**MINUTES OF THE VAN BUREN COUNTY COMMISSION**
**VAN BUREN COUNTY, TENNESSEE**

The Van Buren County Commission met in a Special Called Meeting on January 31, 2023 at 6:00 p.m. at the Van Buren County Administrative Facility & Justice Center. The following action was taken as recorded in Minute Book, "T".

County Attorney Howard Upchurch was absent, Chairman Terry Hickey called him and he wasn't aware of the Special Called Meeting. After much discussion whether or not to have the meeting Chairman Hickey ask for a show of hands for and against having this meeting without the County Attorney present. Meeting started by call to order.

**Call to Order**
Sheriff Michael Brock called the Meeting to Order.

**Roll Call**
Member present: Michael Chandler, Cale Crain, Jordan Delong, Tabitha Denney, Terry Hickey, Terry Hodges, Dusty Madewell, Kenny Smith, Brick Wall, and Michael Woodlee.

Also present: Mayor David Sullivan, Financial Director Heather Woodlee, County Clerk Lisa Rigsby, Jay Williams with zoom and Several Citizens from Van Buren County.

**Prayer**
Commissioner Dusty Madewell led us in prayer.

**Pledge**
Chairman Terry Hickey led us in the Pledge of Allegiance.

**Approve/Disapprove Health Insurance**
Financial Director Heather Woodlee took the floor to explain the Health Insurance bids from the State and Sprouse Insurance. Mrs. Woodlee explained there were 3 bids for Insurance coverage from Sprouse Insurance. The 1st one is the Silver plan that is already offered to the County Employee with a $7,200.00 deductible with it paying 50% but the premium is going up after March around $6.00 per pay period.

The 2nd one is Gold PPO with a deductible being $2,500.00, at the rate of $644.10 and if the County pays half that would be $322.05 with the employee paying $161.03 each pay period. This will be an 80/20 coverage after the deductible is paid.

The 3rd one is the Platinum PPO with a deducible being $500.00 at the rate of $837.95 and if the County pays half it would be $418.98 with the employee paying $209.49 each pay period. After the deductible is paid it will be a 90/10 coverage.

To be able for the County to even consider taking the State Insurance bid the County would have to have 27 employees to sign up and the County doesn't have the numbers that are interested. The County Highway Department is considered a different entity. Sharon Mooneyham was present from the Highway Department asking for approve for Highway employees to be able to make their own decision whether to take the State Insurance. Michael Woodlee made a motion, second by Cale Crain to approve the Highway Department to go with the State insurance if they so desire to. All agreed by voice vote. No opposed. Motion passed.
**Highway options for Insurance as following:**

Highway

**STATE OF TENNESSEE**
**DEPARTMENT OF FINANCE AND ADMINISTRATION**
**BENEFITS ADMINISTRATION**
**312 Rosa L. Parks Avenue**
**Suite 1900 William R. Snodgrass Tennessee Tower**
**Nashville, Tennessee 37243-1102**
**Phone (615) 741-3590 or (800) 253-9981**
**FAX (615) 253-8556**

**Jim Bryson**
COMMISSIONER

**Laurie Lee**
EXECUTIVE DIRECTOR

1/18/2023

Van Buren County Highway
432 Sullivan Rd.
Spencer, TN 38585

Dear Sharon;

By responding to the survey form, you have indicated an interest in learning more about the Local Government Health Insurance Plan. The purpose of the survey was to gather necessary information from your agency regarding eligible employees so health premiums could be determined. Premiums are determined based on the employee demographics you provided. The monthly premiums for **January-December 2023** are as follows:

| **Type of Coverage** | Premier PPO | Standard PPO | Limited PPO | Local CDHP/HSA |
|---|---|---|---|---|
| Employee Only | $866 | $796 | $647 | $597 |
| Employee + Child(ren) | $1,344 | $1,235 | $1003 | $926 |
| Employee + Spouse | $1,948 | $1,791 | $1,455 | $1,343 |
| Employee + Spouse + Child(ren) | $2,339 | $2,150 | $1,747 | $1,612 |

*If selecting Cigna Open Access Plus or Blue Cross Blue Shield network P, a monthly surcharge applies – $65 for Employee only and Employee-Children $130 for Employee+Spouse and Employee+Spouse+Children

If your group wishes to participate, please return the enclosed Intent to Enroll form, Authorization Agreement for Pre-authorized Payment form, a voided check, retiree election form, and a signed copy of the Memorandum of Understanding. Your agency must provide at least a **60-day notice** before enrolling in the Local Government Plan. Your group will be eligible for coverage effective the first of the next month after the 60-day notice of enrollment as long as 50 percent plus one employee enrolls in the Plan. If your agency has less than 20 employees then 50 percent must enroll in the Plan.

You must offer all health insurance plans to your employees. If your agency enrolls in the Local Government Plan, your agency may not offer any other health options other than the Local Government Plan. An important item to remember is that your agency MUST abide by and enforce all the eligibility criteria of the Plan. Individual agencies are not permitted to determine eligibility. This includes number of hours worked or not offering all health plans. The Plan's provisions are strictly enforced.

The dental and vision insurance coverage are voluntary products and are an additional premium cost.

If at any time, the agency no longer covers any employees for more than 60-days the agency will be terminated from the Local Government Plan and will not be allowed to re-join the plan for at least 24 months. If you have any questions, please call me at 615-761-4264. My email address is jessica.southern@tn.gov.

