REQUESTS FOR PROPOSALS

The City of Manchester, Tennessee is requesting proposals for provisions of health, prescription, dental, vision, and life insurance coverage to its employees and their dependents. Proposals should include premium cost for individual, spouse and dependent coverage, coverage percentages, deductible, co-pay, out-of-pocket and specific coverage limitations or maximums, as well as information concerning participating providers (networks, etc.). Consideration will be given to all policies with deductibles, co-payments and out-of-pockets similar to our current coverage, low-cost coverage with multiple options for employees, or plans including higher/lower deductibles, HRA's, HSA's, gap insurance, etc.

The City will consider the best overall policy options considering premium, co-pay, deductible, out-of-pocket maximums and availability of participating providers. The City reserves the right to reject all proposals and/or negotiate further with the entity submitting the most advantageous proposal.

Bid Specifications can be picked up at: City of Manchester 200 West Fort Street Manchester, TN 37355 or by emailing Melissa Gamble at: mgamble@cityofmanchestertn.com. All proposals must be returned **with an original and 7 copies, sealed**, to the Finance Director's Office no later than 4:00 P.M. on May 7, 2015, at 200 West Fort Street Manchester, TN 37355. When you submit your sealed proposal package, you will be requested to sign up for a 20 minute period for a presentation on May 7, 2015 starting at 5:00P.M.

It is the policy of the city of Manchester, Tennessee to ensure compliance with Title VI of the Civil Rights act of 1964; 49 CFR Part 21. No person shall be excluded from participation in or be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the grounds of race, color, sex, age, disability, or national origin.

Bridget Anderson

Finance Director

Health Insurance Specifications
For the City of Manchester, Tennessee

Benefits Features	
Annual Deductible	
Individual	$2500.00/person
Family	$5000.00
Annual Out of Pocket Maximum Amount	
Individual	$5000.00/person
Family	$10000.00
Dependent Age Limit	To Age 26
4th Quarter Deductible Carryover Provision	Included
Benefits for Covered Services	
Primary Care Office Visits	$30 Co-Pay
Specialist Office Visits	$30 Co-Pay
Routine Diagnostic Lab, X-Ray, and Injections	$30 Co-Pay
Advanced Radiological Imaging	80% after Deductible
Provider-Administered Specialty Drug	$100 Co-Pay
Maternity Care	$30 Co-Pay
Preventative Health Care Services	
Well Child Care	No Additional Co-Pay
Annual Well woman Exam	No Additional Co-Pay
Annual Mammography Screening	No Additional Co-Pay
Annual Cervical Cancer Screening	No Additional Co-Pay
Prostate Cancer Screening	No Additional Co-Pay
Immunizations	No Additional Co-Pay
Services Received at a Facility (includes professional and facility charges)	
Inpatient Services	80 % after Deductible
Outpatient Surgery	80 % after Deductible
Advanced Radiological Imaging-Outpatient	80 % after Deductible
Provider-Administered Specialty Drugs	80 % after Deductible
Other Outpatient Services	80 % after Deductible
Emergency Care Services	80 % after Deductible
Emergency Care Advanced Radiological Imaging	80 % after Deductible
Medical Equipment	
Durable Medical Equipment	80 % after Deductible
Prosthetics	80 % after Deductible
Orthotic Appliances	80 % after Deductible

Therapeutic Services	
Therapy (Limited to 30-36 visits per therapy type per year)	80 % after Deductible
Skilled Nursing Facility & Rehabilitation Facility Services	
Limited to 60 days combined	80 % after Deductible
Home Health Services	
Limited to 60 visits per year	80 % after Deductible
Hospice Services	100%
Ambulance Services	80% after Deductible
Prescription Drugs	
Generic	$10.00
Preferred Brand	$35.00
Non-Preferred Brand	$50.00
Contraceptives	100%
Vision Care	
Dental	

*** All policies should comply with the Affordable Care Act.***

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbst.com or by calling 1-800-565-9140.
Contributions made by you and/or your employer to health savings accounts (HSAs), flexible spending arrangements (FSAs), or health reimbursement arrangements (HRAs) may help pay your deductible or other out-of-pocket expenses.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$2,500** person/**$5,000** family Out-of-network: **$5,000** person/**$10,000** family Doesn't apply to preventive care. Copays do not apply to the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: **$5,000** person/**$10,000** family Out-of-network: **$15,000** person/**$30,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premium, balance-billed charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. This plan uses Network S. For a list of **in-network providers**, see www.bcbst.com or call 1-800-565-9140.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

Important Questions	Answers	Why this Matters:
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-Of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 co-pay/visit	40% co-insurance	Office surgery subject to deductible/coinsurance.
	Specialist visit	$30 co-pay/visit	40% co-insurance	Office surgery subject to deductible/coinsurance.
	Other practitioner office visit	20% co-insurance	40% co-insurance	Therapy visits limited to 30 per type per year. Cardiac/Pulmonary Rehab visits limited to 36 per type per year.
	Preventive care/screening/immunization	No Charge	40% co-insurance	
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	40% co-insurance	
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you need drugs to treat your illness or condition	Generic drugs	$10 co-pay	40% co-insurance	30-day supply retail; up to 90 day supply home delivery or Plus90 network. Co-pay per 30-day supply.

