Murfreesboro City Schools

EMPLOYEE BENEFITS

RESOURCE GUIDE

Benefits Enrollment Guide

Our goal is to offer the best employee benefit options possible. This includes health, dental, vision, life, disability, and many other supplemental insurance plans. This booklet is designed to provide an overview of Murfreesboro City Schools' plan options. If more detailed information is needed, please contact the district's Benefits Coordinator.

Kathleen Hunsicker, Benefits Coordinator
Kathleen.Hunsicker@cityschools.net
615-225-2410

When am I eligible to enroll?

New hires will be eligible to make benefit elections within 30 days of their hire date. For existing eligible employees, the benefit choices elected during open enrollment will be effective January 1-December 31. However, it is very important to remember changes (add, change, or terminate) outside of new hire or open enrollment can only be made if the employee experiences a qualifying event as defined by the State of Tennesse group health plan.

Who is eligible?

All full-time employees are eligible to enroll in benefits. If the position is considered interim, the employee will not be eligible until they have worked four months or longer.

Health Options

Enrollment

Enrollment in health insurance is "passive", meaning the elections made from the previous year will roll forward if no changes are made during open enrollment. However, if a change is needed, it must be done through the State's Benefits Administration website, Edison. To login, you'll need your Edison ID which can be found on your medical ID card or by contacting the district's Benefits Coordinator, Kathleen Hunsicker. Only health insurance is enrolled through Edison.

Health Plan Options

(click on each plan for more details)

- Premier PPO
- Standard PPO
- Limited PPO
- Local CDHP/HSA

Network of Providers

- BlueCross BlueShield Network S
- BlueCross BlueShield Network P - broader network offering more providers, but added monthly surcharge of $65/$130 added into monthly premium
- Cigna LocalPlus
- Cigna Open Access - broader network offering more providers, but added monthly surcharge of $65/$130 added into monthly premium

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Tiers of Coverage

- Employee Only
- Employee + Child(ren)
- Employee + Spouse
- Family

Health Cont.

Make Sure Your Doctor is in Network!

Your doctor or hospital changing networks is not a qualifying event, so be sure to confirm your provider is in network before choosing a carrier.

BCBST: 800-558-6213
Cigna: 800-997-1617

If your provider is not listed online, call them directly to confirm!

Pharmacy Benefits Included!

All our health plans include comprehensive prescription drug benefits. The plan you choose will determine your out-of-pocket presciption cost.

For more information about pharmacy benefits, vaccines, and discounts, visit Caremark/CVS or call 877-522-8679.

Additional Health Plan Perks!

To learn more about the State of Tennesse health plan perks including the Employee Assistance Program, Behavioral Health, and wellness programs, visit Partners4Health. Employees (and dependents) must be enrolled in a health plan to access these benefits.

PARTNERS FOR HEALTH

2023 Deductibles/Copays/Out of Pocket Maximums/Coinsurance for In-Network Providers

	Premier PPO	Standard PPO	Limited PPO	Local CDHP
	85% Coinsurance	80% Coinsurance	70% Coinsurance	70% Coinsurance
	$25 Copay	$30 Copay	$35 Copay	$0 Copay
	Deductibles			
Employee Only	$750	$1,300	$1,800	$2,000
Employee + Child(ren)	$1,125	$1,950	$2,500	$4,000
Employee + Spouse	$1,500	$2,600	$2,800	$4,000
Employee + Family	$1,875	$3,250	$3,600	$4,000
	Out of Pocket Maximums			
Employee Only	$3,600	$4,400	$6,800	$5,000
Employee + Child(ren)	$5,400	$6,600	$13,600	$10,000
Employee + Spouse	$7,200	$8,800	$13,600	$10,000
Employee + Family	$9,000	$11,000	$13,600	$10,000

