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Portland, TN

Mary Lou Thompson, Human Resources Manager, HR@cityofportlandtn.gov
615.741.3590
13th Floor, William Snodgrass TN Tower
Nashville, TN 37242

Health Insurance Provider Name and Contact Information
State of Tennessee
13th Floor, William Snodgrass TN Tower
Nashville, TN 37242

3. Please provide the number of employees covered by your health insurance benefits?

126

4. Do you offer any of the following plans?

(x) PPO
(x) POS
(x) HMO

5. Do you offer any of the following options to employees?

( ) Health Reimbursement Account (HRA)
( ) Health Savings Account (HSA)
( ) All of the above (all)
(X) None of the above (none)

6. How long is the elimination period for a new employee?
First of mo. after completing 1 mo.

7. Do you offer a "tier" plan?
(X) Yes
( ) No

8. If "yes," what are the premiums for the tier plan?

Employee __517.84____________
Employee/Spouse ___N/A_____________
Employee kids ___N/A_____________
Family ___1293.02_____________

9. What are your monthly premiums?

	Employee Pays	Employer Pays	Total Premium
Individual	0	$517.84	$517.84
Family	$294.57	$998.46	$1,293.02

10. What is your Annual Deductible?

	In-network	Out-of-network
Individual	300	300
Family	750	750

11. What is the dependent age limit?
19, if in school, 24

12. What is the Lifetime Maximum Benefit?
N/A

13. What is the Pre-Existing Condition waiting period?
6 months, unless previous insurance

14. What is the Office visit co-pay?

	In-network	Out-of-network
PCP/Specialist	$20-POS	$300-POS

15. Diagnostic Services

	In-network	Out-of-network
Routine Diagnostic	90%	70%

Work		
X-Ray	90%	70%
Injections	90%	70%
Non-routine diagnostic services	90%	70%

16. Does the office visit co-pay go towards the annual deductible?

( ) Yes
(X) No

17. Is a referral required to see a specialist?

( ) Yes
(X) No

18. Please provide information on the following preventative health care services:

	In-network	Out-of-network
Well child care and to what age	17 years at 90%	Age 17-70%
Annual well woman exam	90%	70%
Annual mammography screening	90%	70%
Annual cervical cancer screening	90%	70%
Prostate cancer screening	90%	70%
Immunizations and to what age	90%	70%

19. Please provide information on the following services:

	In-network	Out-of-network
Inpatient services	90%	70%
Outpatient surgery	90%	70%
Routine Diagnostic Services Outpatient	90%	70%
Non-routine Diagnostic Services-Outpatient	90%	70%
Provider Administered specialty Pharmacy Products	90%	70%
Other Outpatient Services (i.e. chemotherapy, radiation, dialysis)	90%	70%
Emergency Care Services	90%-$50 copay	70%-$50 copay
Emergency Care Non-Routine Diagnostics	90%-$50 copay	70%-$50 copay

20. Please provide information on the following services:

	In-network	Out-of-network
Durable medical equipment	90%	70%
Prosthetic and Orthotic Appliances	90%	70%

21. Please provide information on the types of therapies covered and the number of visits per year:

	In-network	Out-of-network
Types of therapy	Varies	
Number of visits per year	Varies	

22. Is there a separate deductible for chiropractic care?

No, pays at 90%

23. Please provide information on coverage of skilled nursing facility and rehabilitation facility services:

	In-network	Out-of-network
Services covered	90%	70%
Number of days covered year	100	100

24. Please provide information on coverage of home health services:

	In-network	Out-of-network
Services covered	90%	70%
Number of visits covered year	30	30

25. Please provide information on coverage of hospice services:

	In-network	Out-of-network
Services covered	100%	100%
Number of days covered	Unlimited	Unlimited

26. Please provide information on coverage of ambulance services:

	In-network	Out-of-network
By Air	80%	80%
By Land	80%	80%

27. Does you provide coverage for vision services?

(X) Yes
( ) No

28. What are the co-pays for vision benefits?

	In-network	Out-of-network
Exam	90%	70%
Lens	0	0
Contacts	0	0
Frames	0	0

29. Do you provide a drug card benefit?

(X) Yes
( ) No

30. Please provide the co-pay information for the drug card:

In-network	Out-of-network
$5 generics, $20 Brand, $40 non preferred Brand	Same

31. Do your drug card co-pays go toward annual deductible?

( ) Yes
(X) No

Lewisburg, TN Top of the Document

Connie Edde, Treasurer/Recorder, cedde@ctyoflew.com
888.92432271
801 Pine Street
Chattanooga, TN 3742

Health Insurance Provider Name and Contact Information
BCBS

3. Please provide the number of employees covered by your health insurance benefits?
114

4. Do you offer any of the following plans?
(x) PPO
() POS
() HMO

5. Do you offer any of the following options to employees?
(X) Health Reimbursement Account (HRA)
( ) Health Savings Account (HSA)
( ) All of the above (all)
( ) None of the above (none)

6. How long is the elimination period for a new employee?
30 days

7. Do you offer a "tier" plan?
(X) Yes
( ) No

8. If "yes," what are the premiums for the tier plan?

Employee ____217.6____________
Employee/Spouse __435.2______________
Employee kids _____435.2_______
Family _____626.25___________

9. What are your monthly premiums?

	Employee Pays	Employer Pays	Total Premium
Individual		$217.60	$217.60
Family	$156	$475.58	$626.25

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10. What is your Annual Deductible?