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-Of-Network Provider	Limitations & Exceptions
More information about **prescription drug coverage** is available at www.bcbst.com.	Preferred brand drugs	$35 co-pay	40% co-insurance	30-day supply retail; up to 90 day supply home delivery or Plus90 network. Co-pay per 30-day supply.
	Non-preferred brand drugs	$50 co-pay	40% co-insurance	When a Brand Drug is chosen and a Generic Drug equivalent is available, Your cost share will increase by the difference between the cost of the Brand Drug and the Generic Drug.
	Self-Administered Specialty drugs	$100 co-pay	Not Covered	30 days supply. Must use a pharmacy in Specialty pharmacy network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fees	20% co-insurance	40% co-insurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.
If you need immediate medical attention	Emergency room services	20% co-insurance	20% co-insurance	
	Emergency medical transportation	20% co-insurance	20% co-insurance	
	Urgent care	See Limitations & Exceptions	See Limitations & Exceptions	Urgent Care benefits are determined by place of service, such as physician's office or ER.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fee	20% co-insurance	40% co-insurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 co-pay/visit	40% co-insurance	Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 50% if not obtained.

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-Of-Network Provider	Limitations & Exceptions
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
	Substance use disorder outpatient services	$30 co-pay/visit	40% co-insurance	Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 50% if not obtained.
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you are pregnant	Prenatal and postnatal care	20% co-insurance	40% co-insurance	
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	Limited to 60 visits.
	Rehabilitation services	20% co-insurance	40% co-insurance	Therapy limited to 30 visits per type per year. Cardiac/Pulmonary Rehab limited to 36 visits per year.
	Habilitation services	20% co-insurance	40% co-insurance	
	Skilled nursing care	20% co-insurance	40% co-insurance	Skilled Nursing and Rehabilitation Facility limited to 60 days/year combined.
	Durable medical equipment	20% co-insurance	40% co-insurance	Durable medical equipment over $500 requires prior authorization.
	Hospice service	No Charge	40% co-insurance	Prior Authorization required for Inpatient Hospice.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-565-9140.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-565-9140.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-565-9140.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-565-9140.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Hearing aids for adults	• Routine eye care (Adult)
• Bariatric surgery	• Infertility treatment	• Routine eye care (Children)
• Cosmetic surgery	• Long-term care	• Routine foot care for non-diabetics
• Dental care (Adult)	• Private-duty nursing	• Weight loss programs
• Dental care (Children)		

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Chiropractic care	• Hearing aids for children under 18	• Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-565-9140. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

- Your Plan at 1-800-565-9140 or www.bcbst.com.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.
- Consumer Insurance Services within the Tennessee Department of Commerce and Insurance at 1-800-342-4029 or visit www.tn.gov/insurance/consumerRes.shtml.

Additionally, a consumer assistance program can help you file your appeal. Contact the Tennessee Department of Commerce and Insurance (TDCI) at 1-800-342-4029, https://sbs-tn.naic.org/Lion-Web/servlet/org.naic.sbs.ext.onlineComplaint.OnlineComplaintCtrl?spanishVersion=N, or email them at CIS.Complaints@state.tn.us. You may also write them at 500 James Robertson Pkwy, Davy Crockett Tower, 6th Floor, Nashville, TN 37243.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,150
- **Patient pays** $3,390

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,500
Copays	$60
Co-insurance	$800
Limits or exclusions	$30
Total	**$3,390**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,900
- **Patient pays** $1,500

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$1,500
Co-insurance	$0
Limits or exclusions	$0
Total	**$1,500**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

LIFE INSURANCE SPECIFICATIONS
FOR THE CITY OF MANCHESTER, TENNESSEE

Individual	Coverage
Employee	$30,000
Family	
Employee	$30,000
Spouse	$5,000
Children	$2,000

***Currently, the City pays all premiums for life insurance except for new hires hired after September 1, 2013. Anyone hired after September 1, 2013 may purchase dependent coverage at his or her own expense.**