2023 Deductibles/Copays/Out of Pocket Maximums/Coinsurance for Out-of-Network Providers

	Premier PPO	Standard PPO	Limited PPO	Local CDHP
	60% Coinsurance	60% Coinsurance	50% Coinsurance	50% Coinsurance
	$45 Copay	$50 Copay	$55 Copay	50% Copay
	Deductibles			
Employee Only	$1,500	$2,600	$3,600	$4,000
Employee + Child(ren)	$2,250	$3,900	$4,800	$8,000
Employee + Spouse	$3,000	$5,200	$5,500	$8,000
Employee + Family	$3,750	$6,500	$7,200	$8,000
	Out of Pocket Maximums			
Employee Only	$7,200	$8,800	$13,600	$10,000
Employee + Child(ren)	$10,800	$13,200	$27,200	$20,000
Employee + Spouse	$14,400	$17,600	$27,200	$20,000
Employee + Family	$18,000	$22,000	$27,200	$20,000

2023 Health Plan Comparison of Member Costs — Local Education and Local Government

PPO services in this table ARE NOT subject to a deductible. CDHP/HSA services in this table ARE subject to a deductible and coinsurance with the exception of in-network preventive care and maintenance medications.

HEALTHCARE OPTION	PREMIER PPO		STANDARD PPO		LIMITED PPO		LOCAL CDHP/HSA	
COVERED SERVICES	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**
PREVENTIVE CARE — OFFICE VISITS								
• Well-baby, well-child visits as recommended • Adult annual physical exam • Annual well-woman exam • Immunizations as recommended • Annual hearing and non-refractive vision screening • Screenings including Pap smears, labs, nutritional guidance, tobacco cessation counseling and other services as recommended	No charge	$45	No charge	$50	No charge	$50	No charge	50%
OUTPATIENT SERVICES — SERVICES SUBJECT TO A COINSURANCE MAY BE EXTRA								
Primary Care Office Visit • Family practice, general practice, internal medicine, OB/GYN and pediatrics • Provider based telehealth • Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider • Including surgery in office setting and initial maternity visit	$25	$45	$30	$50	$35	$55	30%	50%
Specialist Office Visit • Including surgery in office setting • Provider based telehealth • Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a specialist	$45	$70	$50	$75	$55	$80	30%	50%
Behavioral Health and Substance Use [2] • Including virtual visits	$25	$45	$30	$50	$35	$55	30%	50%
Telehealth Carrier Programs (MDLive/Teledoc)	$15	N/A	$15	N/A	$15	N/A	30%	N/A
Allergy Injection Without an Office Visit • Allergy Serum has additional member cost	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC	30%	50%
Chiropractic and Acupuncture • Limit of 50 visits of each per year	Visits 1-20: $25 Visits 21-50: $45	Visits 1-20: $45 Visits 21-50: $70	Visits 1-20: $30 Visits 21-50: $50	Visits 1-20: $50 Visits 21-50: $75	Visits 1-20: $35 Visits 21-50: $55	Visits 1-20: $55 Visits 21-50: $80	30%	50%
Convenience Clinic	$25	$45	$30	$50	$35	$55	30%	50%
Urgent Care Facility	$45	$70	$50	$75	$55	$80	30%	50%
PHARMACY								
30-Day Supply	$7 generic; $40 preferred brand; $90 non-preferred	copay plus amount exceeding MAC	$14 generic; $50 preferred brand; $100 non-preferred	copay plus amount exceeding MAC	$14 generic; $60 preferred brand; $110 non-preferred	copay plus amount exceeding MAC	30%	50% plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail order)	$14 generic; $80 preferred brand; $180 non-preferred	N/A - no network	$28 generic; $100 preferred brand; $200 non-preferred	N/A - no network	$28 generic; $120 preferred brand; $220 non-preferred	N/A - no network	30%	N/A - no network
Maintenance Medications (90-day supply of certain maintenance medications from 90-day network pharmacy or mail order) [3]	$7 generic; $40 preferred brand; $160 non-preferred	N/A - no network	$14 generic; $50 preferred brand; $180 non-preferred	N/A - no network	$14 generic; $60 preferred brand; $200 non-preferred	N/A - no network	20% without first having to meet deductible	N/A - no network
Specialty Medication Tier 1 (generics; 30-day supply from a specialty network pharmacy)	20%; min $100; max $200	N/A - no network	20%; min $100; max $200	N/A - no network	20%; min $100; max $200	N/A - no network	30%	N/A - no network
Specialty Medication Tier 2 (all brands; 30-day supply from a specialty network pharmacy)	30%; min $200; max $400		30%; min $200; max $400		30%; min $200; max $400			

2023 Health Plan Comparison of Member Costs — Local Education and Local Government

PPO services in this table ARE subject to a deductible unless noted with a [5]. Local CDHP/HSA services in this table ARE subject to a deductible and coinsurance with the exception of in-network preventive care.

