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 Tennessee health plan perks including the Emotional Wellbeing Solutions, Behavioral Health, and wellness programs, visit Partners4Health. Employees (and dependents) must be enrolled in a health plan to access these benefits.

PARTNERS FOR HEALTH

2025 Deductibles/Copays/Out of Pocket Maximums/Coinsurance for In-Network Providers

No changes in plans from 2024 to 2025

	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

2025 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

2025 Health Plan Comparison of Member Costs — Local Education and Local Government

PARTNERS FOR HEALTH

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.
Coverage for ALL services is subject to medical necessity as determined by the Third Party Administrator.

HEALTH PLAN OPTION	PREMIER PPO NETWORK STATUS & COST [1]		STANDARD PPO NETWORK STATUS & COST [1]		LIMITED PPO NETWORK STATUS & COST [1]		LOCAL CDHP/HSA NETWORK STATUS & COST [1]	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
PREVENTIVE CARE — OFFICE VISITS – AS RECOMMENDED & MEDICALLY NECESSARY								
• Well-baby, well-child visits • Adult annual physical exam • Annual well-woman exam • Immunizations • Annual hearing and non-refractive vision screening • Screenings, labs, nutritional guidance, tobacco cessation counseling & other	$0	$45	$0	$50	$0	$50	$0	50%
OUTPATIENT SERVICES — SERVICES SUBJECT TO COINSURANCE MAY BE EXTRA								
Primary Care Office Visit • Family practice, general practice, internal medicine, OB/GYN and pediatrics • Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) • Initial maternity visit • Surgery in office setting • Provider-based telehealth	$25	$45	$30	$50	$35	$55	30%	50%
Specialist Office Visit • Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) • Surgery in office setting • Provider-based telehealth	$45	$70	$50	$75	$55	$80	30%	50%
Behavioral Health and Substance Use[2] • Including provider-based virtual visits	$25	$45	$30	$50	$35	$55	30%	50%
Telehealth Programs (MDLive/Teledoc/Talkspace)	$15	N/A	$15	N/A	$15	NA	30%	N/A
Allergy Injection Without Office Visit Allergy serum – see page 2	$0	$0	$0	$0	$0	$0	30%	50%
Chiropractic and Acupuncture • Annual limit of 50 visits each	$25/visit 1-20 $45/visit 21-50	$45/visit 1-20 $70/visit 21-50	$30/visit 1-20 $50/visit 21-50	$50/visit 1-20 $75/visit 21-50	$35/visit 1-20 $55/visit 21-50	$55/visit 1-20 $80/visit 21-50	30%	50%
Convenience Clinic	$25	$45	$30	$50	$35	$55	30%	50%
Urgent Care Facility	$45	$70	$50	$75	$55	$80	30%	50%
PHARMACY – GENERIC/PREFERRED/NON-PREFERRED								
30-Day Supply	$7/$40/$90	copay + amount > MAC	$14/$50/$100	copay + amount > MAC	$14/$60/$110	copay + amount > MAC	30%	50% + amount >MAC
90-Day Supply 90-day pharmacy or mail order	$14/$80/$180	N/A - no network	$28/$100/$200	N/A - no network	$28/$120/$220	N/A - no network	30%	N/A - no network
90-Day Supply Certain Maintenance Medications 90-day pharmacy or mail order[3]	$7/$40/$160	N/A - no network	$14/$50/$180	N/A - no network	$14/$60/$200	N/A – no network	20% before deductible	N/A - no network
SPECIALTY PHARMACY MEDICATIONS – 30-DAY SUPPLY								
Generics Tier 1	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
Preferred Brands Tier 2	30%; min $200; max $400	N/A - no network	30%; min $200; max $400	N/A - no network	30%; min $200; max $400	N/A – no network	30%	N/A - no network
Non-Preferred Brands Tier 3	40%; min $300; max $600	N/A - no network	40%; min $300; max $600	N/A - no network	40%; min $300; max $600	N/A - no network	30%	N/A – no network