Dental

Coverage A - Diagnostic and Preventive

	Copays	Deductible	You Pay	Comments
A Coverage In & Out of Network	$0	$0	0%	Exams/XRays/Cleaning/Flouride/Sealants or Preventative Resins/Space Maintainers
Preventive Exam In-Network	$0	$0	0%	Periodic exams are limited to 1 in any 6-month period. A comprehensive, detailed/extensive or periodontal exam is covered once in any 36-month period. An additional comprehensive exam will be eligible for each participating provider once in a 36-month period, assuming the sameprovider has not performed a detailed/extensive or periodontal exam within the same 36-month period.
Emergency Exam In & Out of Network	$0	$0	0%	Emergency exams are limited to 1 in any 12-month period
X-Rays In & Out of Network	$0	$0	0%	Full mouth set of x-rays are limited to 1 in any 36-month period. Bitewings are limited to four films in any 12-month period; all films mustbe taken on the same date of service.
Cleanings In & Out of Network	$0	$0	0%	Cleanings limited to 1 in any 6-month period. A periodontal maintenance procedure(paid under basic periodontal) may replace a regular cleaning for the 1 in 6-month limit
'A' Coverage Fluoride In & Out of Network	$0	$0	0%	Fluoride treatments are limited to 1 in any 12-month period; for members 18 and under
'A' Coverage Sealants In & Out of Network	$0	$0	0%	Sealants or Preventative Resins are eligible once in a lifetime on first and second molars, for dependents age 15 and under
'A' Coverage Space Maintainer In & Out of Network	$0	$0	0%	Space maintainers for dependents age 13 and under. 1 recementation inany 12-month period
'A' Coverage Exams Out-of-Network	$0	$0	0%	Periodic exams are limited to 1 in any 6-month period. A comprehensive, detailed/extensive or periodontal exam is covered once in any 36-month period. An additional comprehensive exam will be eligible for each participating provider once in a 36-month period, assuming the sameprovider has not performed a detailed/extensive or periodontal exam within the same 36-month period.

Coverage B - Basic Services

	Copays	Deductible	You Pay	Comments
B Coverage In-Network	$0	$50	20%	Fillings/Perio/Extractions/Anesthesia/Root Canal/Palliative/StainlessSteel Crowns/Denture Repair
'B' Coverage Anestheva In & Out of Network	$0	$50	20%	General anesthesia or intravenous (IV) sedation provided only in connection with major oral and implant surgery
Fillings In & Out of Network	$0	$50	20%	Fillings 1 per tooth surface in 12-month period; (we do not downgradeposterior composites to amalgams)
'B' Coverage Stainless Steel Crown In & Out of Network	$0	$50	20%	Stainless Steel Crowns are limited to 1 per tooth in any 36-month period
'B' Coverage Palliative In & Out of Network	$0	$50	20%	Palliative treatment for the relief of pain
'B' Coverage Denture Repair In & Out of Network	$0	$50	20%	Repair of full and partial dentures are limited to 1 in any 24-month period
Basic Endodontic In & Out of Network	$0	$50	20%	Pulpotomy and Pulpal Therapy are covered on primary teeth only
Basic Oral Surgery In & Out of Network	$0	$50	20%	Non-surgical or simple extractions
'B' Coverage Scale & Root In & Out of Network	$0	$50	20%	Periodontal scaling and root planning 1 per quadrant in any 24-monthperiod
'B' Coverage Debridement In & Out of Network	$0	$50	20%	Full mouth Debridement is limited to once in a lifetime
'B' Coverage Periodontal Maintenance In & Out of Network	$0	$50	20%	Perio maintenance 1 in any 6-month period and will replace a regular cleaning for the 1 in 6-month limit
'B' Coverage Root Canal In & Out of Network	$0	$50	20%	Eligible Root Canal treatment, is limited to 1 per tooth in any 60-month period
'B' Coverage Apicoectomy In & Out of Network	$0	$50	20%	Apicoectomy is limited to once per root per lifetime
	$0	$50	20%	

Major Oral Surgery In & Out of Network				Eligible Surgical extractions and other oral surgical procedures not Covered under a medical plan
Major Periodontic In & Out of Network	$0	$50	20%	Eligible Surgical periodontics are limited to 1 procedure in any 36-month period
'B' Coverage Out-of-Network	$0	$50	20%	Fillings/Perio/Extractions/Anesthesia/Root Canal/Palliative/StainlessSteel Crowns/Denture Repair

Coverage C - Major Services

	Copays	Deductible	You Pay	Comments
C Coverage In-Network	$0	$50	50%	Crowns/Bridges/Partials/Dentures/Post&Core/Crown& Bridge Repair/Denture Adj, Reline, Rebase
'C' Coverage Crowns In & Out of Network	$0	$50	50%	Eligible Crowns, Inlays, Onlays, Veneers, and Implant supported Prosthesis 1 in any 60-month period. Permanent teeth age 12 and over
Bridges/Partials/Dentures In & Out of Network	$0	$50	50%	Eligible bridges, partials, dentures, and Implant supported Prosthesis1 in any 60-month period for dependents age 16 and over
'C' Coverage Post & Core In & Out of Network	$0	$50	50%	Core Build-up, Post and Core covered only when performed in conjunction with a covered crown or bridge
'C' Coverage Repair Crown/Bridge In & Out of Network	$0	$50	50%	Repair and/or re-cementation are covered only after 12 months from thedate of the initial placement
'C' Coverage Denture Adjustment In & Out of Network	$0	$50	50%	Covered only after 6-months from the date of intial placement
'C' Coverage Denture Reline & Rebase In & Out of Network	$0	$50	50%	Denture reline or rebase is limited to 1 in any 36-month period
Implants In & Out of Network	$0	$50	50%	Implants are covered Benefit level C COVERAGE
'C' Coverage Out-of-Network	$0	$50	50%	Crowns/Bridges/Partials/Dentures/Post&Core/Crown& Bridge Repair/Denture Adj, Reline, Rebase