HEALTHCARE OPTION	PREMIER PPO		STANDARD PPO		LIMITED PPO		LOCAL CDHP/HSA	
COVERED SERVICES	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**
PREVENTIVE CARE — OUTPATIENT FACILITIES								
• Recommended screenings such as colonoscopy, mammogram, colorectal, and bone density scans	No charge [5]	40%	No charge [5]	40%	No charge [5]	50%	No charge	50%
OTHER SERVICES								
Hospital/Facility Services [4] • Inpatient care [7]; outpatient surgery [7] • Inpatient behavioral health and substance use [2] [6]	15%	40%	20%	40%	30%	50%	30%	50%
• Emergency room services [7]	15%		20%		30%		30%	
Maternity • Global billing for labor and delivery and routine services beyond the initial office visit	15%	40%	20%	40%	30%	50%	30%	50%
Home Care [4] • Home health; home infusion therapy	15%	40%	20%	40%	30%	50%	30%	50%
Rehabilitation and Therapy Services • Inpatient and skilled nursing facility [4] • Outpatient PT/ST/OT/ABA [5]; Other therapy	15%	40%	20%	40%	30%	50%	30%	50%
X-Ray, Lab and Diagnostics (not including advanced x-rays, scans and imaging) [5]	15%		20%		30%		30%	50%
Advanced X-Ray, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies [4]	15%	40%	20%	40%	30%	50%	30%	50%
Pathology and Radiology Reading, Interpretation and Results [5]	15%		20%		30%		30%	
Ambulance (medically necessary, air and ground)	15%		20%		30%		30%	
Equipment and Supplies [4] • Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	15%	40%	20%	40%	30%	50%	30%	50%
Allergy Serum	15%	40%	20%	40%	30%	50%	30%	50%
Also Covered	Certain limited Dental benefits, Hospice Care and Out-of-Country Charges are also covered. See Member Handbook for coverage details.							
DEDUCTIBLE — ONLY ELIGIBLE EXPENSES COUNT TOWARD THE DEDUCTIBLE								
Employee Only	$750	$1,500	$1,300	$2,600	$1,800	$3,600	$2,000	$4,000
Employee + Child(ren)	$1,125	$2,250	$1,950	$3,900	$2,500	$4,800	$4,000	$8,000
Employee + Spouse	$1,500	$3,000	$2,600	$5,200	$2,800	$5,500	$4,000	$8,000
Employee + Spouse + Child(ren)	$1,875	$3,750	$3,250	$6,500	$3,600	$7,200	$4,000	$8,000
OUT-OF-POCKET MAXIMUM – MEDICAL AND PHARMACY COMBINED – ELIGIBLE EXPENSES, INCLUDING DEDUCTIBLE, COUNT TOWARD THE OUT-OF-POCKET MAXIMUM								
Employee Only	$3,600	$7,200	$4,400	$8,800	$6,800	$13,600	$5,000	$10,000
Employee + Child(ren)	$5,400	$10,800	$6,600	$13,200	$13,600	$27,200	$10,000	$20,000
Employee + Spouse	$7,200	$14,400	$8,800	$17,600	$13,600	$27,200	$10,000	$20,000
Employee + Spouse + Child(ren)	$9,000	$18,000	$11,000	$22,000	$13,600	$27,200	$10,000	$20,000

For PPO Plans, no single family member will be subject to a deductible or out-of-pocket maximum greater than the "employee only" amount. Once two or more family members (depending on premium level) have met the total deductible and/or out-of-pocket maximum, it will be met by all covered family members. **For Local CDHP Plan,** the deductible and out-of-pocket maximum amount can be met by one or more persons, but must be met in full before it is considered satisfied for the family. No one family member may contribute more than $9,100 to the in-network family out-of-pocket maximum total.

[1] Subject to maximum allowable charge. The MAC is the most a plan will pay for a covered service. For non-emergent care from an out-of-network provider who charges more than the MAC, you will pay the copay or coinsurance PLUS the difference between MAC and actual charge, unless otherwise specified by state or federal law.

