/A	N/A
Out-of-Pocket Max (Ind / Fam)	N/A	N/A	N/A	N/A
Provider Network				
Network Name	Blue Advantage HMO	Blue Advantage HMO	Charter HMO	Charter HMO
Network Website	www.bcbstx.com	www.bcbstx.com	www.myuhc.com	www.myuhc.com
Additional Notes				

Rates (Composite)	Counts	Current		Current				
Employee Only	1	$449.29	9	$379.44	1	$467.58	9	$396.08
Employee + Spouse	0	$898.58	3	$758.88	0	$935.15	3	$792.17
Employee + Child(ren)	0	$898.58	1	$758.88	0	$935.15	1	$792.17
Family	0	$1,347.87	2	$1,138.32	0	$1,402.72	2	$1,188.25
Estimated Monthly Premium		**$449.29**		**$8,727.12**		**$467.58**		**$9,109.90**
Estimated Annual Premium		**$5,391.48**		**$104,725.44**		**$5,610.96**		**$109,318.80**
Percentage Change From Current						**4.1%**		**4.4%**
Annual Dollar Change From Current						**$219.48**		**$4,593.36**

	CURRENT	
Combined Estimated Monthly Premium	**$9,176.41**	**$9,577.48**
Combined Estimated Annual Premium	**$110,116.92**	**$114,929.76**
		4.4%
		$4,812.84

City of Glen Rose

"Dinosaur Capital of Texas"

DEFINED CONTRIBUTION STRATEGY

Effective 10/1/20 - 09/30/21

The City of Glen Rose provides all full time eligible employees $700 to use toward medical, dental & vision benefits.

Medical BASE PLAN HMO HSA $6,650 Deductible / 100% coinsurance		**Total** **Cost of plan**	**City of Glen Rose** **Pays**	**EE Monthly** **Cost**	**EE Bi-weekly** **Cost**
Employee Only	9	$391.41	$391.41	$0.00	$0.00
Employee + Spouse	3	$782.82	$700.00	$82.82	$38.22
Employee + Child(ren)	1	$782.82	$700.00	$82.82	$38.22
Employee + Family	2	$1,174.23	$700.00	$474.23	$218.88
Employees can contribute funds into an HSA account if enrolled in this medical plan.					
Medical BUY-UP PLAN HMO $3,500 Deductible / 70% coinsurance		**Total** **Cost of plan**	**City of Glen Rose** **Pays**	**EE Monthly** **Cost**	**EE Bi-weekly** **Cost**
Employee Only	1	$455.57	$455.57	$0.00	$0.00
Employee + Spouse	0	$911.14	$700.00	$211.14	$97.45
Employee + Child(ren)	0	$911.14	$700.00	$211.14	$97.45
Employee + Family	0	$1,366.81	$700.00	$666.81	$307.76
Total Employees	**27**				
Dental Select DENTAL $1000 Calendar Year Max		**Total** **Cost of plan**	**City of Glen Rose** **Pays**	**EE Monthly** **Cost**	**EE Bi-weekly** **Cost**
Employee Only	10	$26.76	$0.00	$26.76	$12.35
Employee + Spouse	4	$60.17	$0.00	$60.17	$27.77
Employee + Child(ren)	2	$74.87	$0.00	$74.87	$34.56
Employee + Family	5	$105.22	$0.00	$105.22	$48.56
Dental Select Vision EyeMed		**Total** **Cost of plan**	**City of Glen Rose** **Pays**	**EE Monthly** **Cost**	**EE Bi-weekly** **Cost**
Employee Only	7	$9.31	$0.00	$9.31	$4.30
Employee + Spouse	2	$16.23	$0.00	$16.23	$7.49
Employee + Child(ren)	3	$17.00	$0.00	$17.00	$7.85
Employee + Family	5	$27.00	$0.00	$27.00	$12.46

The City of Glen Rose provides all full time eligible employees with LTD and a $40k Life benefit with Mutual of Omaha = $463.38
Additional Life, STD and Supplemental benefits can be purchased individually.