Coverage D - Orthodontics

	Copays	Deductible	You Pay	Comments
D Coverage Orthodontic In-Network	$0	$0	50%	Adult Orthodontics is covered
'D' Coverage Orthodontic Out-of-Network	$0	$0	50%	Adult Orthodontics is covered

Other

	Copays	Deductible	You Pay	Comments
Deductible/Maximum	$0	$0	100%	Deductible (applies to Coverage's B and C only) ***** $ 50.00 Family Deductible Maximum ***** $ 150.00 Benefit Maximums ** $1,000.00 per Calendar Year(Includes Coverage * A * B *C) Ortho Lifetime Maximums: ** $1,000.00
Extended Benefits	$0	$0	100%	Refer to Benefit Booklet or Contact Customer Service Department for extended coverage information.
General Exclusions	$0	$0	100%	Refer to Benefit Booklet or Contact Customer Service Department for specific exclusions
Missing Tooth Clause	$0	$0	100%	Contract does not have a Missing Tooth Clause
Network In & Out of Network	$0	$0	100%	Preferred network in-state with out-of-state Dental GRID, Dental GRID+and the Dentemax networks
Occlusal Guard In & Out of Network	$0	$0	100%	Not Covered
Procedure Exclusions In & Out of Network	$0	$0	100%	Refer to Benefit Booklet or Contact Customer Service Department for specific exclusions
Pre-Determination of Benefits In & Out of Network	$0	$0	100%	Recommended for treatments where the total charges may exceed $200.00
Dental Timely Filing In & Out of Network	$0	$0	100%	Claim must be submitted 1 year and 90 days from the date a covered service was received
TMJ In & Out of Network	$0	$0	100%	TMJ and related expenses are not covered
UM Requirements In & Out of Network	$0	$0	100%	Standard Dental UM guidelines apply
Waiting Period In & Out of Network	$0	$0	100%	No waiting period

Vision

Routine Exam

	Copays	Allowance	You Pay	Comments
In-Network Vision/Routine Exam	$10	$0	0%	$0.00 per year

Lenses

	Copays	Allowance	You Pay	Comments
In-Network Vision/Lens	$25	$0	0%	$0.00 per year

Frames

	Copays	Allowance	You Pay	Comments
In-Network Vision/Frames	$0	$150	80%	$150.00 per 2 years

Contacts

	Copays	Allowance	You Pay	Comments
In-Network Vision/Contacts	$0	$150	100%	$150.00 per year

EMPLOYEE CENSUS 2015

GENDER	COVERAGE	DATE OF BIRTH
MALE	FAMILY	04/28/1989
FEMALE	FAMILY	12/25/1974
MALE	FAMILY	09/07/1978
MALE	FAMILY	10/24/1989
MALE	FAMILY	06/19/1993
FEMALE	FAMILY	08/04/1952
FEMALE	FAMILY	11/10/1973
MALE	FAMILY	10/30/1947
MALE	FAMILY	10/03/1967
MALE	SINGLE	10/29/1986
MALE	FAMILY	05/08/1980
MALE	FAMILY	08/17/1962
MALE	SINGLE	06/18/1954
MALE	SINGLE	09/29/1993
MALE	FAMILY	07/01/1966
MALE	FAMILY	06/30/1963
MALE	FAMILY	12/19/1963
MALE	FAMILY	02/04/1961
MALE	FAMILY	07/19/1964
MALE	FAMILY	01/20/1959
MALE	FAMILY	11/24/1981
MALE	FAMILY	07/09/1945
MALE	FAMILY	01/28/1964
MALE	FAMILY	12/26/1956
MALE	SINGLE	05/31/1995
MALE	FAMILY	04/09/1975
MALE	FAMILY	12/13/1951
MALE	LIFE ONLY	01/11/1969
MALE	FAMILY	05/22/1971
MALE	FAMILY	03/15/1948
MALE	FAMILY	08/10/1966
FEMALE	SINGLE	05/19/1982
MALE	FAMILY	09/14/1972
MALE	FAMILY	01/17/1973
MALE	FAMILY	03/12/1948
MALE	FAMILY	12/17/1973
MALE	FAMILY	09/07/1972
MALE	SINGLE	10/15/1991
MALE	FAMILY	12/29/1964
MALE	FAMILY	02/22/1978
MALE	FAMILY	11/21/1950
MALE	FAMILY	02/27/1984