	In-network	Out-of-network
Individual	2500	
Family	2500	

11. What is the dependent age limit?

24

12. What is the Lifetime Maximum Benefit?

5,000,000

13. What is the Pre-Existing Condition waiting period?

12 months

14. What is the Office visit co-pay?

	In-network	Out-of-network
PCP/Specialist	N/A	N/A

15. Diagnostic Services

	In-network	Out-of-network
Routine Diagnostic Work	N/A	N/A
X-Ray	N/A	N/A
Injections	N/A	N/A
Non-routine diagnostic services	N/A	N/A

16. Does the office visit co-pay go towards the annual deductible?

( ) Yes
(X) No

17. Is a referral required to see a specialist?

( ) Yes
(X) No

18. Please provide information on the following preventative health care services:

	In-network	Out-of-network
Well child care and to what	Copay $20	

age		
Annual well woman exam	Copay $20	
Annual mammography screening	Included	
Annual cervical cancer screening	Included	
Prostate cancer screening	Copay $20	
Immunizations and to what age	6	

19. Please provide information on the following services:

	In-network	Out-of-network
Inpatient services	Deductable	
Outpatient surgery	Deductable	
Routine Diagnostic Services Outpatient	Deductable	
Non-routine Diagnostic Services-Outpatient	Deductable	
Provider Administered specialty Pharmacy Products	Deductable	
Other Outpatient Services (i.e. chemotherapy, radiation, dialysis)	Deductable	
Emergency Care Services	Deductable	
Emergency Care Non-Routine Diagnostics	Deductable	

20. Please provide information on the following services:

	In-network	Out-of-network
Durable medical equipment	Deductible	
Prosthetic and Orthotic Appliances	Deductible	

21. Please provide information on the types of therapies covered and the number of visits per year:

	In-network	Out-of-network
Types of therapy	Mental Substance	abuse
Number of visits per year		

22. Is there a separate deductible for chiropractic care?

No

23. Please provide information on coverage of skilled nursing facility and rehabilitation facility services:

	In-network	Out-of-network
Services covered	Therapy-90% after Deductible	
Number of days covered year	60 days	

24. Please provide information on coverage of home health services:

	In-network	Out-of-network
Services covered	90% after Deductible	
Number of visits covered year	60%	

25. Please provide information on coverage of hospice services:

	In-network	Out-of-network
Services covered	100%	
Number of days covered		

26. Please provide information on coverage of ambulance services:

	In-network	Out-of-network
By Air		
By Land	90% after Deductible	

27. Does you provide coverage for vision services?

( ) Yes
(X) No

28. What are the co-pays for vision benefits?

	In-network	Out-of-network
Exam		
Lens		
Contacts		

Frames		

29. Do you provide a drug card benefit?

(X) Yes
( ) No

30. Please provide the co-pay information for the drug card:

In-network	Out-of-network
10/35/50	

31. Do your drug card co-pays go toward annual deductible?

( ) Yes
(X) No

Athens, TN

Top of the Document

Rita Brown, HR Director, rbrown@cityofathenstn.com
801 Pine Street
Chattanooga, TN 3742

Health Insurance Provider Name and Contact Information
Blue Cross Blue Shield

3. Please provide the number of employees covered by your health insurance benefits?

91

4. Do you offer any of the following plans?

(x) PPO
( ) POS
( ) HMO

5. Do you offer any of the following options to employees?

( ) Health Reimbursement Account (HRA)
( ) Health Savings Account (HSA)
( ) All of the above (all)
(X) None of the above (none)

6. How long is the elimination period for a new employee?

60 Days

7. Do you offer a "tier" plan?

(X) Yes
( ) No

8. If "yes," what are the premiums for the tier plan?

Employee ____336.68____________
Employee/Spouse ____673.36____________
Employee kids _____673.36___________
Family ____968.96____________

9. What are your monthly premiums?

	Employee Pays	Employer Pays	Total Premium
Individual	$158.24	$178.44	$336.68
Family	$465.10	$503.86	$968.96

10. What is your Annual Deductible?

	In-network	Out-of-network
Individual	750	1500
Family	1500	3000

11. What is the dependent age limit?

24

12. What is the Lifetime Maximum Benefit?

5,000,000

13. What is the Pre-Existing Condition waiting period?

12 months

14. What is the Office visit co-pay?

	In-network	Out-of-network
PCP/Specialist	$20/$40	60% after deductible

15. Diagnostic Services

	In-network	Out-of-network
Routine Diagnostic Work	Office Co-Pay	60% after deductible
X-Ray	Office Co-Pay	60% after deductible
Injections	Included Office co-pay	60% after deductible
Non-routine diagnostic services	80% after deductible	60% after deductible

16. Does the office visit co-pay go towards the annual deductible?

( ) Yes
(X) No

17. Is a referral required to see a specialist?

( ) Yes
(X) No

18. Please provide information on the following preventative health care services:

	In-network	Out-of-network
Well child care and to what age	$20	60% a/d

Annual well woman exam		
Annual mammography screening	$20	60% a/d
Annual cervical cancer screening	Included	60% a/d
Prostate cancer screening	Included	60% a/d
Immunizations and to what age	Included	60% a/d

19. Please provide information on the following services:

	In-network	Out-of-network
Inpatient services	80	60
Outpatient surgery	80	60
Routine Diagnostic Services Outpatient	100	60
Non-routine Diagnostic Services-Outpatient	80	60
Provider Administered specialty Pharmacy Products	80	60
Other Outpatient Services (i.e. chemotherapy, radiation, dialysis)	80	60
Emergency Care Services	100 a/d	100 a/d
Emergency Care Non-Routine Diagnostics	80	80

20. Please provide information on the following services:

	In-network	Out-of-network
Durable medical equipment	80%	60%
Prosthetic and Orthotic Appliances	80%	60%

21. Please provide information on the types of therapies covered and the number of visits per year:

	In-network	Out-of-network
Types of therapy	Physical, speech, manipulative, occupational	60% a/d
Number of visits per year	30 (36 cardiac)	60% a/d

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22. Is there a separate deductible for chiropractic care?

No

23. Please provide information on coverage of skilled nursing facility and rehabilitation facility services:

	In-network	Out-of-network
Services covered	80% a/d	60% a/d
Number of days covered year	60 combined	60 combined

24. Please provide information on coverage of home health services:

	In-network	Out-of-network
Services covered	80% a/d	60% a/d
Number of visits covered year	60	60

25. Please provide information on coverage of hospice services:

	In-network	Out-of-network
Services covered	100%	60% a/d
Number of days covered	N/A	N/A

26. Please provide information on coverage of ambulance services:

	In-network	Out-of-network
By Air	80% a/d	80% a/d
By Land	80% a/d	80% a/d

27. Does you provide coverage for vision services?

( ) Yes
(X) No

28. What are the co-pays for vision benefits?

	In-network	Out-of-network
Exam		
Lens		
Contacts		

Frames		

29. Do you provide a drug card benefit?

(X) Yes
( ) No

30. Please provide the co-pay information for the drug card:

In-network	Out-of-network
$10/35/50	$10/35/50

31. Do your drug card co-pays go toward annual deductible?

( ) Yes
(X) No

Millington, TN

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Cindy Donaldson, Personnel Director, cdonaldson@cityofmillington.org