[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization/day treatment programs and intensive outpatient therapy. In addition to services treated as "inpatient," prior authorization (PA) is required for certain outpatient behavioral health services including, but not limited to, applied behavioral analysis, transcranial magnetic stimulation, electroconvulsive therapy, psychological testing, and other behavioral health services as determined by the Contractor's clinical staff.

[3] CDHP list of eligible medications, PPO list of eligible medication classes, and a list of participating Retail-90 pharmacies can be found at https://www.tn.gov/partnersforhealth/health-options/pharmacy.html.

[4] Prior authorization required, for non-emergent services. When using out-of-network providers, benefits for non-emergent medically necessary services will be reduced by half if PA is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided.

[5] For PPO plans, the deductible DOES NOT apply to IN-NETWORK outpatient PT/ST/OT/ABA and other PPO services as noted.

[6] Select Substance Use Treatment Facilities are preferred with an enhanced benefit - PPO members won't have to pay a deductible or coinsurance for facility-based substance use treatment; CDHP members must meet their deductible first, then coinsurance is waived. Copays for PPO and deductible/coinsurance for CDHP will apply for standard outpatient treatment services. Call 855-Here4TN for assistance.

[7] In-network benefits apply to certain out-of-network professional services at certain in-network facilities.

Employee Health Premiums

Monthly Payroll (Salaried Employees)

LOCAL NETWORKS									
BCBS Network S & Cigna LocalPlus	HEALTH PLAN OPTIONS	EMPLOYEE ONLY		EMPLOYEE + CHILD(REN)		EMPLOYEE + SPOUSE		EMPLOYEE + SPOUSE + CHILD(REN)	
		2022	2023	2022	2023	2022	2023	2022	2023
	Premier PPO	$58.12	$54.55	$346.04	$225.20	$475.99	$440.70	$594.21	$532.50
	Standard PPO	$68.90	$62.49	$468.28	$209.20	$609.92	$409.20	$811.12	$494.70
	Limited PPO	$32.01	$30.00	$241.56	$198.00	$429.15	$387.30	$563.52	$468.30
	Local CDHP/HSA	$0.00	$0.00	$240.36	$172.60	$384.64	$337.50	$578.40	$408.00
	MCS HSA CONTRIBUTION	$50/MO	$50/MO						

BROAD NETWORKS									
BCBS Network P & Cigna Open Access	HEALTH PLAN OPTIONS	EMPLOYEE ONLY *$65/mo surcharge		EMPLOYEE + CHILD(REN) *$65/mo surcharge		EMPLOYEE + SPOUSE *$130/mo surcharge		EMPLOYEE + SPOUSE + CHILD(REN) *$130/mo surcharge	
		2022	2023	2022	2023	2022	2023	2022	2023
	Premier PPO	$177.54	$177.23	$603.06	$595.50	$796.70	$799.50	$1,002.10	$952.50
	Standard PPO	$135.72	$129.42	$535.10	$555.50	$702.27	$747.00	$903.49	$889.50
	Limited PPO	$66.72	$71.22	$447.28	$527.50	$683.47	$710.50	$897.21	$845.50
	Local CDHP/HSA	$58.53	$63.97	$307.18	$464.00	$518.28	$627.50	$775.96	$745.00
	MCS HSA CONTRIBUTION	$0/MO	$0/MO						

Premiums are deducted once per month.

Employee Health Premiums

Biweekly Payroll (Hourly Employees)

LOCAL NETWORKS									
BCBS Network S & Cigna LocalPlus	HEALTH PLAN OPTIONS	EMPLOYEE ONLY		EMPLOYEE + CHILD(REN)		EMPLOYEE + SPOUSE		EMPLOYEE + SPOUSE + CHILD(REN)	
		2022	2023	2022	2023	2022	2023	2022	2023
	Premier PPO	$34.87	$32.73	$207.62	$135.12	$285.59	$264.42	$356.53	$319.50
	Standard PPO	$41.34	$37.50	$280.97	$125.52	$365.95	$245.52	$486.67	$296.82
	Limited PPO	$19.22	$18.00	$144.94	$118.80	$257.49	$232.38	$338.11	$280.98
	Local CDHP/HSA	$0.00	$0.00	$144.22	$103.56	$230.78	$202.50	$347.04	$244.80
	MCS HSA CONTRIBUTION	$30/ck	$30/ck						