FEMALE	FAMILY	06/14/1961
MALE	FAMILY	09/08/1985
MALE	FAMILY	05/11/1970
FEMALE	FAMILY	05/26/1957
FEMALE	SINGLE	06/17/1988
MALE	FAMILY	01/11/1971
MALE	FAMILY	03/07/1953
MALE	FAMILY	10/06/1956
FEMALE	SINGLE	08/08/1945
MALE	FAMILY	06/27/1968
MALE	FAMILY	09/15/1973
MALE	SINGLE	10/17/1950
FEMALE	SINGLE	04/01/1956
MALE	FAMILY	10/25/1963
MALE	FAMILY	06/08/1963
MALE	FAMILY	09/12/1978
MALE	SINGLE	08/19/1990
MALE	FAMILY	09/23/1978
FEMALE	SINGLE	10/27/1946
MALE	FAMILY	11/01/1976
MALE	FAMILY	02/11/1967
MALE	FAMILY	06/03/1962
MALE	FAMILY	09/11/1971
MALE	SINGLE	08/30/1989
MALE	FAMILY	05/11/1957
MALE	SINGLE	09/26/1989
MALE	SINGLE	12/28/1959
MALE	SINGLE	11/16/1987
MALE	SINGLE	11/23/1961
MALE	FAMILY	01/16/1976
MALE	FAMILY	06/09/1978
MALE	FAMILY	10/27/1966
MALE	FAMILY	08/08/1966
MALE	FAMILY	01/26/1952
MALE	FAMILY	10/26/1968
FEMALE	FAMILY	10/12/1964
MALE	FAMILY	02/04/1975
MALE	FAMILY	11/19/1977
MALE	SINGLE	01/15/1962
MALE	FAMILY	05/18/1953
FEMALE	SINGLE	07/18/1949
MALE	FAMILY	04/26/1959
MALE	FAMILY	04/21/1989
MALE	FAMILY	03/12/1963
FEMALE	FAMILY	05/03/1980
MALE	SINGLE	03/01/1988
MALE	FAMILY	07/02/1971

MALE	FAMILY	08/30/1976
MALE	FAMILY	02/09/1978
FEMALE	FAMILY	01/16/1967
FEMALE	SINGLE	09/10/1956
MALE	FAMILY	12/24/1980
MALE	FAMILY	07/05/1978
MALE	SINGLE	04/09/1950
MALE	FAMILY	12/30/1972
MALE	SINGLE	01/07/1973
FEMALE	FAMILY	10/19/1962
MALE	FAMILY	01/19/1954
MALE	SINGLE	09/12/1964
MALE	FAMILY	12/04/1954
MALE	SINGLE	04/23/1972
MALE	FAMILY	08/07/1979
FEMALE	FAMILY	08/04/1980
MALE	FAMILY	08/22/1964
MALE	FAMILY	01/04/1963
MALE	FAMILY	06/21/1985
MALE	FAMILY	07/22/1981
MALE	FAMILY	10/03/1968
MALE	SINGLE	05/29/1990
FEMALE	FAMILY	10/06/1976
FEMALE	FAMILY	05/22/1979
FEMALE	SINGLE	01/04/1963
MALE	FAMILY	10/28/1960
MALE	FAMILY	03/28/1983
MALE	SINGLE	02/11/1964
MALE	FAMILY	01/04/1979
FEMALE	SINGLE	03/26/1961
MALE	FAMILY	03/25/1978
MALE	FAMILY	05/31/1971
MALE	FAMILY	07/15/1965
MALE	SINGLE	10/17/1951
MALE	SINGLE	06/23/1971
MALE	FAMILY	09/23/1960
MALE	FAMILY	06/27/1964
MALE	SINGLE	09/12/1960
MALE	FAMILY	03/07/1969
MALE	SINGLE	10/24/1964
FEMALE	SINGLE	11/23/1972
MALE	SINGLE	07/14/1955
FEMALE	SINGLE	08/13/1955
MALE	NONE	05/03/1990
FEMALE	FAMILY	09/15/1958
MALE	SINGLE	03/24/1976
MALE	FAMILY	02/15/1979

MALE	FAMILY	06/28/1969
FEMALE	SINGLE	07/16/1945
MALE	FAMILY	08/24/1972
MALE	SINGLE	12/29/1977
FEMALE	FAMILY	11/08/1976
MALE	FAMILY	11/30/1964
MALE	FAMILY	06/24/1956
MALE	FAMILY	05/28/1969
MALE	FAMILY	07/07/1959

TOTAL # OF EMPLOYEES WITH INSURANCE: 145

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One Cameron Hill Circle
Chattanooga, Tennessee 37402

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STATEMENT OF ACCOUNT

City of Manchester

GROUP ID: 113634
SUB-GROUP ID: 0001
DUE DATE: 04/01/15
BILLING FROM: 04/01/15
BILLING THRU: 04/30/15
STATEMENT NO: 150750001794
PHONE: (931)728-4652
PHONE EXT: 1301