MONTHLY EMPLOYER COST	**$18,900.00**
PEPM COST	**$700.00**
ANNUAL COST	**$226,800.00**

City of Glen Rose
"Dinosaur Capital of Texas"

Dental Plan Analysis

October 1, 2021 Renewal

	Current / Renewal	Option 1	Option 2
	Mutual of Omaha	DentalSelect	Guardian
	PPO	PPO	PPO
Benefits			
Carrier Rating	A	A	A
Annual Dental Max Benefit (per person)	$1,000	$1,000	$1,000
Annual Deductible			
Individual	$50	$50	$50
Family	$150	$150	$150
Diagnostic & Preventive (Type I)	100%	100%	100%
Deductible Waived	Yes	Yes	Yes
Basic Services (Type II)	80%	80%	80%
Major Services (Type III)	50%	50%	50%
Periodontic & Endodontic Coverage	Major	Major	Major
Orthodontic Services (Type IV)	50%	50%	50%
Lifetime Ortho Max Benefit (per person)	$1,000	$1,000	$1,000
Annual Open Enrollment	Yes	Yes	Yes
New Hire Waiting Periods	None	None	None
Late Entrant Waiting Periods	None	None	None
Provider Network			
Network Name	Platinum Network	Platinum Network	Dental Guard Preferred
Network Website	www.mutualofomaha.com	www.dentalselect.com	www.glic.com
Out of Network Claims	90th Percentile	90th	90th
Other Features			
Rollover Benefit	Yes	No	Yes
Dependent Child / Student Age Limit	26	26	26
Employer Contribution	100%	100%	100%
Minimum Participation Requirement	75%	75%	75%
Rate Guarantee	1 Year	1 Year	1 Year
Additional Notes			
Rates	Current / Renewal		
Employee Only 6	$24.97 / $24.97	$26.30	$30.15
Employee + Spouse 3	$56.11 / $56.11	$57.25	$61.20
Employee + Child(ren) 1	$69.81 / $69.81	$70.88	$79.81
Family 3	$98.01 / $98.01	$99.00	$118.48
Estimated Monthly Premium	**$681.99 / $681.99**	**$697.43**	**$799.75**
Estimated Annual Premium	**$8,183.88 / $8,183.88**	**$8,369.16**	**$9,597.00**
Percentage Change From Current	**0.0%**	**2.3%**	**17.3%**
Annual Dollar Change From Current	**$0.00**	**$15.44**	**$117.76**

City of Glen Rose
"Dinosaur Capital of Texas"

Voluntary Vision Plan Analysis
October 1, 2021 Renewal

		Current / Renewal		Option 1	Option 2
		Mutual of Omaha		DentalSelect	Guardian
		Vision		Vision	Vision
Benefits					
Carrier Rating		A		A	A
Eye Exam / Refraction		$10 Copay		$10 Copay	$10 Copay
Frequency		Every 12 months		Every 12 months	Every Calendar Year
Lenses					
Single		$25 Copay		$25 Copay	$25 Copay
Bifocal		$25 Copay		$25 Copay	$25 Copay
Trifocal		$25 Copay		$25 Copay	$25 Copay
Lenticular		$25 Copay		$25 Copay	$25 Copay
Frequency		Every 12 months		Every 12 months	Every Calendar Year
Frames		$130 allowance, 20% off balance		$130 allowance, 20% off balance	$130 allowance, 20% off balance
Frequency		Every 24 months		Every 12 months	Every Other Calendar Year
Contact Lenses (Elective)		$150 allowance, 15% off balance		$150 allowance, 15% off balance	$150 allowance, 15% off balance
Frequency		Every 12 months		Every 12 months	Every Calendar Year
Provider Network					
Network Name		EyeMed		EyeMed	VSP
Network Website		www.eyemed.com		www.eyemed.com	www.vsp.com
Employer Contribution		0%		0%	0%
Minimum Participation Requirement		2 Enrolled		2 Enrolled	2 Enrolled
Rate Guarantee		1 Year		1 Year	2 Years
Additional Notes					
Rates		Current	Renewal		
Employee Only	6	$5.49	$5.49	$6.69	$6.73
Employee + Spouse	3	$12.61	$12.61	$11.53	$11.33
Employee + Child(ren)	1	$13.98	$13.98	$12.06	$11.56
Family	3	$21.34	$21.34	$19.05	$18.29
Estimated Monthly Premium		**$148.77**	**$148.77**	**$143.94**	**$140.80**
Estimated Annual Premium		**$1,785.24**	**$1,785.24**	**$1,727.28**	**$1,689.60**
Percentage Change From Current		**0.0%**		**-3.2%**	**-5.4%**
Annual Dollar Change From Current		**$0.00**		**($57.96)**	**($95.64)**

City of Glen Rose

"Dinosaur Capital of Texas"