Health Insurance Provider Name and Contact Information
Cigna

3. Please provide the number of employees covered by your health insurance benefits?
127

4. Do you offer any of the following plans?
(x) PPO
(x) POS
( ) HMO

5. Do you offer any of the following options to employees?
( ) Health Reimbursement Account (HRA)
( ) Health Savings Account (HSA)
( ) All of the above (all)
(X) None of the above (none)

6. How long is the elimination period for a new employee?
30 days

7. Do you offer a "tier" plan?
( ) Yes
(X) No

8. If "yes," what are the premiums for the tier plan?

Employee _________________
Employee/Spouse _________________
Employee kids _________________
Family _________________

9. What are your monthly premiums?

	Employee Pays	Employer Pays	Total Premium
Individual	$156.10	$289.90	$446.00
Family	$319.20	$592.80	$912.00

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10. What is your Annual Deductible?

	In-network	Out-of-network
Individual	0	200
Family	0	600

11. What is the dependent age limit?

25 if full time student

12. What is the Lifetime Maximum Benefit?

unlimited

13. What is the Pre-Existing Condition waiting period?

Continuous 12 month period

14. What is the Office visit co-pay?

	In-network	Out-of-network
PCP/Specialist		

15. Diagnostic Services

	In-network	Out-of-network
Routine Diagnostic Work		
X-Ray		
Injections		
Non-routine diagnostic services		

16. Does the office visit co-pay go towards the annual deductible?

(X) Yes
( ) No

17. Is a referral required to see a specialist?

( ) Yes
(X) No

18. Please provide information on the following preventative health care services:

	In-network	Out-of-network
Well child care and to what age		
Annual well woman exam		

Annual mammography screening		
Annual cervical cancer screening		
Prostate cancer screening		
Immunizations and to what age		

19. Please provide information on the following services:

	In-network	Out-of-network
Inpatient services		
Outpatient surgery		
Routine Diagnostic Services Outpatient		
Non-routine Diagnostic Services-Outpatient		
Provider Administered specialty Pharmacy Products		
Other Outpatient Services (i.e. chemotherapy, radiation, dialysis)		
Emergency Care Services		
Emergency Care Non-Routine Diagnostics		

20. Please provide information on the following services:

	In-network	Out-of-network
Durable medical equipment		
Prosthetic and Orthotic Appliances		

21. Please provide information on the types of therapies covered and the number of visits per year:

	In-network	Out-of-network
Types of therapy		
Number of visits per year		

22. Is there a separate deductible for chiropractic care?

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23. Please provide information on coverage of skilled nursing facility and rehabilitation facility services:

	In-network	Out-of-network
Services covered		
Number of days covered year		

24. Please provide information on coverage of home health services:

	In-network	Out-of-network
Services covered		
Number of visits covered year		

25. Please provide information on coverage of hospice services:

	In-network	Out-of-network
Services covered		
Number of days covered		

26. Please provide information on coverage of ambulance services:

	In-network	Out-of-network
By Air		
By Land		

27. Does you provide coverage for vision services?

( ) Yes
( ) No

28. What are the co-pays for vision benefits?

	In-network	Out-of-network
Exam		
Lens		
Contacts		
Frames		

29. Do you provide a drug card benefit?

( ) Yes
( ) No

30. Please provide the co-pay information for the drug card:

In-network	Out-of-network

31. Do your drug card co-pays go toward annual deductible?

( ) Yes
( ) No

Martin, TN

Top of the Document

Celeste Taylor, HR Officer, CTAYLOR@CITYOFMARTIN.NET

Health Insurance Provider Name and Contact Information
Blue Cross Blue Shield of Tennessee

3. Please provide the number of employees covered by your health insurance benefits?
135

4. Do you offer any of the following plans?
(x) PPO
(x) POS
( ) HMO

5. Do you offer any of the following options to employees?
( ) Health Reimbursement Account (HRA)
(X) Health Savings Account (HSA)
( ) All of the above (all)
( ) None of the above (none)

6. How long is the elimination period for a new employee?
First month following hire date

7. Do you offer a "tier" plan?
( ) Yes
(X) No

8. If "yes," what are the premiums for the tier plan?

Employee _________________
Employee/Spouse _________________
Employee kids _________________
Family _________________

9. What are your monthly premiums?

	Employee Pays	Employer Pays	Total Premium
Individual	$57.16	$228.66	$285.82
Family	$127.48	$509.90	$637.38

10. What is your Annual Deductible?

	In-network	Out-of-network
Individual	2500	5000
Family	5000	10,000

11. What is the dependent age limit?

24

12. What is the Lifetime Maximum Benefit?

13. What is the Pre-Existing Condition waiting period?

14. What is the Office visit co-pay?

	In-network	Out-of-network
PCP/Specialist		

15. Diagnostic Services

	In-network	Out-of-network
Routine Diagnostic Work	100% AFTER DEDUCTABLE	
X-Ray	100% AFTER DEDUCTABLE	
Injections	100% AFTER DEDUCTABLE	
Non-routine diagnostic services	100% AFTER DEDUCTABLE	

16. Does the office visit co-pay go towards the annual deductible?

( ) Yes
(X) No

17. Is a referral required to see a specialist?

(X) Yes
( ) No

18. Please provide information on the following preventative health care services:

	In-network	Out-of-network
Well child care and to what	AGE 6-20 COPAY	

age		
Annual well woman exam	20 COPAY	
Annual mammography screening	20 COPAY	
Annual cervical cancer screening	20 COPAY	
Prostate cancer screening	20 COPAY	
Immunizations and to what age	AGE 6 - 20 COPAY	

19. Please provide information on the following services:

	In-network	Out-of-network
Inpatient services	100% AFTER DEDUCTABLE	
Outpatient surgery	100% AFTER DEDUCTABLE	
Routine Diagnostic Services Outpatient	100% AFTER DEDUCTABLE	
Non-routine Diagnostic Services-Outpatient	100% AFTER DEDUCTABLE	
Provider Administered specialty Pharmacy Products	100% AFTER DEDUCTABLE	
Other Outpatient Services (i.e. chemotherapy, radiation, dialysis)	100% AFTER DEDUCTABLE	
Emergency Care Services	100% AFTER DEDUCTABLE	
Emergency Care Non-Routine Diagnostics	100% AFTER DEDUCTABLE	

20. Please provide information on the following services:

	In-network	Out-of-network
Durable medical equipment	100 % AFTER DEDUCTABLE	
Prosthetic and Orthotic Appliances	100 % AFTER DEDUCTABLE	

21. Please provide information on the types of therapies covered and the number of visits per year:

	In-network	Out-of-network
Types of therapy	TYPES NOT SPECIFIED	TYPES NOT SPECIFIED
Number of visits per year	30 VISITS PER CALENDAR YEAR	

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22. Is there a separate deductible for chiropractic care?