BROAD NETWORKS									
BCBS Network P & Cigna Open Access	HEALTH PLAN OPTIONS	EMPLOYEE ONLY *$65/mo surcharge		EMPLOYEE + CHILD(REN) *$65/mo surcharge		EMPLOYEE + SPOUSE *$130/mo surcharge		EMPLOYEE + SPOUSE + CHILD(REN) *$130/mo surcharge	
		2022	2023	2022	2023	2022	2023	2022	2023
	Premier PPO	$121.52	$121.34	$376.84	$372.30	$508.02	$509.70	$631.26	$601.50
	Standard PPO	$96.43	$92.65	$336.06	$348.30	$451.36	$478.20	$572.09	$563.70
	Limited PPO	$55.03	$57.73	$283.37	$331.50	$440.08	$456.30	$568.33	$537.30
	Local CDHP/HSA	$50.12	$53.38	$199.31	$293.40	$340.97	$406.50	$495.58	$477.00
	MCS HSA CONTRIBUTION	$0/ck	$0/ck						

Premiums are deducted 20 times per year on the first two paychecks of the month.

Basic Dental

BlueCross BlueShield of Tennessee

Murfreesboro City Schools

Summary of Benefits	DentalBlue	Standard Plan
	Dental Option: Basic **Effective Date: January 1, 2023**	
Deductible Calendar Year Applies to Coverage B only	**Individual** $50	**Family** $150
Benefit Maximums Applies to Coverage A, B, and C (per Calendar Year)	$750	
Benefit Percentages apply to	Any Dentist*	
Covered Services	**Benefit Percentages**	
Coverage A Exams, X-rays Cleanings, Fluoride Sealants, Space Maintainers	100%	
Coverage B Basic Restorative Services Basic Endodontics Basic Periodontics Basic Oral Surgery	80%	
Coverage C - Major Restorative and Prosthodontics Major Endodontics Major Periodontics Major Oral Surgery	0%	
Coverage D - Orthodontics	Not Available	
Choice Option	Network Dentists paid at PPO fee schedule; non-network dentists paid at 70th percentile of UCR	
National Network	Included	
Blue365	Discounts on health and wellness services including routine vision care, Lasik surgery, weight loss and fitness centers, and more	

Enhanced Dental

BlueCross BlueShield of Tennessee

Murfreesboro City Schools

Summary of Benefits	DentalBlue	Standard Plan
	Dental Option: Enhanced **Effective Date: January 1, 2023**	
Deductible Calendar Year Applies to Coverage B and C only	**Individual** $50	**Family** $150
Benefit Maximums Applies to Coverage A, B, and C (per Calendar Year) Coverage D (per Lifetime)	$1,500 $1,250	
Benefit Percentages apply to	Any Dentist*	

Covered Services	Benefit Percentages
Coverage A Exams, X-rays Cleanings, Fluoride Sealants, Space Maintainers	100%
Coverage B Basic Restorative Services Basic and Major Endodontics Basic and Major Periodontics Basic and Major Oral Surgery	80%
Coverage C - 6 Month Waiting Period Major Restorative and Prosthodontics	50%
Coverage D - 12 Month Waiting Period Orthodontics-Child to age 19	50%
Choice Option	Network Dentists paid at PPO fee schedule; non-network dentists paid at 70th percentile of UCR
National Network	Included
Blue365	Discounts on health and wellness services including routine vision care, Lasik surgery, weight loss and fitness centers, and more

Vision

BlueCross BlueShield of Tennessee
An Independent Licensee of the BlueCross BlueShield Association

Group Name: Murfreesboro City Schools
Group Number: 125200
Effective Date: 01/01/2023