2025 Local Education and Local Government Comparison. 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 except for in-network preventive care. **Coverage for ALL services is subject to medical necessity as determined by the Third Party Administrator.**

HEALTH PLAN OPTION	PREMIER PPO NETWORK STATUS & COST [1]		STANDARD PPO NETWORK STATUS & COST [1]		LIMITED PPO NETWORK STATUS & COST [1]		LOCAL CDHP/HSA NETWORK STATUS & COST [1]	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
PREVENTIVE CARE – OUTPATIENT FACILITIES – AS RECOMMENDED & MEDICALLY NECESSARY								
Screenings such as colonoscopy, mammogram, colorectal, lung imaging and bone density scans [5]	$0	40%	$0	40%	$0	50%	$0	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 after first visit; Routine services & labor and delivery	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 (Excludes advanced studies below) [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 (air and ground)	15%		20%		30%		30%	
Durable Medical Equipment, External Prosthetics and Medical Supplies [4]	15%	40%	20%	40%	30%	50%	30%	50%
Allergy Serum	15%	40%	20%	40%	30%	50%	30%	50%
Also Covered	Limited Dental benefits, Hospice Care and Out-of-Country Charges. 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 — ELIGIBLE EXPENSES FOR MEDICAL, BEHAVIORAL AND PHARMACY, COMBINED, INCLUDING DEDUCTIBLE								
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 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.

[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 is required for certain outpatient behavioral health services including, but not limited to, applied behavioral analysis, transcranial magnetic stimulation, psychological testing, and other behavioral health services as determined by the Contractor's clinical staff.

[3] Additional information on the maintenance drug benefit 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] Enhanced benefit for select preferred Substance Use Treatment Facilities - PPO members won't 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 + FAMILY	
		2024	2025	2024	2025	2024	2025	2024	2025
	Premier PPO	$56.97	$60.33	$235.00	$248.80	$481.20	$339.60	$555.60	$392.20
	Standard PPO	$33.10	$35.05	$209.20	$221.46	$409.20	$315.40	$494.70	$364.40
	Limited PPO	$0.00	$0.00	$103.10	$109.10	$387.30	$298.00	$468.30	$344.00
	Local CDHP/HSA	$0.00	$0.00	$90.00	$95.30	$337.50	$260.00	$408.00	$300.40
	MCS HSA CONTRIBUTION	$50/MO	$50/MO	$0/MO	$50/MO	$0/MO	$50/MO	$0/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 + FAMILY *$150/mo surcharge	
		2024	2025	2024	2025	2024	2025	2024	2025
	Premier PPO	$186.68	$135.33	$630.00	$333.80	$877.00	$489.60	$1,001.00	$542.20
	Standard PPO	$136.27	$110.05	$588.50	$306.46	$820.00	$465.40	$935.50	$514.40
	Limited PPO	$74.97	$75.00	$558.00	$194.10	$778.50	$448.00	$887.50	$494.00
	Local CDHP/HSA	$67.56	$75.00	$492.50	$180.30	$689.00	$410.00	$784.50	$450.40
	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 + FAMILY	
		2024	2025	2024	2025	2024	2025	2024	2025
	Premier PPO	$34.18	$36.20	$141.00	$149.28	$288.72	$203.76	$333.36	$235.32
	Standard PPO	$19.86	$21.03	$125.52	$132.88	$245.52	$189.24	$296.82	$218.64
	Limited PPO	$0.00	$0.00	$61.86	$65.46	$232.38	$178.80	$280.98	$206.40
	Local CDHP/HSA	$0.00	$0.00	$54.00	$57.18	$202.50	$156.00	$244.80	$180.24
	MCS HSA CONTRIBUTION	$30/ck	$30/ck	$0/ck	$30/ck	$0/ck	$30/ck	$0/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 + FAMILY *$150/mo surcharge	
		2024	2025	2024	2025	2024	2025	2024	2025
	Premier PPO	$127.01	$96.20	$393.00	$215.28	$556.20	$323.76	$630.60	$355.32
	Standard PPO	$96.76	$81.03	$368.10	$198.88	$522.00	$309.24	$591.30	$338.64
	Limited PPO	$59.98	$60.00	$349.80	$131.46	$497.10	$298.80	$562.50	$326.40
	Local CDHP/HSA	$55.54	$60.00	$310.50	$123.18	$443.40	$276.00	$500.70	$300.24
	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	BCBST Dental	
	Dental Option: 1 **Effective Date: 1/1/2025**	
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)	$750	
Benefit Percentages apply to	**Network Providers**	**Non-network Providers**
Covered Services	**Benefit Percentages**	**Benefit Percentages**
Coverage A Exams, X-rays Cleanings, Fluoride Sealants, Space Maintainers	100%	50%
Coverage B Basic Restorative Services Basic and Major Endodontics Basic and Major Periodontics Basic and Major Oral Surgery	80%	50%
Coverage C Major Restorative and Prosthodontics	0%	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 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