ACCOUNT DETAIL

CONTRACT: 1 BCBST Plan Ids

BENEFIT PLAN	NUMBER OF SUBSCRIBERS	NUMBER OF DEPENDENTS	CURRENT BILLING	RETRO	NET
DEN OPT 1	144	254	$7,402.38	$0.00	$7,402.38
DEN OPT 1	0	3	$0.00	$44.14	$44.14
L4079600	1-	0	$0.00	$5.40-	$5.40
L4079601	1-	0	$0.00	$0.81-	$0.81
L4079602	4	0	$0.00	$3.44	$3.44
MED OPT 1	3	7	$3,713.83	$0.00	$3,713.83
MED OPT 2	140	247	$167,317.73	$0.00	$167,317.73
MED OPT 2	0	3	$0.00	$758.61	$758.61
VIS OPT 1	143	261	$1,791.41	$0.00	$1,791.41
VIS OPT 1	0	3	$0.00	$9.17	$9.17
CURRENT BILLING FOR CONTRACT:			$180,225.35	$809.15	$181,034.50
GRAND TOTAL FOR ALL CONTRACTS:			$180,225.35	$809.15	$181,034.50
TOTAL MISCELLANEOUS BILLING ITEMS:					$25.00
OUTSTANDING BALANCE AS OF: 03/17/15					$0.00
TOTAL DUE:					$181,059.50

Demographic Breakdown of Members

Current Period (10/1/13 through 9/30/14)

Age Range	Male				Female			
	Employee	Spouse	Children	Total	Employee	Spouse	Children	Total
less than 1	0	0	3	3	0	0	3	3
1 - 6	0	0	20	20	0	0	12	12
7 - 19	0	0	47	47	0	0	41	41
20 - 35	23	2	17	42	5	25	22	52
36 - 45	33	4	0	37	5	19	0	24
46 - 55	36	5	0	41	9	23	0	32
56 - 64	19	3	0	22	6	11	0	17
65 and over	5	0	0	5	3	3	0	6
Total	**116**	**14**	**87**	**217**	**28**	**81**	**78**	**187**

Age Range	Total				Percent of Total Employees	Percent of Total Members	BCBST % Employees	BCBST % Members
	Employee	Spouse	Children	Total				
less than 1	0	0	6	6	0.0%	1.5%	0.0%	0.8%
1 - 6	0	0	32	32	0.0%	7.9%	0.0%	6.3%
7 - 19	0	0	88	88	0.0%	21.8%	0.2%	18.3%
20 - 35	28	27	39	94	19.4%	23.3%	27.1%	23.9%
36 - 45	38	23	0	61	26.4%	15.1%	24.1%	16.8%
46 - 55	45	28	0	73	31.3%	18.1%	26.4%	18.3%
56 - 64	25	14	0	39	17.4%	9.7%	18.8%	13.0%
65 and over	8	3	0	11	5.6%	2.7%	3.5%	2.6%
Total	**144**	**95**	**165**	**404**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Type of Member	Average Age	Change from Prior Period	BCBST Average Age
Employee	46.8	0.1%	44.0
Spouse	44.7	0.0%	46.0
Child	13.4	-2.5%	12.0
Total	**32.6**	**-1.7%**	**41.4**

Type of Contract	Average Number of Contracts	% of Total Contracts	BCBST % of Total Contracts
Employee	37	25.7%	51.9%
Emp & Spouse	32	22.2%	13.4%
Emp & Child(ren)	13	9.0%	10.7%
Family	62	43.1%	24.0%
Other	0	0.0%	0.0%
Total	**144**	**100.0%**	**100.0%**

Paid Claims by Age & Type of Member

Prior Period (10/1/12 through 9/30/13)

Age Range	Male				Female			
	Employee	Spouse	Children	Total	Employee	Spouse	Children	Total
LESS THAN 1	$0	$0	$15,406	$15,406	$0	$0	$9,854	$9,854
1-6	$0	$0	$13,615	$13,615	$0	$0	$12,799	$12,799
7-19	$0	$0	$45,327	$45,327	$0	$0	$38,320	$38,320
20-35	$33,068	$565	$197,642	$231,275	$16,062	$77,893	$49,567	$143,522
36-45	$97,060	$2,040	$373	$99,473	$13,513	$175,300	$0	$188,814
46-55	$135,463	$31,458	$0	$166,921	$29,231	$174,457	$0	$203,688
56-64	$207,486	$5,210	$0	$212,696	$3,089	$61,387	$0	$64,476
65 AND OVER	$13,247	$52,251	$0	$65,498	$4,999	$5,054	$0	$10,053
Total	**$486,323**	**$91,524**	**$272,364**	**$850,211**	**$66,893**	**$494,093**	**$110,540**	**$671,525**

Age Range	Total				Percent of Total Claims	BCBST Percent of Total Claims
	Employee	Spouse	Children	Total		
LESS THAN 1	$0	$0	$25,260	$25,260	1.7%	1.3%
1-6	$0	$0	$26,414	$26,414	1.7%	4.6%
7-19	$0	$0	$83,647	$83,647	5.5%	12.1%
20-35	$49,130	$78,458	$247,209	$374,797	24.6%	19.0%
36-45	$110,573	$177,340	$373	$288,287	18.9%	16.9%
46-55	$164,693	$205,915	$0	$370,609	24.4%	22.6%
56-64	$210,574	$66,597	$0	$277,172	18.2%	18.8%
65 AND OVER	$18,245	$57,306	$0	$75,551	5.0%	4.7%
Total	**$553,216**	**$585,617**	**$382,904**	**$1,521,736**	**100.0%**	**100.0%**