Sincerely,

Jessica Southern

| STATE INSURANCE<br>BCBS | PREMIER PPPO | STANDARD PPO | LIMITED PPO |
|---|---|---|---|
| PREMIUM MONTH | $866.00 | $796.00 | $647.00 |
| 1/2 MONTHLY | $433.00 | $398.00 | $323.50 |
| PER PAY PERIOD | $216.50 | $199.00 | $161.75 |
| DEDUCTIBLE | $750.00 | $1,300.00 | $1,800.00 |
| AFTER DEDUCTIBLE | 85/15 | 80/20 | 70/30 |
| DR OFFICE COPAY | $25/$45 | $30/$50 | $35/$55 |
| PHARMACY | $7/$40/$90 | $14/$50/$100 | $14/$60/$110 |
| **GENERIC/PREFERRED/NON-PREFERRED | | DENTAL & VISION OFFERED | |

| | PLATINUM PPO | GOLD PPO |
|---|---|---|
| PREMIUM MONTH | $837.62 | $644.10 |
| 1/2 MONTHLY | $418.81 | $322.05 |
| PER PAY PERIOD | $209.41 | $161.03 |
| DEDUCTIBLE | $500 | $2,500.00 |
| AFTER DEDUCTIBLE | 90/10 | 80/20 |
| DR OFFICE COPAY | $20/$40 | $35/$55 |
| PHARMACY | $10/35/50 | $5/20%/40% |
| **GENERIC/PREFERRED/NON-PREFERRED | | DENTAL/VISION " |

**Sprouce Insurance the Silver Plan (This is the current plan that is provided now for 7 County Employees) Listed as following for the record:**

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

December 5, 2022

Group: 130393

Van Buren County
500 College Street
Spencer, TN 38585

Eff 3-1-23
Currently -

Dear Group Administrator,

The Affordable Care Act (ACA) is bringing changes to employee eligibility provisions, and you have let us know that you prefer to determine your employees' eligibility dates yourselves. We're making that update for our 2015 renewals to better meet your needs.

**Effective on your group's renewal on or after Jan. 1, 2015,** you can make eligibility determinations and set effective dates for new employees, employees who have qualifying events and employees whose coverage is terminating. This update applies to all your BlueCross BlueShield of Tennessee products.

**Submitting Employee Information to BlueCross**

Beginning on your 2015 renewal, all you need to do is let us know the employee effective date and the employee hire date on the new employee enrollment you submit to BlueCross. You can send any enrollment changes or terminations through the same channels. You can let us know the effective date and hire date by including them in the designated spots on both the paper forms and on-line enrollment screens.

**Be sure to base any eligibility or termination dates you set on legal guidelines and your health plan's insurance eligibility requirements.** If you have specific questions about your health plan, contact your BlueCross broker or account executive. If you have specific questions about ACA guidelines, talk with your legal counsel.

**Let Us Know If You Have Questions**

We wanted to let you know about this update to our policies in advance and hope it will help you simplify your business' internal processes. If you have questions about this letter, call your BlueCross broker or your sales or account executive.

Best of health,

BCBST Logo

G. Henry Smith
Senior Vice President, Operations and
Chief Marketing Officer

BlueCross BlueShield of Tennessee

An Independent Licensee of the BlueCross BlueShield Association

# EHB Medical Renewal

## Composite Rates

Issued For Larry R. Sprouse
Effective March 1, 2023

Group: Van Buren County

Group ID: 130393

### Plan Information

Effective Date: 03/01/2023
Benefit Date: 03/01/2023
Network: Blue Network S

Business Location: Van buren County
Rep Name: David Lawson III
COBRA: Yes with INL

Rating Area: 7
Employees: 14
Members: 14

| Renewal Plan | Plan Description | Office Visit | Teladoc Health |
|---|---|---|---|
| Silver 152 | $7,200/$8,700/50% | $35 OV / $75 Spec | $0 Copay |
| **Urgent Care** | **IP Hospital** | **Emergency Room** | |
| $75 | Ded/Coin | $750 then Ded/Coin | |
| **Pharmacy** | **Rx Formulary** | | **Monthly Premium** |
| $10/$75/$150 | Essential | | $7,705.98 |

| Current Plan | Plan Description | Office Visit | PhysicianNow |
|---|---|---|---|
| Silver 130 | $7,200/$8,550/50% | $35 OV / $75 Spec | $0 Copay |
| **Urgent Care** | **IP Hospital** | **Emergency Room** | |
| $75 | Ded/Coin | $500 then Ded/Coins | |
| **Pharmacy** | **Rx Formulary** | | |
| $10/$75/$150 | Essential | | |

### Composite Rate Information

| Tier | Counts | Current Rates | Renewal Rates |
|---|---|---|---|
| Employee Only | 14 | $527.66 | $550.43 |
| Employee/Spouse | 0 | $1,055.31 | $1,100.85 |
| Employee/Child | 0 | $976.16 | $1,018.29 |
| Family | 0 | $1,503.82 | $1,568.72 |

½ Employer 275.00 | Employee 138.00 per check

**Monthly Premium: $7,706.02**
****Total Increase: 4.3%**

**Base Plan Increase: 2.5%**
**Demographic Increase: 1.8%**

Commission Disclosure: The rates presented in this proposal include standard commissions, and may include additional compensation. If you have questions, please contact your broker or BCBST representative.

