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

**What's an HSA?**
Click here to see how a health savings account can work for you!

## Network of Providers

- BlueCross BlueShield Network S
- BlueCross BlueShield Network P - broader network offering more providers, but added monthly surcharge of $75-$150 added into monthly premium
- Cigna LocalPlus
- Cigna Open Access - broader network offering more providers, but added monthly surcharge of $75-$150 added into monthly premium

## 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.

## 2024 Deductibles/Copays/Out of Pocket Maximums/Coinsurance for In-Network Providers

No changes in plans from 2023 to 2024

| | 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 |

## 2024 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 |

## 2024 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<br>• Adult annual physical exam<br>• Annual well-woman exam<br>• Immunizations as recommended<br>• Annual hearing and non-refractive vision screening<br>• 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**<br>• Family practice, general practice, internal medicine, OB/GYN and pediatrics<br>• Provider based telehealth<br>• Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider<br>• Including surgery in office setting and initial maternity visit | $25 | $45 | $30 | $50 | $35 | $55 | 30% | 50% |
| **Specialist Office Visit**<br>• Including surgery in office setting<br>• Provider based telehealth<br>• 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]<br>• 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**<br>• 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**<br>• Limit of 50 visits of each per year | Visits 1-20: $25<br>Visits 21-50: $45 | Visits 1-20: $45<br>Visits 21-50: $70 | Visits 1-20: $30<br>Visits 21-50: $50 | Visits 1-20: $50<br>Visits 21-50: $75 | Visits 1-20: $35<br>Visits 21-50: $55 | Visits 1-20: $55<br>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;<br>$40 preferred brand;<br>$90 non-preferred | copay plus amount exceeding MAC | $14 generic;<br>$50 preferred brand;<br>$100 non-preferred | copay plus amount exceeding MAC | $14 generic;<br>$60 preferred brand;<br>$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;<br>$80 preferred brand;<br>$180 non-preferred | N/A - no network | $28 generic;<br>$100 preferred brand;<br>$200 non-preferred | N/A - no network | $28 generic;<br>$120 preferred brand;<br>$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;<br>$40 preferred brand;<br>$160 non-preferred | N/A - no network | $14 generic;<br>$50 preferred brand;<br>$180 non-preferred | N/A - no network | $14 generic;<br>$60 preferred brand;<br>$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%;<br>min $100; max $200 | N/A - no network | 20%;<br>min $100; max $200 | N/A - no network | 20%;<br>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%;<br>min $200; max $400 | | 30%;<br>min $200; max $400 | | 30%;<br>min $200; max $400 | | | |

## 2024 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, lung imaging 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]<br>• Inpatient care [7]; outpatient surgery [7]<br>• 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**<br>• 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]<br>• Home health; home infusion therapy | 15% | 40% | 20% | 40% | 30% | 50% | 30% | 50% |
| **Rehabilitation and Therapy Services**<br>• Inpatient and skilled nursing facility [4]<br>• 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**<br>• 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]<br>• Durable medical equipment and external prosthetics<br>• 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 $8,700 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.

# 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) | |
| | | 2023 | 2024 | 2023 | 2024 | 2023 | 2024 | 2023 | 2024 |
| | Premier PPO | $54.55 | $56.97 | $225.20 | $235.00 | $440.70 | $481.20 | $532.50 | $555.60 |
| | Standard PPO | $62.49 | $33.10 | $209.20 | $209.20 | $409.20 | $409.20 | $494.70 | $494.70 |
| | Limited PPO | $30.00 | $0.00 | $198.00 | $103.10 | $387.30 | $387.30 | $468.30 | $468.30 |
| | Local CDHP/HSA | $0.00 | $0.00 | $172.60 | $90.00 | $337.50 | $337.50 | $408.00 | $408.00 |
| | MCS HSA CONTRIBUTION | $50/MO | $50/MO | | | | | | |

| BROAD NETWORKS | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| BCBS Network P & Cigna Open Access | HEALTH PLAN OPTIONS | EMPLOYEE ONLY *$75/mo surcharge | | EMPLOYEE + CHILD(REN) *$85/mo surcharge | | EMPLOYEE + SPOUSE *$150/mo surcharge | | EMPLOYEE + SPOUSE + CHILD(REN) *$150/mo surcharge | |
| | | 2023 | 2024 | 2023 | 2024 | 2023 | 2024 | 2023 | 2024 |
| | Premier PPO | $177.23 | $186.68 | $595.50 | $630.00 | $799.50 | $877.00 | $952.50 | $1,001.00 |
| | Standard PPO | $129.42 | $136.27 | $555.50 | $588.50 | $747.00 | $820.00 | $889.50 | $935.50 |
| | Limited PPO | $71.22 | $74.97 | $527.50 | $558.00 | $710.50 | $778.50 | $845.50 | $887.50 |
| | Local CDHP/HSA | $63.97 | $67.56 | $464.00 | $492.50 | $627.50 | $689.00 | $745.00 | $784.50 |
| | 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) | |
| | | 2023 | 2024 | 2023 | 2024 | 2023 | 2024 | 2023 | 2024 |
| | Premier PPO | $32.73 | $34.18 | $135.12 | $141.00 | $264.42 | $288.72 | $319.50 | $333.36 |
| | Standard PPO | $37.50 | $19.86 | $125.52 | $125.52 | $245.52 | $245.52 | $296.82 | $296.82 |
| | Limited PPO | $18.00 | $0.00 | $118.80 | $61.86 | $232.38 | $232.38 | $280.98 | $280.98 |
| | Local CDHP/HSA | $0.00 | $0.00 | $103.56 | $54.00 | $202.50 | $202.50 | $244.80 | $244.80 |
| | MCS HSA CONTRIBUTION | $30/ck | $30/ck | | | | | | |