No

23. Please provide information on coverage of skilled nursing facility and rehabilitation facility services:

	In-network	Out-of-network
Services covered		
Number of days covered year	Limited to 60 days combined	

24. Please provide information on coverage of home health services:

	In-network	Out-of-network
Services covered		
Number of visits covered year	60 visits per year	

25. Please provide information on coverage of hospice services:

	In-network	Out-of-network
Services covered	100% AFTER DEDUCTABLE	
Number of days covered	NOT STATED	NOT STATED

26. Please provide information on coverage of ambulance services:

	In-network	Out-of-network
By Air	100% AFTER DEDUCTABLE	
By Land	100% AFTER DEDUCTABLE	

27. Does you provide coverage for vision services?

(X) Yes
( ) No

28. What are the co-pays for vision benefits?

	In-network	Out-of-network
Exam	20$ COPAY	UP TO 35$ REIMB.
Lens	LENS COVERED IN FULL EVERY CALENDAR YEAR	LENS COVERED IN FULL EVERY CALENDAR YEAR
Contacts	$120 ALLOWANCE INSTEAD OF LENS	$120 ALLOWANCE INSTEAD OF LENS

Frames	120$ EVERY OTHER CALENDAR YEAR , PLUS 20% OFF ANY OUT OF POCKET COSTS	120$ EVERY OTHER CALENDAR YEAR , PLUS 20% OFF ANY OUT OF POCKET COSTS

29. Do you provide a drug card benefit?

(X) Yes
( ) No

30. Please provide the co-pay information for the drug card:

In-network	Out-of-network
100% AFTER DEDUCTABLE	

31. Do your drug card co-pays go toward annual deductible?

(X) Yes
( ) No

Shelbyville, TN

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Betty Lamb, City Recorder, betty.lamb@shelbyvilletn.org

Health Insurance Provider Name and Contact Information

Blue Cross Blue Shield of Tennessee

3. Please provide the number of employees covered by your health insurance benefits?

4. Do you offer any of the following plans?

(x) PPO
( ) POS
) HMO

5. Do you offer any of the following options to employees?

( ) Health Reimbursement Account (HRA)
(X) Health Savings Account (HSA)
( ) All of the above (all)
( ) None of the above (none)

6. How long is the elimination period for a new employee?

7. Do you offer a "tier" plan?

(X) Yes
( ) No

8. If "yes," what are the premiums for the tier plan?

Employee _________________
Employee/Spouse _________________
Employee kids _________________
Family _________________

9. What are your monthly premiums?

	Employee Pays	Employer Pays	Total Premium
Individual			
Family			

10. What is your Annual Deductible?

	In-network	Out-of-network
Individual		
Family		

11. What is the dependent age limit?

12. What is the Lifetime Maximum Benefit?

13. What is the Pre-Existing Condition waiting period?

14. What is the Office visit co-pay?

	In-network	Out-of-network
PCP/Specialist	20	

15. Diagnostic Services

	In-network	Out-of-network
Routine Diagnostic Work		
X-Ray		
Injections		
Non-routine diagnostic services		

16. Does the office visit co-pay go towards the annual deductible?

( ) Yes
(X) No

17. Is a referral required to see a specialist?

(X) Yes
( ) No

18. Please provide information on the following preventative health care services:

	In-network	Out-of-network
Well child care and to what age		
Annual well woman exam		

Annual mammography screening		
Annual cervical cancer screening		
Prostate cancer screening		
Immunizations and to what age		

19. Please provide information on the following services:

	In-network	Out-of-network
Inpatient services		
Outpatient surgery		
Routine Diagnostic Services Outpatient		
Non-routine Diagnostic Services-Outpatient		
Provider Administered specialty Pharmacy Products		
Other Outpatient Services (i.e. chemotherapy, radiation, dialysis)		
Emergency Care Services		
Emergency Care Non-Routine Diagnostics		

20. Please provide information on the following services:

	In-network	Out-of-network
Durable medical equipment		
Prosthetic and Orthotic Appliances		

21. Please provide information on the types of therapies covered and the number of visits per year:

	In-network	Out-of-network
Types of therapy		
Number of visits per year		

22. Is there a separate deductible for chiropractic care?

UT | MTAS

23. Please provide information on coverage of skilled nursing facility and rehabilitation facility services:

	In-network	Out-of-network
Services covered		
Number of days covered year		

24. Please provide information on coverage of home health services:

	In-network	Out-of-network
Services covered		
Number of visits covered year		

25. Please provide information on coverage of hospice services:

	In-network	Out-of-network
Services covered		
Number of days covered		

26. Please provide information on coverage of ambulance services:

	In-network	Out-of-network
By Air		
By Land		

27. Does you provide coverage for vision services?

(X) Yes
( ) No

28. What are the co-pays for vision benefits?

	In-network	Out-of-network
Exam		
Lens		
Contacts		
Frames		

UT | MTAS

29. Do you provide a drug card benefit?

(X) Yes
( ) No

30. Please provide the co-pay information for the drug card:

In-network	Out-of-network

31. Do your drug card co-pays go toward annual deductible?

( ) Yes
( ) No

UT MTAS

Brownsville, TN

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Jerry Taylor, City Clerk, jtcityhall@bellsouth.net
801 Pine Street
Chattanooga, TN 37402

Health Insurance Provider Name and Contact Information
Blue Cross Blue Shield

3. Please provide the number of employees covered by your health insurance benefits?

125

4. Do you offer any of the following plans?

(x) PPO
( ) POS
( ) HMO

5. Do you offer any of the following options to employees?

(X) Health Reimbursement Account (HRA)
( ) Health Savings Account (HSA)
( ) All of the above (all)
( ) None of the above (none)