- EHB composite rate quotes should be submitted to the home office prior to the effective/renewal date. Composite rating may not be available for late submissions.
- Rates are not final until confirmed by BCBST home office.
- COBRA Admin charge of $0.33 is included in the member rate.
- Benefit Administration Period is from January through December.
- This is not a grandfathered health plan, as permitted by the ACA.
- 50% of net eligible employees must be enrolled (employees w/ other coverage are excluded from the calculation)
- No minimum employer contribution required.
- Rates and benefits offered are based on employer attestation of group size, if provided. If employer attestation not provided,

rates and benefits are based on the information provided during the prior calendar year.
- MLR Survey Results: Small.
- BlueCross BlueShield of Tennessee assumes that your plan meets the requirements to be considered Minimum Essential Coverage. If this is not accurate, please inform us immediately. The Minimum Value (MV) statement included on this plan's SBC is based on proposed rules, the MV calculator on the CMS website, and benefits administered by BCBST. The determination of MV is ultimately an employer or plan sponsor responsibility. You may contact a third party such as an actuarial consulting firm for a review if you disagree with our indication.
- BLUECROSS BLUESHIELD OF TENNESSEE DOES NOT CONDUCT NONDISCRIMINATION TESTING REQUIRED PURSUANT TO IRS RULES.

** Total Increase: 1.02503 * 1.01768 = 1.04315 => 0.04315 (Subject to Rounding)

Essential Health Benefits: Yes | Minimum Essential Coverage: Yes | Minimum Value: Yes | Status / Quote: Pending / 106

**Sprouse Insurance BCBS**

| | **Platinum PPO** | **Gold PPO** |
|---|---|---|
| **Premium month** | **$837.62** | **$644.10** |
| **Deductible** | **$500.00** | **$2,500.00** |
| **After Deductible** | **90/10** | **80/20** |
| **Dr. Office Copay** | **$20/40** | **$35/55** |
| **Pharmacy** | **$10/35/50** | **$5/20/40** |

After much discussion on this matter, the above options will be offered to the County Employees to choose what plan that will best suit their lifestyles and will take effect March 1, 2023. Tabitha Denney made a motion, second by Terry Hodges that the County no matter which plan the employee chooses the County will pay $322.05 per month, per employee.

Upon roll call: Michael Chandler, Cale Crain, Jordan Delong, Tabitha Denney, Terry Hickey, Terry Hodges, Dusty Madewell, Kenny Smith, Brick Wall and Michael Woodlee voted yes. No changes to any yes vote. Motion passed**. Health Insurance Policies are as following for the record:**

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

**Van Buren County Government**
Benefit Summary

Effective Date: 03/01/2023
Network: Blue Network S

**SG Platinum 35S ($500/$2000/90%)**

| Benefit Plan Features | Your Cost In-Network | Your Cost Out-Of-Network [1] |
|---|---|---|
| **Annual Deductible** | | |
| Individual/Family | $500 / $1,000 | $1,000 / $2,000 |
| **Annual Out-of-Pocket Maximum** (includes copays, coinsurance and deductibles) | | |
| Individual/Family | $2,000 / $4,000 | $6,000 / $12,000 |
| **Covered Services** | | |
| **Preventive Care Services** [13] (See Page 3 for a list) | Covered at 100% | 50% after Deductible |
| **Practitioner Office Services** | | |
| Primary Care Office Visits [2] | $20 Copay | 50% after Deductible |
| Specialist Office Visits | $40 Copay | 50% after Deductible |
| Office Surgery [4, 5, 6] | 10% after Deductible | 50% after Deductible |
| Routine Diagnostic Lab, X-Ray & Injections | $25 Copay | 50% after Deductible |
| Advanced Radiological Imaging [3, 5, 7] | $150 Copay | 50% after Deductible |
| **Teladoc Health Virtual Care** | Covered at 100% | Not Covered |
| **Services Received at a Facility** (includes professional and facility charges) | | |
| Inpatient Services [3, 5] | 10% after Deductible | 50% after Deductible |
| Outpatient Surgery [4, 5, 6] | 10% after Deductible | 50% after Deductible |
| Routine Diagnostic Services - Outpatient | $25 Copay | 50% after Deductible |
| Advanced Radiological Imaging - Outpatient [3, 5, 7] | $150 Copay | 50% after Deductible |
| Other Outpatient Services [8] | 10% after Deductible | 50% after Deductible |
| Urgent Care Center Services | $40 Copay | 50% after Deductible |
| Emergency Care Services [10] | $150 Copay | $150 Copay |
| Emergency Care Advanced Radiological Imaging [7] | $150 Copay | $150 Copay |
| **Skilled Nursing & Rehabilitation Facility Services** [3, 5] Limited to 60 days combined per annual benefit period | 10% after Deductible | 50% after Deductible |
| **Medical Equipment** [4, 5] | | |
| Durable Medical Equipment | 10% after Deductible | 50% after Deductible |
| Prosthetics or Orthotics | 10% after Deductible | 50% after Deductible |
| Hearing Aids [22] | 10% after Deductible | 50% after Deductible |
| **Behavioral Health Services** | | |
| Inpatient: Unlimited days per annual benefit period [3, 5] | 10% after Deductible | 50% after Deductible |
| Outpatient: Unlimited days per annual benefit period [14, 18] | $20 Copay | 50% after Deductible |
| **Therapy Services** | | |
| Rehabilitative [4, 5, 9] & Habilitative [4, 5, 21] Limits apply; See footnotes | 10% after Deductible | 50% after Deductible |

| Covered Services (continued) | | |
|---|---|---|
| **Home Health Care Services** [4, 5, 9, 21] | 10% after Deductible | 50% after Deductible |
| **Hospice Services** [5, 23] | Covered at 100% | 50% after Deductible |
| **Ambulance Services** [4] | 10% after Deductible | 10% after Deductible |
| **Prescription Drugs** [4, 11, 12, 16, 20] | | |
| **Prescription Contraceptives** [16] | Covered at 100% | 50% after Deductible |
| **Retail Network, Plus90 or Home Delivery Network** [15] | | |
| Generic | $10 Copay | 50% after Deductible |
| Preferred | $35 Copay | 50% after Deductible |
| Non-Preferred | $50 Copay | 50% after Deductible |
| **Self-administered Specialty Drugs** [17, 24] | | |
| Specialty Pharmacy Network | 50% | Not Covered |
| **Provider-administered Specialty Drugs** [4, 17] | | |
| Specialty Pharmacy Network | 50% | Not Covered |