Paid Claims by Age & Type of Member

Current Period (10/1/13 through 9/30/14)

Age Range	Male				Female			
	Employee	Spouse	Children	Total	Employee	Spouse	Children	Total
LESS THAN 1	$0	$0	$8,686	$8,686	$0	$0	$4,569	$4,569
1-6	$0	$0	$23,237	$23,237	$0	$0	$11,604	$11,604
7-19	$0	$0	$31,111	$31,111	$0	$0	$25,804	$25,804
20-35	$22,626	$1,006	$58,460	$82,091	$18,370	$68,273	$56,033	$142,675
36-45	$83,239	$794	$0	$84,033	$6,242	$94,756	$0	$100,998
46-55	$220,491	$5,172	$0	$225,662	$54,368	$324,612	$0	$378,980
56-64	$102,193	$22,000	$0	$124,193	$4,687	$131,482	$0	$136,169
65 AND OVER	$13,433	$0	$0	$13,433	$5,992	$10,831	$0	$16,823
Total	**$441,982**	**$28,972**	**$121,494**	**$592,447**	**$89,658**	**$629,954**	**$98,009**	**$817,621**

Age Range	Total				Percent of Total Claims	BCBST Percent of Total Claims
	Employee	Spouse	Children	Total		
LESS THAN 1	$0	$0	$13,255	$13,255	0.9%	1.3%
1-6	$0	$0	$34,841	$34,841	2.5%	4.6%
7-19	$0	$0	$56,915	$56,915	4.0%	12.3%
20-35	$40,996	$69,278	$114,492	$224,766	15.9%	19.3%
36-45	$89,481	$95,550	$0	$185,031	13.1%	16.8%
46-55	$274,858	$329,784	$0	$604,642	42.9%	22.1%
56-64	$106,880	$153,482	$0	$260,362	18.5%	18.8%
65 AND OVER	$19,425	$10,831	$0	$30,256	2.1%	4.6%
Total	**$531,640**	**$658,926**	**$219,503**	**$1,410,069**	**100.0%**	**100.0%**

Claimants and Paid Claims by Dollar Range

	Prior Period 10/1/12 – 9/30/13					Current Period 10/1/13 – 9/30/14				
Dollar Range	Number of Claimants	Percent of Total Members	Paid Claims	Percent of Total Paid Claims	BCBST Percent of Total Paid	Number of Claimants	Percent of Total Members	Paid Claims	Percent of Total Paid Claims	BCBST Percent of Total Paid
NO PAID DOLLAR	22	5.5%	-$6,548	-0.4%	-0.7%	15	3.7%	-$5,074	-0.4%	-0.7%
$1 - $99	44	11.0%	$2,177	0.1%	0.2%	45	11.1%	$2,704	0.2%	0.2%
$100 - $249	54	13.5%	$8,734	0.6%	0.8%	62	15.3%	$10,179	0.7%	0.8%
$250 - $499	58	14.5%	$21,976	1.4%	1.6%	49	12.1%	$18,216	1.3%	1.6%
$500 - $999	41	10.3%	$29,448	1.9%	3.2%	62	15.3%	$44,413	3.1%	3.2%
$1,000 - $2,499	78	19.5%	$123,424	8.1%	7.8%	66	16.3%	$109,733	7.8%	7.8%
$2,500 - $4,999	39	9.8%	$136,346	9.0%	9.4%	47	11.6%	$162,119	11.5%	9.4%
$5,000 - $9,999	28	7.0%	$200,982	13.2%	12.8%	28	6.9%	$202,940	14.4%	12.8%
$10,000 - $24,999	23	5.8%	$337,236	22.2%	18.5%	20	5.0%	$311,344	22.1%	18.5%
$25,000 - $49,999	6	1.5%	$231,055	15.2%	14.4%	5	1.2%	$213,125	15.1%	14.4%
$50,000 - $74,999	1	0.3%	$50,919	3.3%	8.4%	1	0.2%	$52,653	3.7%	8.4%
$75,000 - $99,999	1	0.3%	$75,176	4.9%	5.0%	0	0.0%	$0	0.0%	5.0%
$100,000 AND ABOVE	2	0.5%	$310,812	20.4%	18.7%	2	0.5%	$287,717	20.4%	18.7%
Total	397	99.3%	$1,521,736	100.0%	100.0%	402	99.5%	$1,410,069	100.0%	100.0%