6. How long is the elimination period for a new employee?

First month – after 30 days

7. Do you offer a "tier" plan?

(X) Yes
( ) No

8. If "yes," what are the premiums for the tier plan?

Employee ____277.94____________
Employee/Spouse ___583.67_____________
Employee kids __500.29______________
Family _____833.82___________

9. What are your monthly premiums?

	Employee Pays	Employer Pays	Total Premium
Individual	$0.00	$277.94	$277.94
Family	$277.94	$555.88	$833.92

10. What is your Annual Deductible?

	In-network	Out-of-network
Individual	5,000.00	
Family	10,000	

11. What is the dependent age limit?

23

12. What is the Lifetime Maximum Benefit?

1,000,000

13. What is the Pre-Existing Condition waiting period?

1 year

14. What is the Office visit co-pay?

	In-network	Out-of-network
PCP/Specialist	30	

15. Diagnostic Services

	In-network	Out-of-network
Routine Diagnostic Work	30	
X-Ray	30	
Injections	30	
Non-routine diagnostic services	30	

16. Does the office visit co-pay go towards the annual deductible?

( ) Yes
(X) No

17. Is a referral required to see a specialist?

( ) Yes
(X) No

18. Please provide information on the following preventative health care services:

	In-network	Out-of-network
Well child care and to what age		

Annual well woman exam		
Annual mammography screening		
Annual cervical cancer screening		
Prostate cancer screening		
Immunizations and to what age		

19. Please provide information on the following services:

	In-network	Out-of-network
Inpatient services		
Outpatient surgery		
Routine Diagnostic Services Outpatient		
Non-routine Diagnostic Services-Outpatient		
Provider Administered specialty Pharmacy Products		
Other Outpatient Services (i.e. chemotherapy, radiation, dialysis)		
Emergency Care Services		
Emergency Care Non-Routine Diagnostics		

20. Please provide information on the following services:

	In-network	Out-of-network
Durable medical equipment		
Prosthetic and Orthotic Appliances		

21. Please provide information on the types of therapies covered and the number of visits per year:

	In-network	Out-of-network
Types of therapy		
Number of visits per year		

22. Is there a separate deductible for chiropractic care?

No

23. Please provide information on coverage of skilled nursing facility and rehabilitation facility services:

	In-network	Out-of-network
Services covered		
Number of days covered year	30	

24. Please provide information on coverage of home health services:

	In-network	Out-of-network
Services covered		
Number of visits covered year	30	

25. Please provide information on coverage of hospice services:

	In-network	Out-of-network
Services covered		
Number of days covered		

26. Please provide information on coverage of ambulance services:

	In-network	Out-of-network
By Air		
By Land	To first medical treatment	

27. Does you provide coverage for vision services?

( ) Yes
(X) No

28. What are the co-pays for vision benefits?

	In-network	Out-of-network
Exam		
Lens		
Contacts		

Frames		

29. Do you provide a drug card benefit?

(X) Yes
( ) No

30. Please provide the co-pay information for the drug card:

In-network	Out-of-network
10/35/50	

31. Do your drug card co-pays go toward annual deductible?

( ) Yes
(X) No

Dickson, TN

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Tammy Dotson, Associate Accountant, tammys@cityofdickson.com
1.800.515.2121 EXT. 3265
801 Pine Street
Chattanooga, TN 37042

Health Insurance Provider Name and Contact Information
Blue Cross Blue Shield

3. Please provide the number of employees covered by your health insurance benefits?

167

4. Do you offer any of the following plans?

(x) PPO
( ) POS
( ) HMO

5. Do you offer any of the following options to employees?

( ) Health Reimbursement Account (HRA)
( ) Health Savings Account (HSA)
(X) All of the above (all)
( ) None of the above (none)

6. How long is the elimination period for a new employee?

6 months

7. Do you offer a "tier" plan?

( ) Yes
(X) No

8. If "yes," what are the premiums for the tier plan?

Employee _________________
Employee/Spouse _________________
Employee kids _________________
Family _________________

9. What are your monthly premiums?

	Employee Pays	Employer Pays	Total Premium
Individual		$287.37	$287.37
Family	$259.20	$259.20	$518.40

10. What is your Annual Deductible?

	In-network	Out-of-network
Individual	1500	3000
Family	1500	6000

11. What is the dependent age limit?

24

12. What is the Lifetime Maximum Benefit?

5,000,000

13. What is the Pre-Existing Condition waiting period?

12 months if no prior coverage

14. What is the Office visit co-pay?

	In-network	Out-of-network
PCP/Specialist	20	

15. Diagnostic Services

	In-network	Out-of-network
Routine Diagnostic Work	100% AFTER DED. HAS BEEN MET	70% AFTER DED.
X-Ray	100% AFTER DED. HAS BEEN MET	70% AFTER DED.
Injections	100% AFTER DED. HAS BEEN MET	70% AFTER DED.
Non-routine diagnostic services	100% AFTER DED. HAS BEEN MET	70% AFTER DED.

16. Does the office visit co-pay go towards the annual deductible?

(X) Yes
( ) No

17. Is a referral required to see a specialist?

(X) Yes
( ) No

18. Please provide information on the following preventative health care services:

	In-network	Out-of-network
Well child care and to what age	20 COPAY 6 YEARS OLD	70% AFTER DED.
Annual well woman exam	20 COPAY	70% AFTER DED.
Annual mammography screening	NO ADDITIONAL COPAY	70% AFTER DED.
Annual cervical cancer screening	NO ADDITIONAL COPAY	70% AFTER DED.
Prostate cancer screening	NO ADDITIONAL COPAY	70% AFTER DED.
Immunizations and to what age	NO ADDITIONAL COPAY	70% AFTER DED.

19. Please provide information on the following services:

	In-network	Out-of-network
Inpatient services	100% AFTER DED.	70% AFTER DED.
Outpatient surgery	100% AFTER DED.	70% AFTER DED.
Routine Diagnostic Services Outpatient	100% AFTER DED.	70% AFTER DED.
Non-routine Diagnostic Services-Outpatient	100% AFTER DED.	70% AFTER DED.
Provider Administered specialty Pharmacy Products	100% AFTER DED.	70% AFTER DED.
Other Outpatient Services (i.e. chemotherapy, radiation, dialysis)	100% AFTER DED.	70% AFTER DED.
Emergency Care Services	100% AFTER DED.	70% AFTER DED.
Emergency Care Non-Routine Diagnostics	100% AFTER DED.	70% AFTER DED.