**Notes:**

1. Out-of-network benefits may be based on BlueCross BlueShield of Tennessee maximum allowable charge. You may be responsible for any unpaid billed charges for certain services received from out-of-network providers. For emergency care services received at an out-of-network facility, covered items and services received from an out-of-network provider at an in-network facility (unless you give certain providers written consent), or emergent and authorized air ambulance services, in-network benefits including deductible will apply up to the qualified payment amount, and the provider may not bill you for more than your in-network cost share.
2. The lower copay applies to Family Medicine, General Practice, General Internal Medicine, OB/GYN, Pediatrics, and Behavioral Health services. The copay for Physician Assistants or Nurse Practitioners may be based on the provider type of the billing provider.
3. Prior authorization is required.
4. Certain procedures, services, medication and equipment may require prior authorization.
5. If prior authorization is required but not obtained and services are medically necessary, when using network providers outside Tennessee for physician and outpatient services and all services from out-of-network providers, benefits will be reduced to 60%. If services are not medically necessary, no benefits will be provided.
6. Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures and invasive diagnostic services(e.g. colonoscopy, sigmoidoscopy and endoscopy for non-preventive purposes).
7. Includes CT scans, PET scans, MRIs, nuclear medicine and other similar technologies.
8. Includes services such as chemotherapy, infusions, injections, radiation therapy and renal dialysis.
9. Physical, speech, acupuncture, spinal manipulation and occupational therapies are limited to 20 visits per therapy type per annual benefit period. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per annual benefit period.
10. Copay, if applicable, waived if admitted to hospital.
11. Visit www.bcbst.com/rx for the Essential Formulary which includes specialty drugs.
12. Copay, if applicable, applied per prescription, up to a 30 day supply.
13. Services include annual physical, childhood immunizations, recommended adult immunizations and vision and hearing screenings performed by the physician during the preventive health exam.
14. Outpatient behavioral health benefits are determined by place of service. Benefits displayed are for services received in an office setting; separate benefits may apply for outpatient services received in an alternate setting.
15. Your plan requires you to receive long-term medications in a 90 day supply from home delivery or at a retail pharmacy in the Plus90 Network. If You continue to refill a Prescription that a Practitioner will prescribe in a ninety (90) day supply at a non-Plus90 Network Pharmacy after the third fill, Your claim will be denied. Visit www.bcbst.com/rx to find a list of pharmacies in the Plus90 Network.

2

16. Certain prescription drugs are covered at 100% at network pharmacies, in accordance with the Preventive Services provision of the Affordable Care Act and are identified on the drug formulary with an "ACA" indicator. Visit www.bcbst.com/rx for the Essential Formulary.
17. You have a distinct network for self-administered specialty drugs and provider-administered specialty drugs. To receive benefits, you must use a Specialty Pharmacy Network provider. Visit www.bcbst.com/rx for a list of providers in the Specialty Pharmacy Network. Self-administered specialty drugs are limited to a 30 day supply.
18. If applicable, the office visit copay limit applies to office visits for medical and behavioral health conditions combined.
19. If applicable, this plan provides copays for preventive care medications instead of having to meet your plan's deductible for certain prescription drugs. This list contains some of the most commonly prescribed preventive care drugs and is not all-inclusive. Visit www.bcbst.com/rx for the Essential Plus Formulary.
20. A financial penalty may be applied if you choose a brand name drug when a generic equivalent is available. Please refer to your Evidence of Coverage (EOC) for specific information.
21. Therapy Services - Habilitative: Physical, speech and occupational therapies are limited to 20 visits per therapy type per annual benefit period.
22. Limited to 1 per ear every 3 years.
23. Inpatient Hospice requires prior authorization.
24. If you receive Copay Assistance that discounts the cost of certain Specialty Drugs, the Plan may reduce the benefits it provides in proportion to the amount of the Copay Assistance. Additionally, the Plan may exclude from accumulation toward any Deductible or Out-of-Pocket Maximum the value of any Copay Assistance applied to any Copayment, Deductible and/or Coinsurance that the Plan would require you to pay if you did not receive the Copay Assistance.

**Limitations and Exclusions.** These pages summarize the benefits of your health care plan. Your Evidence of Coverage (EOC) defines the full terms and conditions in greater detail. Should any questions arise concerning benefits, the EOC will govern. For a complete list of limitations and exclusions, please refer to your EOC.