Life and AD&D Plan Analysis

October 1, 2021 Renewal

	Current / Renewal	Option 1
	Mutual of Omaha	Guardian
	Basic Term Life and AD&D	Basic Term Life and AD&D
Benefits		
Carrier Rating	A	A
Class 1	All full time employees	All full time employees
Life & AD&D Benefit Amount	$40,000	$40,000
Benefit Maximum	$40,000	$40,000
Benefit Minimum	$40,000	$40,000
Guarantee Issue	$40,000	$40,000
Age Reduction at 65	35%	35%
Age Reduction at 70	50%	60%
Age Reduction at 75		
Portability	Included with EOI	Included with EOI
Rate Guarantee	1 Year (In rate guarantee)	2 Years
Additional Notes		
Rates	Current / Renewal	
Rate per $1,000 Volume	$680,000	$680,000
Life / $1,000	$0.127	$0.250
AD&D / $1,000	$0.031	$0.023
Estimated Monthly Premium	**$107.44**	**$185.64**
Estimated Annual Premium	**$1,289.28**	**$2,227.68**
Percentage Change From Current	**0.0%**	**72.8%**
Annual Dollar Change From Current	**$0.00**	**$78.20**

City of Glen Rose

"Dinosaur Capital of Texas"

Voluntary Life and AD&D Plan Analysis
October 1, 2021 Renewal

	Current / Renewal		Option 1	
	Mutual of Omaha		Guardian	
	Voluntary Term Life and AD&D		Voluntary Term Life and AD&D	
Employee				
Benefit Amount	$10,000 - $300,000		$25,000 - $200,000	
Benefit Increments	$10,000		$25,000	
Maximum Amount	Lesser of 5 X Salary or $300,000		$200,000	
Minimum Amount	$10,000		$25,000	
Guarantee Issue Amount	**$70,000**		**$50,000**	
Spouse Benefit				
Benefit Amount	Not to exceed 100% of Employee amount		Not to exceed 100% of Employee amount	
Benefit Increments	$5,000		$10,000	
Maximum Amount	$500,000		$25,000	
Guarantee Issue Amount	**$20,000**		**$25,000**	
Child Benefit				
Benefit Amount	$2,000 - $10,000		$10,000	
Benefit Increments	$2,000		$10,000	
Guarantee Issue Amount	**$10,000**		**$10,000**	
AD&D Benefits	100% of Vol. Life Amount		100% of Vol. Life Amount	
Age Reductions	35% at age 70, 55% at age 75		35% at age 65, 60% at age 70	
Other Features				
Waiver of Premium	Included		Included	
Accelerated Benefits	Included		Included	
Portablility / Conversion	Convert to individual policy		Convert to individual policy	
Rate Guarantee	2 Years		2 Years	
Participation Requirements	50% Enrolled		50% Enrolled	
Additional Notes	Spouse based on employee's age		Spouse based on employee's age	
Rates	Current / Renewal		Current / Renewal	
	Employee/Spouse ($1000)	Child Rate / $1,000	Employee/Spouse ($1000)	Child Rate / $1,000
<25	$0.099	$0.160	$0.110	$0.131
25-29	$0.099		$0.110	
30-34	$0.099		$0.120	
35-39	$0.177		$0.158	
40-44	$0.229		$0.223	
45-49	$0.411		$0.358	
50-54	$0.723		$0.586	
55-59	$1.347		$0.908	
60-64	$2.023		$1.242	
65-69	$3.323		$2.196	
70-74	$4.961		$4.342	
75+	$4.961		$4.342	
AD&D Rate	**$0.031**	**$0.040**	**$0.029**	**$0.029**

City of Glen Rose

"Dinosaur Capital of Texas"

Long Term Disability Plan Analysis
October 1, 2021 Renewal

	Current / Renewal Mutual of Omaha Group LTD
Benefits	
Carrier Rating	A
Class	All full time employees
Benefit Percentage	60%
Maximum Monthly Benefit	$6,000
Guarantee Issue	$6,000
Own Occupation	2 year own occupation
Benefit Duration	SSNRA
Contributory (Tax Free Benefit)	No
Elimination Period	90 days
Pre-Existing	3 / 12
Social Security Integration	Primary & Family
Partial Disability Formula	Included
Survivor Benefit	3 x's last month benefit
Plan Limitations	
Mental & Nervous / Self-Reported	24 month benefit
Mandatory Rehab	Included
Other Features	
Waiver of Premium	Included
Employer Contribution	100%
Minimum Participation Requirement	100%
Rate Guarantee	1 Year (In rate guarantee)
Additional Notes	
Rates	Current / Renewal
Volume	$82,608
Rate per $100	$0.380
Estimated Monthly Premium	**$313.91**
Estimated Annual Premium	**$3,766.92**
Percentage Change From Current	**0.0%**
Annual Dollar Change From Current	**$0.00**