20. Please provide information on the following services:

	In-network	Out-of-network
Durable medical equipment	100% AFTER DED.	70% AFTER DED.
Prosthetic and Orthotic Appliances	100% AFTER DED.	70% AFTER DED.

21. Please provide information on the types of therapies covered and the number of visits per year:

	In-network	Out-of-network
Types of therapy	100% AFTER DED.	70% AFTER DED.

Number of visits per year	LIMITED 30-36 VISITS PER YEAR PER THERAPY TYPE	70% AFTER DED.

22. Is there a separate deductible for chiropractic care?

none

23. Please provide information on coverage of skilled nursing facility and rehabilitation facility services:

	In-network	Out-of-network
Services covered	100% AFTER DED.	70% AFTER DED.
Number of days covered year	LIMITED TO 60 DAYS COMBINED 100% AFTER DED.	70% AFTER DED.

24. Please provide information on coverage of home health services:

	In-network	Out-of-network
Services covered	100% AFTER DED.	70% AFTER DED.
Number of visits covered year	LIMITED TO 60 VISITS PER YEAR	70% AFTER DED

25. Please provide information on coverage of hospice services:

	In-network	Out-of-network
Services covered	100%	70% AFTER DED.
Number of days covered		

26. Please provide information on coverage of ambulance services:

	In-network	Out-of-network
By Air	100% AFTER DED.	100% AFTER DED.
By Land	100% AFTER DED.	100% AFTER DED.

27. Does you provide coverage for vision services?

(X) Yes
( ) No

28. What are the co-pays for vision benefits?

	In-network	Out-of-network
Exam	20.00 CO-PAY 1 EYE EXAM PER CALENDAR YEAR	20.00 CO-PAY 1 EYE EXAM PER CALENDAR YEAR

Lens	EXCLUSION	EXCLUSION
Contacts	EXCLUSION	EXCLUSION
Frames	EXCLUSION	EXCLUSION

29. Do you provide a drug card benefit?

(X) Yes
( ) No

30. Please provide the co-pay information for the drug card:

In-network	Out-of-network
10/35/50	

31. Do your drug card co-pays go toward annual deductible?

( ) Yes
(X) No

Lakeland, TN

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Cheryl Yarbro, Human Resources Coordinator, cyarbro@lakelandtn.org
800.253.9981
Nashville, TN

Health Insurance Provider Name and Contact Information
State of Tennessee

3. Please provide the number of employees covered by your health insurance benefits?

29

4. Do you offer any of the following plans?

(x) PPO
(x) POS
( ) HMO

5. Do you offer any of the following options to employees?

( ) Health Reimbursement Account (HRA)
( ) Health Savings Account (HSA)
( ) All of the above (all)
(X) None of the above (none)

6. How long is the elimination period for a new employee?

7. Do you offer a "tier" plan?

( ) Yes
(X) No

8. If "yes," what are the premiums for the tier plan?

Employee _________________
Employee/Spouse _________________
Employee kids _________________
Family _________________

9. What are your monthly premiums?

	Employee Pays	Employer Pays	Total Premium
Individual		$497.63	$497.63
Family		$744.81	$744.81

10. What is your Annual Deductible?

	In-network	Out-of-network
Individual	0	300
Family	0	750

11. What is the dependent age limit?

24 if in school

12. What is the Lifetime Maximum Benefit?

unlimited

13. What is the Pre-Existing Condition waiting period?

6 months

14. What is the Office visit co-pay?

	In-network	Out-of-network
PCP/Specialist	$20/$25	70% of MAC after $300 Deductible

15. Diagnostic Services

	In-network	Out-of-network
Routine Diagnostic Work	100%	70% of MAC after $300 Deductible
X-Ray	100%	70% of MAC after $300 Deductible
Injections	$20 copay/$25 Specialist	
Non-routine diagnostic services		

16. Does the office visit co-pay go towards the annual deductible?

(X) Yes
( ) No

17. Is a referral required to see a specialist?

(X) Yes
( ) No

18. Please provide information on the following preventative health care services:

	In-network	Out-of-network
Well child care and to what age	100%	70% after $300 Deductible
Annual well woman exam	$20/$25	70%
Annual mammography screening	$20/$25	70%
Annual cervical cancer screening	$20/$25	70%
Prostate cancer screening	$20/$25	70%
Immunizations and to what age	$20/$25	70%

19. Please provide information on the following services:

	In-network	Out-of-network
Inpatient services	100%	70%
Outpatient surgery	$20 Physician/Facility 100%	70%
Routine Diagnostic Services Outpatient	$20/$25	70%
Non-routine Diagnostic Services-Outpatient		
Provider Administered specialty Pharmacy Products		
Other Outpatient Services (i.e. chemotherapy, radiation, dialysis)		
Emergency Care Services	$50	$50 copay and 70% after deductible
Emergency Care Non-Routine Diagnostics		

20. Please provide information on the following services:

	In-network	Out-of-network
Durable medical equipment	100%	70%
Prosthetic and Orthotic Appliances		

21. Please provide information on the types of therapies covered and the number of visits per year:

	In-network	Out-of-network

Types of therapy		
Number of visits per year		

22. Is there a separate deductible for chiropractic care?

$20

23. Please provide information on coverage of skilled nursing facility and rehabilitation facility services:

	In-network	Out-of-network
Services covered	$25 copay per day	70% MAC after deductible
Number of days covered year	100 day limit following approved hospitalization	70% per diem after deductible

24. Please provide information on coverage of home health services:

	In-network	Out-of-network
Services covered		
Number of visits covered year		

25. Please provide information on coverage of hospice services:

	In-network	Out-of-network
Services covered	Hospice Care	100% of MAC
Number of days covered		

26. Please provide information on coverage of ambulance services:

	In-network	Out-of-network
By Air	100% of reasonable charges	100% of reasonable charges
By Land	100% of reasonable charges	100% of reasonable charges