| BROAD NETWORKS | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| BCBS Network P & Cigna Open Access | HEALTH PLAN OPTIONS | EMPLOYEE ONLY *$75/mo surcharge | | EMPLOYEE + CHILD(REN) *$85/mo surcharge | | EMPLOYEE + SPOUSE *$150/mo surcharge | | EMPLOYEE + SPOUSE + CHILD(REN) *$150/mo surcharge | |
| | | 2023 | 2024 | 2023 | 2024 | 2023 | 2024 | 2023 | 2024 |
| | Premier PPO | $121.34 | $127.01 | $372.30 | $393.00 | $509.70 | $556.20 | $601.50 | $630.60 |
| | Standard PPO | $92.65 | $96.76 | $348.30 | $368.10 | $478.20 | $522.00 | $563.70 | $591.30 |
| | Limited PPO | $57.73 | $59.98 | $331.50 | $349.80 | $456.30 | $497.10 | $537.30 | $562.50 |
| | Local CDHP/HSA | $53.38 | $55.54 | $293.40 | $310.50 | $406.50 | $443.40 | $477.00 | $500.70 |
| | MCS HSA CONTRIBUTION | $0/ck | $0/ck | | | | | | |

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

# Basic Dental

| Murfreesboro City Schools | | |
|---|---|---|
| **Summary of Benefits** | **BCBST Dental** | |
| | **Dental Option: 1** | |
| | **Effective Date: 1/1/2024** | |
| **Deductible Calendar Year** | **Individual** | **Family** |
| Applies to Coverage B and C only | $50 | $150 |
| **Benefit Maximums**<br>Applies to Coverage A, B, and C (per Calendar Year) | $750 | |
| **Benefit Percentages apply to** | **Network Providers** | **Non-network Providers** |
| **Covered Services** | **Benefit Percentages** | **Benefit Percentages** |
| **Coverage A**<br>Exams, X-rays<br>Cleanings, Fluoride<br>Sealants, Space Maintainers | 100% | 50% |
| **Coverage B**<br>Basic Restorative Services<br>Basic and Major Endodontics<br>Basic and Major Periodontics<br>Basic and Major Oral Surgery | 80% | 50% |
| **Coverage C**<br>Major Restorative and Prosthodontics | 0% | 0% |
| **Coverage D**<br>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 servicec including routine vision care, Lasik surgery, weight loss and fitness centers, and more | |

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 Coverage, and Schedule of Benefits sections of the Evidence of Coverage.

When applicable, benefits will be paid based on the Benefit Percentages listed above. Members will be responsible for co-insurance (when benefit percentages are less than 100%), deductible(s), and all other charges when benefit maximums have been met.

*Members may see any dentist. We have contracted dentists in our network that have agreed to limit their charges to our fee schedule. Because we have no contract with non-network dentists, members may be responsible for any billed charges that exceed our Maximum Allowable Charge.

# Enhanced Dental

| Murfreesboro City Schools | | |
|---|---|---|
| **Summary of Benefits** | **BCBST Dental** | |
| | **Dental Option: 2**<br>**Effective Date: 1/1/2024** | |
| **Deductible Calendar Year**<br>Applies to Coverage B and C only | **Individual**<br>$50 | **Family**<br>$150 |
| **Benefit Maximums**<br>Applies to Coverage A, B, and C (per Calendar Year)<br>Coverage D (per Lifetime) | $1,500<br>$1,250 | |
| **Benefit Percentages apply to** | **Network Providers** | **Non-network Providers** |
| **Covered Services** | **Benefit Percentages** | **Benefit Percentages** |
| **Coverage A**<br>Exams, X-rays<br>Cleanings, Fluoride<br>Sealants, Space Maintainers | 100% | 100% |
| **Coverage B**<br>Basic Restorative Services<br>Basic and Major Endodontics<br>Basic and Major Periodontics<br>Basic and Major Oral Surgery | 80% | 80% |
| **Coverage C**<br>Major Restorative and Prosthodontics | 50% | 50% |
| **Coverage D**<br>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 servicec including routine vision care, Lasik surgery, weight loss and fitness centers, and more | |

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 Coverage, and Schedule of Benefits sections of the Evidence of Coverage.

When applicable, benefits will be paid based on the Benefit Percentages listed above. Members will be responsible for co-insurance (when benefit percentages are less than 100%), deductible(s), and all other charges when benefit maximums have been met.

*Members may see any dentist. We have contracted dentists in our network that have agreed to limit their charges to our fee schedule. Because we have no contract with non-network dentists, members may be responsible for any billed charges that exceed our Maximum Allowable Charge.