BlueCross BlueShield of Tennessee

Murfreesboro City Schools

Summary of Benefits	BCBST Dental	
	Dental Option: 2	
	Effective Date: 1/1/2025	
Deductible Calendar Year	**Individual**	**Family**
Applies to Coverage B and C only	$50	$150
Benefit Maximums		
Applies to Coverage A, B, and C (per Calendar Year)	$1,500	
Coverage D (per Lifetime)	$1,250	
Benefit Percentages apply to	**Network Providers**	**Non-network Providers**
Covered Services	**Benefit Percentages**	**Benefit Percentages**
Coverage A Exams, X-rays Cleanings, Fluoride Sealants, Space Maintainers	100%	100%
Coverage B Basic Restorative Services Basic and Major Endodontics Basic and Major Periodontics Basic and Major Oral Surgery	80%	80%
Coverage C Major Restorative and Prosthodontics	50%	50%
Coverage D 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

Blue Cross Blue Shield of Tennessee

Murfreesboro City Schools

VisionBlue

Summary of Benefits — **Effective Date: January 1, 2025**

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 ***$45 maximum reimbursement ****Up to 2 additional per year

Employee Dental/Vision Premiums

Monthly Payroll (Salaried Employees)

DENTAL PREMIUMS

BCBS	DENTAL PLAN OPTIONS	EMPLOYEE ONLY	EMPLOYEE + 1 DEPENDENT	EMPLOYEE + 2 OR MORE DEPENDENTS
		2025	2025	2025
	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 + FAMILY
		2025	2025	2025	2025
	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
		2025	2025	2025
	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 + FAMILY
		2025	2025	2025	2025
	Vision	$4.92	$10.12	$9.65	$14.38

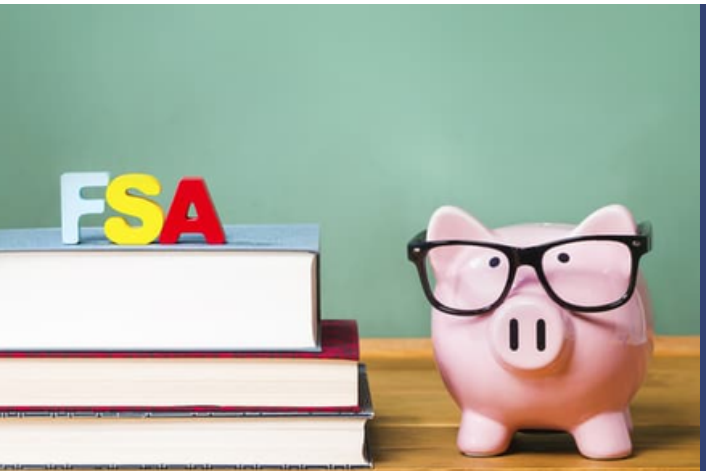
Premiums are deducted 20 times per year on the first two paychecks of the month.

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.

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