27. Does you provide coverage for vision services?

(X) Yes
( ) No

28. What are the co-pays for vision benefits?

	In-network	Out-of-network

Exam	$10/$25 one visit per year	70%
Lens		
Contacts		
Frames		

29. Do you provide a drug card benefit?

(X) Yes
( ) No

30. Please provide the co-pay information for the drug card:

In-network	Out-of-network
$5/$20/$40	70% after deductible

31. Do your drug card co-pays go toward annual deductible?

( ) Yes
(X) No

Elizabethton TN

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Angie Lyons, Human Resources Director, alyons@cityofelizabethton.org
800.565.9140
801 Pine Street
Chattanooga, TN 37402

Health Insurance Provider Name and Contact Information
Blue Cross Blue Shield of Tennessee

3. Please provide the number of employees covered by your health insurance benefits?

300

4. Do you offer any of the following plans?

(x) PPO
( ) POS
( ) HMO

5. Do you offer any of the following options to employees?

( ) Health Reimbursement Account (HRA)
( ) Health Savings Account (HSA)
( ) All of the above (all)
(X) None of the above (none)

6. How long is the elimination period for a new employee?

First month following 60 days of hire date

7. Do you offer a "tier" plan?

(X) Yes
( ) No

8. If "yes," what are the premiums for the tier plan?

Employee ___387.33_____________
Employee/Spouse ________________
Employee kids ________________
Family ___1,105.51_____________

9. What are your monthly premiums?

	Employee Pays	Employer Pays	Total Premium
Individual	$0.00	$387.33	$387.33
Family	$574.54	$530.97	$1,105.51

10. What is your Annual Deductible?

	In-network	Out-of-network
Individual	1500	3000
Family	3000	6000

11. What is the dependent age limit?

24

12. What is the Lifetime Maximum Benefit?

5,000,000

13. What is the Pre-Existing Condition waiting period?

no pre-existing waiting period if continuation of coverage

14. What is the Office visit co-pay?

	In-network	Out-of-network
PCP/Specialist	$25/$40	subject to deductible

15. Diagnostic Services

	In-network	Out-of-network
Routine Diagnostic Work	100%	subject to deductible
X-Ray	Done in office paid by OV copay, MRI, CT, etc subject to deductible	subject to deductible
Injections	100%	subject to deductible
Non-routine diagnostic services	subject to deductible	subject to deductible

16. Does the office visit co-pay go towards the annual deductible?

( ) Yes
(X) No

17. Is a referral required to see a specialist?

( ) Yes
(X) No

18. Please provide information on the following preventative health care services:

	In-network	Out-of-network
Well child care and to what age		
Annual well woman exam	100%	subject to ded.
Annual mammography screening	100%	subject to ded.
Annual cervical cancer screening	100%	subject to ded.
Prostate cancer screening	100%	subject to ded.
Immunizations and to what age		

19. Please provide information on the following services:

	In-network	Out-of-network
Inpatient services		
Outpatient surgery		
Routine Diagnostic Services Outpatient		
Non-routine Diagnostic Services-Outpatient		
Provider Administered specialty Pharmacy Products		
Other Outpatient Services (i.e. chemotherapy, radiation, dialysis)		
Emergency Care Services		
Emergency Care Non-Routine Diagnostics		

20. Please provide information on the following services:

	In-network	Out-of-network
Durable medical equipment		
Prosthetic and Orthotic Appliances		

21. Please provide information on the types of therapies covered and the number of visits per year:

	In-network	Out-of-network
Types of therapy		

Number of visits per year		

22. Is there a separate deductible for chiropractic care?

23. Please provide information on coverage of skilled nursing facility and rehabilitation facility services:

	In-network	Out-of-network
Services covered		
Number of days covered year		

24. Please provide information on coverage of home health services:

	In-network	Out-of-network
Services covered		
Number of visits covered year		

25. Please provide information on coverage of hospice services:

	In-network	Out-of-network
Services covered		
Number of days covered		

26. Please provide information on coverage of ambulance services:

	In-network	Out-of-network
By Air		
By Land		

27. Does you provide coverage for vision services?

( ) Yes
( ) No

28. What are the co-pays for vision benefits?

	In-network	Out-of-network
Exam		

Lens		
Contacts		
Frames		

29. Do you provide a drug card benefit?

( ) Yes
( ) No

30. Please provide the co-pay information for the drug card:

In-network	Out-of-network

31. Do your drug card co-pays go toward annual deductible?

( ) Yes
( ) No

Lawrenceburg, TN

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Sue Brown, Benefit Administrator, sbrown@lawrenceburgtn.org
800.253.9981
13th Floor Wm. R Snodgrass TN Tower
312 8TH Avenue North
Nashville, TN 37243

Health Insurance Provider Name and Contact Information
State of TN Local Government Plan

3. Please provide the number of employees covered by your health insurance benefits?
133

4. Do you offer any of the following plans?
(x) PPO
(x) POS
( ) HMO

5. Do you offer any of the following options to employees?
( ) Health Reimbursement Account (HRA)
( ) Health Savings Account (HSA)
( ) All of the above (all)
(X) None of the above (none)

6. How long is the elimination period for a new employee?
6 months

7. Do you offer a "tier" plan?
( ) Yes
(X) No

8. If "yes," what are the premiums for the tier plan?

Employee ________________
Employee/Spouse ________________
Employee kids ________________
Family ________________

9. What are your monthly premiums?

	Employee Pays	Employer Pays	Total Premium
Individual	$0.00	$497.63	$497.63
Family	$100.00	$1,142.44	$1,242.44

10. What is your Annual Deductible?

	In-network	Out-of-network
Individual	NONE	300
Family	NONE	750

11. What is the dependent age limit?

24

12. What is the Lifetime Maximum Benefit?

none

13. What is the Pre-Existing Condition waiting period?

6 months

14. What is the Office visit co-pay?

	In-network	Out-of-network
PCP/Specialist	$20.00 GENERAL $25.00 SPEC.	70% of MAC after deductible

15. Diagnostic Services

	In-network	Out-of-network
Routine Diagnostic Work	100%	70% of MAC after deductible
X-Ray	100%	70% of MAC after deductible
Injections	100%	70% of MAC after deductible
Non-routine diagnostic services	100%	70% of MAC after deductible