# Vision

## Murfreesboro City Schools

### VisionBlue

**Summary of Benefits** — **Effective Date: January 1, 2024**

| Benefit Category | In-Network | Out-of-Network |
|---|---|---|
| **Exams (Limited to one exam and one contact lens fitting/follow-up within a 12-month period)** | | |
| Comprehensive Eye Exam | $10 Copay | Up to $35 |
| Retinal Imaging | Up to $39 | Not Covered |
| Contact Lens Fitting and Follow-up - Standard | $55 Copay | Not Covered |
| Contact Lens Fitting and Follow-up - Premium | 10% off retail | Not Covered |
| **Vision Materials** | | |
| Standard Plastic Lenses (Limited to one set of standard plastic lenses within a 12-month period) | | |
| Single | $20 Copay | Up to $30 |
| Bifocal | $20 Copay | Up to $45 |
| Trifocal | $20 Copay | Up to $60 |
| Frames (Limited to one pair of frames within a 12-month period) | $0 Copay up to $120 allowance* | Up to $60 |
| Contacts (Limited to one set of lenses within a 12-month period in lieu of eyeglasses) | | |
| Conventional | $0 Copay up to $120 allowance** | Up to $96 |
| Disposable | $0 Copay up to $120 allowance | Up to $96 |
| Medically Necessary | Covered at 100% | Up to $200 |
| Lens Options (Limited to one set of lenses within a 12-month period) | | |
| Standard Polycarbonate | $40 | Not Covered |
| Standared Polycarbonate (For covered dependent children under age 19) | No Copay | Up to $5 |
| UV Treatment | $15 Copay | Not Covered |
| Tint | $15 Copay | Not Covered |
| Standard Plastic Scratch Coating | $15 Copay | Not Covered |
| Standard Progressive Lenses (add on to Bifocal) | $65 Copay | $0 Additional*** |
| Premium Progressive Lenses (add on to Bifocal) | $65 Copay, 20% Discount Off of Retail Price, Less $120 Allowance | $0 Additional*** |
| Standard Anti-reflective Coating | $45 Copay | Not Covered |
| **Diabetic Care Services******** | | |
| Office Service Visit *(Medical Follow-up Exam)* | Covered 100% | $77 |
| Retinal Imaging | Covered 100% | $50 |
| Extended Ophthalmoscopy | Covered 100% | $15 |
| Gonioscopy | Covered 100% | $15 |
| Scanning Laser | Covered 100% | $33 |

Notes

1. 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.
2. When applicable, benefits are paid after the copay listed above and to the allowance listed. Members are responsible for amounts exceeding the allowance.
3. 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 responsicble for all charges that exceed the out-of-network reimbursement.

* 20% off balance over allowance
** 15% off balance over allowance
***$45 maximum reimbursement
****Up to 2 additional per year

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association
® Registered marks of the BlueCross BlueShield Association, an Association of Independent BlueCross BlueShield Plans.

# Employee Dental/Vision Premiums

## Monthly Payroll (Salaried Employees)

### DENTAL PREMIUMS

| BCBS | DENTAL PLAN OPTIONS | EMPLOYEE ONLY | EMPLOYEE + 1 DEPENDENT | EMPLOYEE + 2 OR MORE DEPENDENTS |
|---|---|---|---|---|
| | | 2024 | 2024 | 2024 |
| | Basic Dental | $0.00 | $23.53 | $36.82 |
| | Enhanced Dental | $16.59 | $58.68 | $116.22 |

### VISION PREMIUMS

| BCBS | VISION PLAN OPTION | EMPLOYEE ONLY | EMPLOYEE + CHILD(REN) | EMPLOYEE + SPOUSE | EMPLOYEE + SPOUSE + CHILD(REN) |
|---|---|---|---|---|---|
| | | 2024 | 2024 | 2024 | 2024 |
| | Vision | $8.20 | $16.87 | $16.08 | $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 |
|---|---|---|---|---|
| | | 2024 | 2024 | 2024 |
| | Basic Dental | $0.00 | $14.12 | $22.09 |
| | Enhanced Dental | $9.95 | $35.21 | $69.73 |

### VISION PREMIUMS

| BCBS | VISION PLAN OPTION | EMPLOYEE ONLY | EMPLOYEE + CHILD(REN) | EMPLOYEE + SPOUSE | EMPLOYEE + SPOUSE + CHILD(REN) |
|---|---|---|---|---|---|
| | | 2024 | 2024 | 2024 | 2024 |
| | Vision | $4.92 | $10.12 | $9.65 | $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.

---

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

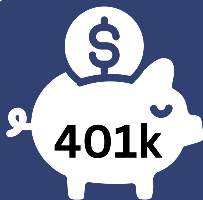
Click here for plan features

---

Certified personnel hired after July 1, 2014

Click here for plan features

---




Open to all certified and classified personnel

Click here for plan features

**Ryan Marlin**, Empower Plan Advisor
Ryan.Marlin@Empower-Retirement.com
615-564-7007

---

Questions?

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

---

# Customer Service Contacts

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