Quote #: 108 - Van Buren County Government

# Summary of Preventive Care Services
# Covered at 100%

**In-network preventive care services that are covered with no member cost share include, but are not limited to:**

- Primary care services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention (CDC)
- Bright Futures recommendations for infants, children and adolescents that are supported by the Health Resources and Services Administration (HRSA)
- Preventive care and screening for women as provided in the guidelines supported by HRSA

**The following preventive care services are covered (not an all-inclusive list).**
**Coverage of some services may depend on age and/or risk exposure.**

**All Members:**

- One preventive health exam per annual benefit period; more frequent preventive exams are covered for children up to age 3
- All standard immunizations adopted by the CDC
- Screening for colorectal cancer (age 45 – 75), high cholesterol and lipids (age 45 and older for women; age 35 and older for men), high blood pressure, obesity, diabetes and depression (age 12 and older)
- Screening for lung cancer for adults (age 50 - 80) who have a 20 pack-year smoking history and either currently smoke or have quit within the past 15 years, per annual benefit period
- Screening for HIV and certain sexually transmitted diseases and counseling for the prevention of sexually transmitted diseases
- Screening and counseling in primary care setting for alcohol misuse and tobacco use; alcohol misuse and tobacco cessation counseling limited to 8 visits per type per annual benefit period
- Dietary counseling for adults with hyperlipidemia, hypertension, type 2 diabetes, obesity, coronary artery disease and/or congestive heart failure; limited to 12 visits per annual benefit period
- One retinopathy screening for diabetics per annual benefit period
- Hemoglobin (A1C) testing

**Women:**

- Well-woman visit, including annual sexually transmitted infection (STI) counseling and annual domestic violence screening & counseling per annual benefit period
- Cervical Cancer Screening per annual benefit period
- Screening of pregnant women for iron deficiency, bacteriuria, hepatitis B virus, Rh factor incompatibility, gestational diabetes
- Breastfeeding support/counseling and supplies, including lactation support services and counseling by a trained provider and one breast pump per pregnancy
- Counseling women at high risk of breast cancer for chemoprevention, including risks and benefits
- Mammography screening (age 40 and older) and genetic counseling and, if indicated after counseling, BRCA testing for BRCA breast cancer gene
- Osteoporosis screening (age 60 and older)
- HPV testing once every 3 years, beginning at age 30
- FDA-approved contraceptive methods and counseling
  Medical plan: Injectable or implantable contraceptives and barrier methods, sterilization for women
  Rx plan: Generic oral & injectable contraceptives, vaginal contraceptive, patch, prescription emergency contraception

**Men:**

- Prostate cancer screening (age 50 and older)
- One-time abdominal aortic aneurysm screening (age 65 – 75 for men who have ever smoked)

**Children:**

- Newborn screening for hearing, phenylketonuria (PKU), thyroid disease, sickle cell anemia and cystic fibrosis
- Development delays and autism screening
- Iron deficiency screening

**Pediatric Dental**[2]

| Benefit Plan Features | Your Cost In-Network | Your Cost Out-Of-Network[1] |
|---|---|---|
| **Coverage A** | | |
| Diagnostic and Preventive Services<br>Exams<br>Cleanings<br>X-rays | No Member Cost Share | No Member Cost Share |
| **Coverage B** | | |
| Basic Restorative Services<br>Basic Endodontics and Periodontics<br>Oral Surgery | 20% | 20% |
| **Coverage C** | | |
| Major Restorative and Prosthodontics<br>Major Endodontics and Periodontics<br>Implants | 50% | 50% |
| **Coverage D** (Requires Prior Authorization)<br>Medically Necessary Orthodontia | 10% after Deductible | 50% after Deductible |

**Pediatric Vision**[2]

| Benefit Plan Features | Your Cost In-Network | Your Cost Out-Of-Network[1] |
|---|---|---|
| **Exams**[3]<br>Comprehensive Eye Exam<br>Contact Lens Fitting and Follow-up (Limited to two) | No Member Cost Share | 40% |
| **Frames**[4]<br>Designated available frame at provider location | No Member Cost Share | 40% |
| **Standard Lenses (Glass or Plastic)**[3,4]<br>Single<br>Bifocal<br>Trifocal<br>Lenticular<br>Standard Progressive | No Member Cost Share | 40% |
| **Lens Options**[3,4]<br>Standard Polycarbonate<br>UV Treatment<br>Tint<br>Standard Plastic Scratch Coating<br>Photocromatic/Transitions Plastic | No Member Cost Share | 40% |
| **Contacts (includes materials only)**[3,4]<br>Extended Wear/Extended Wear Disposables<br>Daily Wear/Disposables | No Member Cost Share | 40% |

**Notes:**

1. Out-of-network benefit payment based on maximum allowable charge. You are responsible for paying any amount exceeding the maximum allowable charge.
2. Coverage for members under age 19 only.
3. Vision Exams, eyeglass frames and lenses and contact lenses are covered once every annual benefit period. Prescription Sunglasses will be handled as any other lens.

4. Certain restrictions apply.

**Limitations and Exclusions.** These pages summarize the benefits of your health care plan. Your Evidence of Coverage (EOC) defines the full terms and conditions in greater detail. Should any questions arise concerning benefits, the EOC will govern. For a complete list of limitations and exclusions, please refer to your EOC.

Quote #: 108 - Van Buren County Government

## Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

If you need these services, contact a consumer advisor at the number on the back of your Member ID card (for TTY help, call 1-800-848-0298 or 711).