VisionBlue

Benefit	In-Network Member Cost	Out-of-Network Reimbursement	
VISION EXAMINATION			
Comprehensive Eye Examination	$10 Copayment	Up to $35	One exam within a 12 month period for each member covered under the plan.
Retinal Imaging	Up to $39	N/A	
Contact Lenses Fit and Follow-Up			
Standard	$55 Copayment	N/A	
Premium	10% off retail	N/A	
VISION MATERIALS			
Standard Plastic Lenses			One set of lenses within a 12 month period for each member covered under the plan.
Single Vision	$20 Copayment	Up to $30	
Bifocal	$20 Copayment	Up to $45	
Trifocal	$20 Copayment	Up to $60	
Frames	$0 Copayment up to $120 allowance, 20% off balance over allowance	Up to $60	One pair of frames within a 12 month period for each member covered under the plan.
Contacts			One set of lenses within a 12 month period for each member covered under the plan (In lieu of lenses + frames).
Conventional	$0 copay up to $120 allowance, 15% off balance over allowance	Out-of-network up to $96	
Disposable	$0 copay up to $120 allowance	Out-of-network up to $96	
Medically Necessary	Paid in Full	Up to $200	
Lens Options			One set of lenses within a 12 month period for each member covered under the plan.
Standard Polycarbonate	$40 Copayment	Up to $0	
Standard Polycarbonate *(For covered dependent children under 19 years of age)*	$0 Copayment	Up to $5	
UV Treatment	$15 Copayment	Up to $0	
Tint	$15 Copayment	Up to $0	
Standard Plastic Scratch Coating	$15 Copayment	Up to $0	
Standard Progressive Lenses (add on to Bifocal)	$65 Additional Copayment	$0 Additional *	
Premium Progressive Lenses (add on to Bifocal)	$65 Additional Copayment, 20% off retail price less $120 allowance	$0 Additional *	
Standard Anti-Reflective Coating	$45 Copayment	Up to $0	
Other Lens Options	20% off retail	N/A	
* $45 maximum reimbursement			
Diabetic Eye Care *(Care and testing for diabetic members)*			Up to 2 services per year for each listed service.**
Exam	$0	Up to $77	
Retinal Imaging	$0	Up to $50	
Extended Ophthalmoscopy	$0	Up to $15	
Gonioscopy	$0	Up to $15	
Scanning Laser	$0	Up to $33	

**Some or all of the diagnostic services described above will be provided as deemed appropriate, subject to provider determination of service necessity and the benefit frequency limitations referenced above.

- This document serves as a summary of the benefits that are detailed in the Evidence of Coverage. These benefits are subject to the Covered Services and Limitations on Covered Services, Exclusions from Covered Services, and Schedule of Benefits sections of the Evidence of Coverage.
- When applicable benefits are paid after the Copayment listed above and to the allowance listed, members are responsible for amounts above the allowance.
- Members may see any vision care provider. However, contracted providers in our network have agreed to limit certain charges and provide additional discounts once the allowance has been reached. Because we have no contract with non-network providers, members are responsible for all charges that exceed the out-of-network reimbursement.

Employee Dental/Vision Premiums

Monthly Payroll (Salaried Employees)

DENTAL PREMIUMS

BCBS	DENTAL PLAN OPTIONS	EMPLOYEE ONLY		EMPLOYEE + 1 DEPENDENT		EMPLOYEE + 2 OR MORE DEPENDENTS	
		2022	2023	2022	2023	2022	2023
	Basic Dental	$0.00	$0.00	$22.73	$23.53	$35.57	$36.82
	Enhanced Dental	$16.03	$16.59	$56.70	$58.68	$112.29	$116.22

VISION PREMIUMS

BCBS	VISION PLAN OPTION	EMPLOYEE ONLY		EMPLOYEE + CHILD(REN)		EMPLOYEE + SPOUSE		EMPLOYEE + SPOUSE + CHILD(REN)	
		2022	2023	2022	2023	2022	2023	2022	2023
	Vision	$8.20	$8.20	$16.87	$16.87	$16.08	$16.08	$23.97	$23.97

Premiums are deducted once per month.

