IBERIA PARISH TOURIST COMMISSION
BOARD OF DIRECTORS MEETING
AGENDA
May 21, 2024 @ 10:30 A.M.
Iberia Parish Tourist Commission Office
2513 LA-14, New Iberia, LA 70560

1. Call to order
2. Roll call
3. Public comment
4. Approval of April 2024 Minutes
5. Approval of April 2024 Finance Report
6. Discuss and consider employee health, dental and life insurance recommendation by Executive Director
7. Executive Director's Report
8. Board of Director's Reports
9. Adjournment

Iberia Parish Tourist Commission

Group Health Analysis

July 1, 2024 - June 30. 2025

	Option 1		Option 2		Option 3		Option 4	
	BCBS of LA Group Care Copay 80/60 $1500		**BCBS of LA** Group Care 80/60 $1000		**BCBS of LA** Group Care Copay 80/60 $2000		**BCBS of LA** Blue Saver 100/80 $2000	
Rates								
Age Rated	See Employee Rates		See Employee Rates		See Employee Rates		See Employee Rates	
Estimated Monthly Premium	**$1,418**		**$1,379**		**$1,383**		**$1,426**	
Estimated Annual Premium	**$17,011**		**$16,548**		**$16,593**		**$17,114**	
Rate Guarantee	**1 Year**		**1 Year**		**1 Year**		**1 Year**	
	In-Network	**Out-of Network**	**In-Network**	**Out-of Network**	**In-Network**	**Out-of Network**	**In-Network**	**Out-of Network**
Network	PPO		PPO		PPO		PPO	
Deductible								
Individual	$1,500	$3,000	$1,000	$2,000	$2,000	$4,000	$2,000	$4,000
Family Maximum	$4,500	$9,000	$3,000	$6,000	$6,000	$12,000	$4,000	$8,000
Out of Pocket								
Individual	$9,100	$18,200	$8,500	$17,000	$9,100	$18,200	$7,500	$15,000
Family Maximum	$18,200	$36,400	$17,000	$34,000	$18,200	$36,400	$15,000	$30,000
Deductible Included	Included	Included	Included	Included	Included	Included	Included	Included
Coinsurance								
Plan Pays	80%	60%	80%	60%	80%	60%	100%	80%
Subscriber Pays	20%	40%	20%	40%	20%	40%	0%	20%
Office Visit Copay								
Primary Care Physician	$40	60% After Ded.	80% After Ded.	60% After Ded.	$40	60% After Ded.	100% After Ded.	80% After Ded.
Quality Blue Primary Care	$25	N/A	80% After Ded.	N/A	$25	N/A	100% After Ded.	N/A
Specialist	$55	60% After Ded.	80% After Ded.	60% After Ded.	$55	60% After Ded.	100% After Ded.	80% After Ded.
Urgent Care	$55	60% After Ded.	80% After Ded.	60% After Ded.	$55	60% After Ded.	100% After Ded.	80% After Ded.
Preventive Care	100%	60%	100%	60%	100%	60%	100%	80%
If you have a test								
Diagnostic Test (x-ray, blood work)	80% After Ded.	60% After Ded.	80% After Ded.	60% After Ded.	80% After Ded.	60% After Ded.	100% After Ded.	80% After Ded.
Imaging (CT/PET scans, MRIs)	80% After Ded.	60% After Ded.	80% After Ded.	60% After Ded.	80% After Ded.	60% After Ded.	100% After Ded.	80% After Ded.
Hospitalization								
Inpatient	80% After Ded.	60% After Ded.	80% After Ded.	60% After Ded.	80% After Ded.	60% After Ded.	100% After Ded.	80% After Ded.
Outpatient	80% After Ded.	60% After Ded.	80% After Ded.	60% After Ded.	80% After Ded.	60% After Ded.	100% After Ded.	80% After Ded.
Emergency Room Visits	80% After Ded.	80% After Ded.	80% After Ded.	80% After Ded.	80% After Ded.	80% After Ded.	100% After Ded.	100% After Ded.
Prescription Coverage	**In-Network**	**Mail Order**	**In-Network**	**Mail Order**	**In-Network**	**Mail Order**	**In-Network**	**Mail Order**
Prescription Deductible	$0 per person		$0 per person		$0 per person		$0 per person	
Tier 1	$7	$21	$15	$45	$7	$21	100% After Ded.	N/A
Tier 2	$30	$90	$40	$120	$30	$90	80% After Ded.	N/A
Tier 3	$70	$210	$70	$210	$70	$210	80% After Ded.	N/A
Tier 4	10% w/ $150 Max	N/A	10% w/ $150 Max	N/A	10% w/ $150 Max	N/A	80% After Ded.	N/A
PPACA Plan Status	Non-Grandfathered		Non-Grandfathered		Non-Grandfathered		Non-Grandfathered	

The rates and benefits shown in this proposal are for an illustrative comparison only. Please refer to the carrier's certificate of coverage or policy for a complete description of benefits, exclusions, and limitations. In the event of a discrepancy, the carrier's contract will always govern. Rates shown are not final until final underwriting is approved by carrier.