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

# BlueCross BlueShield of Tennessee

An Independent Licensee of the BlueCross BlueShield Association

# EHB Medical Renewal

## Composite Rates

Issued For Larry R. Sprouse
Effective March 1, 2023

**Group: Van Buren County Government** — **Group ID: 130393**

## Plan Information

Effective Date: 03/01/2023
Benefit Date: 03/01/2023
Network: Blue Network S

Business Location: Van buren County
Rep Name: David Lawson III
COBRA: Yes with INL

Rating Area: 7
Employees: 14
Members: 14

| Renewal Plan | Plan Description | Office Visit | Teladoc Health |
|---|---|---|---|
| Platinum 35 | $500/$2,000/90% | $20 OV / $40 Spec | $0 Copay |
| **Urgent Care** | **IP Hospital** | **Emergency Room** | |
| $40 | Ded/Coin | $150 | |
| **Pharmacy** | **Rx Formulary** | | **Monthly Premium** |
| $10/$35/$50 | Essential | | $11,731.23 |

## Composite Rate Information

| Tier | Counts | Medical Rate | Cobra Admin | Total Rate |
|---|---|---|---|---|
| Employee Only | 14 | $837.62 | $0.33 | $837.95 |
| Employee/Spouse | 0 | $1,675.23 | $0.66 | $1,675.89 |
| Employee/Child | 0 | $1,549.59 | $0.61 | $1,550.20 |
| Family | 0 | $2,387.20 | $0.94 | $2,388.14 |
| | | | **Monthly Premium :** | **$11,731.30** |

½ Employer 418.98/mth | Employee 209.49 per one

Commission Disclosure: The rates presented in this proposal include standard commissions, and may include additional compensation. If you have questions, please contact your broker or BCBST representative.

- EHB composite rate quotes should be submitted to the home office prior to the effective/renewal date. Composite rating may not be available for late submissions.
- Rates are not final until confirmed by BCBST home office.
- COBRA Admin charge of $0.33 is included in the member rate.
- Benefit Administration Period is from January through December.
- This is not a grandfathered health plan, as permitted by the ACA.
- 50% of net eligible employees must be enrolled (employees w/ other coverage are excluded from the calculation)
- No minimum employer contribution required.
- Rates and benefits offered are based on employer attestation of group size, if provided. If employer attestation not provided, rates and benefits are based on the information provided during the prior calendar year.
- MLR Survey Results: Small.
- BlueCross BlueShield of Tennessee assumes that your plan meets the requirements to be considered Minimum Essential Coverage. If this is not accurate, please inform us immediately. The Minimum Value (MV) statement included on this plan's SBC is based on proposed rules, the MV calculator on the CMS website, and benefits administered by BCBST. The determination of MV is ultimately an employer or plan sponsor responsibility. You may contact a third party such as an actuarial consulting firm for a review if you disagree with our indication.
- BLUECROSS BLUESHIELD OF TENNESSEE DOES NOT CONDUCT NONDISCRIMINATION TESTING REQUIRED PURSUANT TO IRS RULES.

Essential Health Benefits: Yes | Minimum Essential Coverage: Yes | Minimum Value: Yes | Status / Quote: Pending / 108

BlueCross BlueShield
of Tennessee
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**Van Buren County Government**
Benefit Summary
**SG Gold 109S ($2500/$7000/80%)**

Effective Date: 03/01/2023
Network: Blue Network S

| Benefit Plan Features | Your Cost In-Network | Your Cost Out-Of-Network [1] |
|---|---|---|
| **Annual Deductible** | | |
| Individual/Family | $2,500 / $5,000 | $5,000 / $10,000 |
| **Annual Out-of-Pocket Maximum** (includes copays, coinsurance and deductibles) | | |
| Individual/Family | $7,000 / $14,000 | $21,000 / $42,000 |
| **Covered Services** | | |
| **Preventive Care Services** [13] (See Page 3 for a list) | Covered at 100% | 50% after Deductible |
| **Practitioner Office Services** | | |
| Primary Care Office Visits [2] | $35 Copay | 50% after Deductible |
| Specialist Office Visits | $55 Copay | 50% after Deductible |
| Office Surgery [4, 5, 6] | 20% after Deductible | 50% after Deductible |
| Routine Diagnostic Lab, X-Ray & Injections | $25 Copay | 50% after Deductible |
| Advanced Radiological Imaging [3, 5, 7] | 20% after Deductible | 50% after Deductible |
| **Teladoc Health Virtual Care** | Covered at 100% | Not Covered |
| **Services Received at a Facility** (includes professional and facility charges) | | |
| Inpatient Services [3, 5] | $600 Copay | 50% after Deductible |
| Outpatient Surgery [4, 5, 6] | 20% after Deductible | 50% after Deductible |
| Routine Diagnostic Services - Outpatient | $25 Copay | 50% after Deductible |
| Advanced Radiological Imaging - Outpatient [3, 5, 7] | 20% after Deductible | 50% after Deductible |
| Other Outpatient Services [6] | 20% after Deductible | 50% after Deductible |
| Urgent Care Center Services | $55 Copay | 50% after Deductible |
| Emergency Care Services [10] | $750 Copay then 20% after Deductible | $750 Copay then 20% after Deductible |
| Emergency Care Advanced Radiological Imaging [7] | 20% after Deductible | 20% after Deductible |
| **Skilled Nursing & Rehabilitation Facility Services** [3, 5] | | |
| Limited to 60 days combined per annual benefit period | 20% after Deductible | 50% after Deductible |
| **Medical Equipment** [4, 5] | | |
| Durable Medical Equipment | 20% after Deductible | 50% after Deductible |
| Prosthetics or Orthotics | 20% after Deductible | 50% after Deductible |
| Hearing Aids [22] | 20% after Deductible | 50% after Deductible |
| **Behavioral Health Services** | | |
| Inpatient: Unlimited days per annual benefit period [3, 5] | $600 Copay | 50% after Deductible |
| Outpatient: Unlimited days per annual benefit period [14, 18] | $35 Copay | 50% after Deductible |
| **Therapy Services** | | |
| Rehabilitative [4, 5, 9] & Habilitative [4, 5, 21] Limits apply; See footnotes | 20% after Deductible | 50% after Deductible |