16. Does the office visit co-pay go towards the annual deductible?

( ) Yes
(X) No

17. Is a referral required to see a specialist?

( ) Yes
(X) No

18. Please provide information on the following preventative health care services:

	In-network	Out-of-network
Well child care and to what age	100% - 17	70% - 17
Annual well woman exam	100%	70%
Annual mammography screening	100%	70%
Annual cervical cancer screening	100%	70%
Prostate cancer screening	100%	70%
Immunizations and to what age	100%	70%

19. Please provide information on the following services:

	In-network	Out-of-network
Inpatient services	100	300
Outpatient surgery	100%	70%
Routine Diagnostic Services Outpatient	100%	70%
Non-routine Diagnostic Services-Outpatient	100%	70%
Provider Administered specialty Pharmacy Products	100%	70%
Other Outpatient Services (i.e. chemotherapy, radiation, dialysis)	100%	70%
Emergency Care Services	100%	70%
Emergency Care Non-Routine Diagnostics	100%	70%

20. Please provide information on the following services:

	In-network	Out-of-network
Durable medical equipment	100%	70%
Prosthetic and Orthotic Appliances	100%	70%

21. Please provide information on the types of therapies covered and the number of visits per year:

	In-network	Out-of-network

Types of therapy	Phys, speech, occup-20 copay	phys, speech, occup. 70%
Number of visits per year	45	45

22. Is there a separate deductible for chiropractic care?

20 copay-no deductible

23. Please provide information on coverage of skilled nursing facility and rehabilitation facility services:

	In-network	Out-of-network
Services covered	Inpatient, out patient, skilled nursing facility	same
Number of days covered year	100 day limit	100 day limit

24. Please provide information on coverage of home health services:

	In-network	Out-of-network
Services covered	Home Health Care	Home Health Care
Number of visits covered year	125 per year 20 copay	125 per year 70% MAC

25. Please provide information on coverage of hospice services:

	In-network	Out-of-network
Services covered	Through an approved program	Through approved program
Number of days covered	100% of MAC - 6 months	100% of MAC - 6 months

26. Please provide information on coverage of ambulance services:

	In-network	Out-of-network
By Air	100% of reasonable charges	100% of reasonable charges
By Land	100% of reasonable charges	100% of reasonable charges

27. Does you provide coverage for vision services?

(X) Yes
( ) No

28. What are the co-pays for vision benefits?

	In-network	Out-of-network

Exam	opt 10 opht25	70% of MAC
Lens	0	0
Contacts	0	0
Frames	0	0

29. Do you provide a drug card benefit?

(X) Yes
( ) No

30. Please provide the co-pay information for the drug card:

In-network	Out-of-network
5/20/40	70% of MAC

31. Do your drug card co-pays go toward annual deductible?

( ) Yes
(X) No

Goodlettsville, TN

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Dawn Freeman, Human Resources, dfreeman@cityofgoodlettsville.org

Health Insurance Provider Name and Contact Information

Blue Cross Blue Shield

3. Please provide the number of employees covered by your health insurance benefits?

135

4. Do you offer any of the following plans?

(x) PPO
( ) POS
( ) HMO

5. Do you offer any of the following options to employees?

(X) Health Reimbursement Account (HRA)
( ) Health Savings Account (HSA)
( ) All of the above (all)
( ) None of the above (none)

6. How long is the elimination period for a new employee?

30 days plus 1st of next month

7. Do you offer a "tier" plan?

(X) Yes
( ) No

8. If "yes," what are the premiums for the tier plan?

Employee ____10____________
Employee/Spouse ________________
Employee kids ________________
Family ____50____________

9. What are your monthly premiums?

	Employee Pays	Employer Pays	Total Premium
Individual	$10.00	$262.55	$272.55
Family	$50.00	$655.08	$705.08

10. What is your Annual Deductible?

	In-network	Out-of-network
Individual	5000	
Family	10000	

11. What is the dependent age limit?

24

12. What is the Lifetime Maximum Benefit?

1,000,000

13. What is the Pre-Existing Condition waiting period?

12 months

14. What is the Office visit co-pay?

	In-network	Out-of-network
PCP/Specialist	35	

15. Diagnostic Services

	In-network	Out-of-network
Routine Diagnostic Work		
X-Ray		
Injections		
Non-routine diagnostic services		

16. Does the office visit co-pay go towards the annual deductible?

( ) Yes
(X) No

17. Is a referral required to see a specialist?

( ) Yes
(X) No

18. Please provide information on the following preventative health care services:

	In-network	Out-of-network
Well child care and to what age		
Annual well woman exam		

Annual mammography screening		
Annual cervical cancer screening		
Prostate cancer screening		
Immunizations and to what age		

19. Please provide information on the following services:

	In-network	Out-of-network
Inpatient services		
Outpatient surgery		
Routine Diagnostic Services Outpatient		
Non-routine Diagnostic Services-Outpatient		
Provider Administered specialty Pharmacy Products		
Other Outpatient Services (i.e. chemotherapy, radiation, dialysis)		
Emergency Care Services		
Emergency Care Non-Routine Diagnostics		

20. Please provide information on the following services:

	In-network	Out-of-network
Durable medical equipment		
Prosthetic and Orthotic Appliances		

21. Please provide information on the types of therapies covered and the number of visits per year:

	In-network	Out-of-network
Types of therapy		
Number of visits per year		

22. Is there a separate deductible for chiropractic care?

no

23. Please provide information on coverage of skilled nursing facility and rehabilitation facility services:

	In-network	Out-of-network
Services covered		
Number of days covered year		

24. Please provide information on coverage of home health services:

	In-network	Out-of-network
Services covered		
Number of visits covered year		

25. Please provide information on coverage of hospice services:

	In-network	Out-of-network
Services covered		
Number of days covered		

26. Please provide information on coverage of ambulance services:

	In-network	Out-of-network
By Air		
By Land		

27. Does you provide coverage for vision services?

( ) Yes
(X) No

28. What are the co-pays for vision benefits?

	In-network	Out-of-network
Exam		
Lens		
Contacts		
Frames		

29. Do you provide a drug card benefit?

(X) Yes
( ) No

30. Please provide the co-pay information for the drug card:

In-network	Out-of-network
10,35,50	

31. Do your drug card co-pays go toward annual deductible?

( ) Yes
(X) No

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