Biweekly Payroll (Hourly Employees)

DENTAL PREMIUMS

BCBS	DENTAL PLAN OPTIONS	EMPLOYEE ONLY		EMPLOYEE + 1 DEPENDENT		EMPLOYEE + 2 OR MORE DEPENDENTS	
		2022	2023	2022	2023	2022	2023
	Basic Dental	$0.00	$0.00	$13.64	$14.12	$21.34	$22.09
	Enhanced Dental	$9.62	$9.95	$34.02	$35.21	$67.37	$69.73

VISION PREMIUMS

BCBS	VISION PLAN OPTION	EMPLOYEE ONLY		EMPLOYEE + CHILD(REN)		EMPLOYEE + SPOUSE		EMPLOYEE + SPOUSE + CHILD(REN)	
		2022	2023	2022	2023	2022	2023	2022	2023
	Vision	$4.92	$4.92	$10.12	$10.12	$9.65	$9.65	$14.38	$14.38

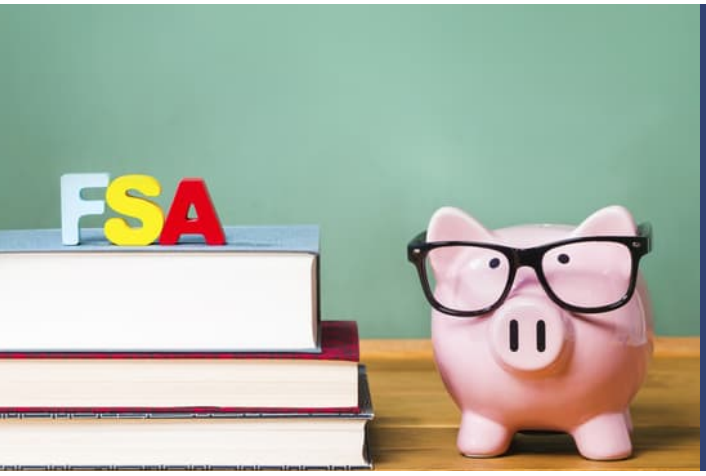
Premiums are deducted 20 times per year on the first two paychecks of the month.

Section 125 Benefits

Offered through USAble Life and Trustmark Life

Every November, employees are offered certain eligible supplemental benefits which are payroll deducted tax free. Employees can choose to participate in all, part, or none of the available options. Elections cannot be changed outside of open enrollment or a qualifying event.

Policies include, but are not limited to, the following:



FLEXIBLE SPENDING ACCOUNTS

FSA's are a great way to put money aside, tax free, to cover eligible expenses. Employees can choose between medical, dental, vision, and dependent care (daycare) Flexible Spending Accounts.

SHORT AND LONG TERM DISABILITY

In the event you are injured or sick and cannot work, you still need a check to cover your monthly obligations. For covered disability claims, these plans directly pay you a monthly amount.

VOLUNTARY GROUP TERM LIFE

Term life insurance is great If you need additional life protection for you and your eligible family members. You select the benefit amounts to suit your specific situation.

Tennessee Consolidated Retirement System

All full-time employees become members of TCRS at time of hire. If an employee has previously worked under a TCRS contributor, the service time/contributions will accumulate as long as the member has met certain vesting requirements. For more information regarding retirement and 401k plan features, visit the links below.

Legacy

Certified personnel hired prior to July 1, 2014 and all classified personnel

Click here for plan features

Hybrid

Certified personnel hired after July 1, 2014

Click here for plan features

Open to all certified and classified personnel

Click here for plan features

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Questions?

Kathleen Hunsicker, Benefits Coordinator
Kathleen.Hunsicker@cityschools.net
615-225-2410

Customer Service Contacts

Contact	Phone	Website/Email
Kathleen Hunsicker *Murfreesboro City Schools* *Benefits Coordinator*	615-225-2410	Kathleen.Hunsicker@cityschools.net
Benefits Administration *Health Insurance* *State of TN Group Health*	615-741-3590	Partners4Health
BlueCross BlueShield *Dental and Vision Insurance*	615-523-1478	BCBST
BlueCross BlueShield *Medical Insurance*	800-558-6213	BCBST
Cigna *Medical Insurance*	800-244-6224	Cigna
USAble Life *Supplemental Plans*	800-370-5856	USAble Life
Trustmark Life *Life Insurance*	800-918-8877	Trustmark Life
TASC *Flexible Spending Accounts*	800-422-4661	TASC
TCRS *Retirement System*	800-922-7772	Tennessee Consolidated Retirement