| Covered Services (continued) | | |
|---|---|---|
| **Home Health Care Services** [4, 5, 9, 21] | 20% after Deductible | 50% after Deductible |
| **Hospice Services** [5, 23] | Covered at 100% | 50% after Deductible |
| **Ambulance Services** [4] | 20% after Deductible | 20% after Deductible |
| **Prescription Drugs** [4, 11, 12, 16, 20] | | |
| **Prescription Contraceptives** [16] | Covered at 100% | 50% after Deductible |
| **Retail Network, Plus90 or Home Delivery Network** [15] | | |
| Generic | $5 Copay | 50% after Deductible |
| Preferred | 20% | 50% after Deductible |
| Non-Preferred | 40% | 50% after Deductible |
| **Self-administered Specialty Drugs** [17, 24] | | |
| Specialty Pharmacy Network | 40% | Not Covered |
| **Provider-administered Specialty Drugs** [4, 17] | | |
| Specialty Pharmacy Network | 40% | Not Covered |

**Notes:**

1. Out-of-network benefits may be based on BlueCross BlueShield of Tennessee maximum allowable charge. You may be responsible for any unpaid billed charges for certain services received from out-of-network providers. For emergency care services received at an out-of-network facility, covered items and services received from an out-of-network provider at an in-network facility (unless you give certain providers written consent), or emergent and authorized air ambulance services, in-network benefits including deductible will apply up to the qualified payment amount, and the provider may not bill you for more than your in-network cost share.
2. The lower copay applies to Family Medicine, General Practice, General Internal Medicine, OB/GYN, Pediatrics, and Behavioral Health services. The copay for Physician Assistants or Nurse Practitioners may be based on the provider type of the billing provider.
3. Prior authorization is required.
4. Certain procedures, services, medication and equipment may require prior authorization.
5. If prior authorization is required but not obtained and services are medically necessary, when using network providers outside Tennessee for physician and outpatient services and all services from out-of-network providers, benefits will be reduced to 60%. If services are not medically necessary, no benefits will be provided.
6. Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures and invasive diagnostic services(e.g. colonoscopy, sigmoidoscopy and endoscopy for non-preventive purposes).
7. Includes CT scans, PET scans, MRIs, nuclear medicine and other similar technologies.
8. Includes services such as chemotherapy, infusions, injections, radiation therapy and renal dialysis.
9. Physical, speech, acupuncture, spinal manipulation and occupational therapies are limited to 20 visits per therapy type per annual benefit period. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per annual benefit period.
10. Copay, if applicable, waived if admitted to hospital.
11. Visit www.bcbst.com/rx for the Essential Formulary which includes specialty drugs.
12. Copay, if applicable, applied per prescription, up to a 30 day supply.
13. Services include annual physical, childhood immunizations, recommended adult immunizations and vision and hearing screenings performed by the physician during the preventive health exam.
14. Outpatient behavioral health benefits are determined by place of service. Benefits displayed are for services received in an office setting; separate benefits may apply for outpatient services received in an alternate setting.
15. Your plan requires you to receive long-term medications in a 90 day supply from home delivery or at a retail pharmacy in the Plus90 Network. If You continue to refill a Prescription that a Practitioner will prescribe in a ninety (90) day supply at a non-Plus90 Network Retail Network Pharmacy after the third fill, Your claim will be denied. Visit www.bcbst.com/rx to find a list of pharmacies in the Plus90 Network.

16. Certain prescription drugs are covered at 100% at network pharmacies, in accordance with the Preventive Services provision of the Affordable Care Act and are identified on the drug formulary with an "ACA" indicator. Visit www.bcbst.com/rx for the Essential Formulary.
17. You have a distinct network for self-administered specialty drugs and provider-administered specialty drugs. To receive benefits, you must use a Specialty Pharmacy Network provider. Visit www.bcbst.com/rx for a list of providers in the Specialty Pharmacy Network. Self-administered specialty drugs are limited to a 30 day supply.
18. If applicable, the office visit copay limit applies to office visits for medical and behavioral health conditions combined.
19. If applicable, this plan provides copays for preventive care medications instead of having to meet your plan's deductible for certain prescription drugs. This list contains some of the most commonly prescribed preventive care drugs and is not all-inclusive. Visit www.bcbst.com/rx for the Essential Plus Formulary.
20. A financial penalty may be applied if you choose a brand name drug when a generic equivalent is available. Please refer to your Evidence of Coverage (EOC) for specific information.
21. Therapy Services - Habilitative: Physical, speech and occupational therapies are limited to 20 visits per therapy type per annual benefit period.
22. Limited to 1 per ear every 3 years.
23. Inpatient Hospice requires prior authorization.
24. If you receive Copay Assistance that discounts the cost of certain Specialty Drugs, the Plan may reduce the benefits it provides in proportion to the amount of the Copay Assistance. Additionally, the Plan may exclude from accumulation toward any Deductible or Out-of-Pocket Maximum the value of any Copay Assistance applied to any Copayment, Deductible and/or Coinsurance that the Plan would require you to pay if you did not receive the Copay Assistance.

**Limitations and Exclusions.** These pages summarize the benefits of your health care plan. Your Evidence of Coverage (EOC) defines the full terms and conditions in greater detail. Should any questions arise concerning benefits, the EOC will govern. For a complete list of limitations and exclusions, please refer to your EOC.