Claimants and Paid Claims by Dollar Range – Continuum of Care

10/1/13 – 9/30/14

Dollar Range	Number of Claimants	Percent of Total Members	Paid Claims	Percent of Total Paid Claims	Claimants Active in Continuum of Care Programs							
					Lifestyle Mgmt.	Percent of Total	Nurseline Calls	Percent of Total	Case Mgmt.	Percent of Total	Disease Mgmt.	Percent of Total
NO PAID DOLLAR	15	3.7%	-$5,074	-0.4%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
$1 – $99	45	11.1%	$2,704	0.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
$100 – $249	62	15.3%	$10,179	0.7%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
$250 – $499	49	12.1%	$18,216	1.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
$500 – $999	62	15.3%	$44,413	3.1%	0	0.0%	1	0.2%	0	0.0%	3	0.7%
$1,000 – $2,499	66	16.3%	$109,733	7.8%	0	0.0%	0	0.0%	0	0.0%	5	1.2%
$2,500 – $4,999	47	11.6%	$162,119	11.5%	0	0.0%	0	0.0%	1	0.2%	2	0.5%
$5,000 – $9,999	28	6.9%	$202,940	14.4%	0	0.0%	1	0.2%	1	0.2%	7	1.7%
$10,000 – $24,999	20	5.0%	$311,344	22.1%	0	0.0%	0	0.0%	0	0.0%	6	1.5%
$25,000 – $49,999	5	1.2%	$213,125	15.1%	0	0.0%	1	0.2%	3	0.7%	3	0.7%
$50,000 – $74,999	1	0.2%	$52,653	3.7%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
$75,000 – $99,999	0	0.0%	$0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
$100,000 AND ABOVE	2	0.5%	$287,717	20.4%	0	0.0%	0	0.0%	2	0.5%	1	0.2%
Total	402	99.5%	$1,410,069	100.0%	0	0.0%	3	0.7%	7	1.7%	27	6.7%
X Indicates that this program has been purchased					X		X		X		X	

Paid Claims by Type of Service*

Per Employee Per Year Basis (PEPY)

Prior Period (Incurred 7/1/12 through 6/30/13)
Current Period (Incurred 7/1/13 through 6/30/14)

Provider Category	Prior Total Paid Claims	Current Total Paid Claims	Prior Total Paid Claims PEPY	Current Total Paid Claims PEPY	Percent Change Paid Claims PEPY	BCBST Paid Claims PEPY	Variance Current vs. BCBST Claims PEPY
Inpatient Facility	$286,607	$457,009	$1,949.70	$3,155.41	61.8%	$1,798.07	75.5%
Outpatient Facility	$228,431	$186,613	$1,553.95	$1,288.46	-17.1%	$1,923.47	-33.0%
Inpatient Physician	$67,599	$60,469	$459.85	$417.50	-9.2%	$307.01	36.0%
Outpatient Physician	$81,482	$69,633	$554.29	$480.78	-13.3%	$473.36	1.6%
Physician Office	$261,759	$393,005	$1,780.67	$2,713.49	52.4%	$1,496.44	81.3%
Total Physician	$410,841	$523,107	$2,794.82	$3,611.77	29.2%	$2,276.82	58.6%
Total Miscellaneous Services	$60,116	$103,222	$408.95	$712.69	74.3%	$200.81	254.9%
Total All Providers (Excluding Prescription Drugs)	$985,994	$1,269,951	$6,707.45	$8,768.36	30.7%	$6,199.16	41.4%
Total Prescription Drugs	$269,928	$311,638	$1,836.24	$2,151.70	17.2%	$1,732.70	24.2%
Total All Providers	$1,255,922	$1,581,590	$8,543.69	$10,920.06	27.8%	$7,931.86	37.7%

*Incurred date reports are based on dates of service, rather than paid date. The study period is three months prior to the dates used for paid date reports to allow three months of claims payment run-out.

Paid Claims by Type of Service*

Per Member Per Month Basis (PMPM)

Prior Period (Incurred 7/1/12 through 6/30/13)
Current Period (Incurred 7/1/13 through 6/30/14)

Provider Category	Prior Total Paid Claims	Current Total Paid Claims	Prior Total Paid Claims PMPM	Current Total Paid Claims PMPM	Percent Change Paid Claims PMPM	BCBST Paid Claims PMPM	Variance Current vs. BCBST Claims PMPM
Inpatient Facility	$286,607	$457,009	$59.57	$94.07	57.9%	$74.48	26.3%
Outpatient Facility	$228,431	$186,613	$47.48	$38.41	-19.1%	$79.67	-51.8%
Inpatient Physician	$67,599	$60,469	$14.05	$12.45	-11.4%	$12.72	-2.1%
Outpatient Physician	$81,482	$69,633	$16.94	$14.33	-15.4%	$19.61	-26.9%
Physician Office	$261,759	$393,005	$54.41	$80.90	48.7%	$61.99	30.5%
Total Physician	$410,841	$523,107	$85.40	$107.68	26.1%	$94.31	14.2%
Total Miscellaneous Services	$60,116	$103,222	$12.50	$21.25	70.0%	$8.32	155.4%
Total All Providers (Excluding Prescription Drugs)	$985,994	$1,269,951	$204.94	$261.41	27.6%	$256.79	1.8%
Total Prescription Drugs	$269,928	$311,638	$56.11	$64.15	14.3%	$72.10	-11.0%
Total All Providers	$1,255,922	$1,581,590	$261.05	$325.56	24.7%	$328.89	-1.0%

*Incurred date reports are based on dates of service, rather than paid date. The study period is three months prior to the dates used for paid date reports to allow three months of claims payment run-out.