Quote #: 107 - Van Buren County Government

# Summary of Preventive Care Services
# Covered at 100%

**In-network preventive care services that are covered with no member cost share include, but are not limited to:**

- Primary care services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention (CDC)
- Bright Futures recommendations for infants, children and adolescents that are supported by the Health Resources and Services Administration (HRSA)
- Preventive care and screening for women as provided in the guidelines supported by HRSA

**The following preventive care services are covered (not an all-inclusive list).**
**Coverage of some services may depend on age and/or risk exposure.**

**All Members:**

- One preventive health exam per annual benefit period; more frequent preventive exams are covered for children up to age 3
- All standard immunizations adopted by the CDC
- Screening for colorectal cancer (age 45 – 75), high cholesterol and lipids (age 45 and older for women; age 35 and older for men), high blood pressure, obesity, diabetes and depression (age 12 and older)
- Screening for lung cancer for adults (age 50 - 80) who have a 20 pack-year smoking history and either currently smoke or have quit within the past 15 years, per annual benefit period
- Screening for HIV and certain sexually transmitted diseases and counseling for the prevention of sexually transmitted diseases
- Screening and counseling in primary care setting for alcohol misuse and tobacco use; alcohol misuse and tobacco cessation counseling limited to 8 visits per type per annual benefit period
- Dietary counseling for adults with hyperlipidemia, hypertension, type 2 diabetes, obesity, coronary artery disease and/or congestive heart failure; limited to 12 visits per annual benefit period
- One retinopathy screening for diabetics per annual benefit period
- Hemoglobin (A1C) testing

**Women:**

- Well-woman visit, including annual sexually transmitted infection (STI) counseling and annual domestic violence screening & counseling per annual benefit period
- Cervical Cancer Screening per annual benefit period
- Screening of pregnant women for iron deficiency, bacteriuria, hepatitis B virus, Rh factor incompatibility, gestational diabetes
- Breastfeeding support/counseling and supplies, including lactation support services and counseling by a trained provider and one breast pump per pregnancy
- Counseling women at high risk of breast cancer for chemoprevention, including risks and benefits
- Mammography screening (age 40 and older) and genetic counseling and, if indicated after counseling, BRCA testing for BRCA breast cancer gene
- Osteoporosis screening (age 60 and older)
- HPV testing once every 3 years, beginning at age 30
- FDA-approved contraceptive methods and counseling
  Medical plan: Injectable or implantable contraceptives and barrier methods, sterilization for women
  Rx plan: Generic oral & injectable contraceptives, vaginal contraceptive, patch, prescription emergency contraception

**Men:**

- Prostate cancer screening (age 50 and older)
- One-time abdominal aortic aneurysm screening (age 65 – 75 for men who have ever smoked)

**Children:**

- Newborn screening for hearing, phenylketonuria (PKU), thyroid disease, sickle cell anemia and cystic fibrosis
- Development delays and autism screening
- Iron deficiency screening

**Pediatric Dental**[2]

| Benefit Plan Features | Your Cost In-Network | Your Cost Out-Of-Network[1] |
|---|---|---|
| **Coverage A** | | |
| Diagnostic and Preventive Services<br>Exams<br>Cleanings<br>X-rays | No Member Cost Share | No Member Cost Share |
| **Coverage B** | | |
| Basic Restorative Services<br>Basic Endodontics and Periodontics<br>Oral Surgery | 20% | 20% |
| **Coverage C** | | |
| Major Restorative and Prosthodontics<br>Major Endodontics and Periodontics<br>Implants | 50% | 50% |
| **Coverage D** (Requires Prior Authorization)<br>Medically Necessary Orthodontia | 20% after Deductible | 50% after Deductible |

**Pediatric Vision**[2]

| Benefit Plan Features | Your Cost In-Network | Your Cost Out-Of-Network[1] |
|---|---|---|
| **Exams**[3]<br>Comprehensive Eye Exam<br>Contact Lens Fitting and Follow-up (Limited to two) | No Member Cost Share | 40% |
| **Frames**[4]<br>Designated available frame at provider location | No Member Cost Share | 40% |
| **Standard Lenses (Glass or Plastic)**[3,4]<br>Single<br>Bifocal<br>Trifocal<br>Lenticular<br>Standard Progressive | No Member Cost Share | 40% |
| **Lens Options**[3,4]<br>Standard Polycarbonate<br>UV Treatment<br>Tint<br>Standard Plastic Scratch Coating<br>Photocromatic/Transitions Plastic | No Member Cost Share | 40% |
| **Contacts (includes materials only)**[3,4]<br>Extended Wear/Extended Wear Disposables<br>Daily Wear/Disposables | No Member Cost Share | 40% |

**Notes:**

1. Out-of-network benefit payment based on maximum allowable charge. You are responsible for paying any amount exceeding the maximum allowable charge.
2. Coverage for members under age 19 only.
3. Vision Exams, eyeglass frames and lenses and contact lenses are covered once every annual benefit period. Prescription Sunglasses will be handled as any other lens.

4. Certain restrictions apply.

**Limitations and Exclusions.** These pages summarize the benefits of your health care plan. Your Evidence of Coverage (EOC) defines the full terms and conditions in greater detail. Should any questions arise concerning benefits, the EOC will govern. For a complete list of limitations and exclusions, please refer to your EOC.

Quote #: 107 - Van Buren County Government

## Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

If you need these services, contact a consumer advisor at the number on the back of your Member ID card (for TTY help, call 1-800-848-0298 or 711).

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

# BlueCross BlueShield of Tennessee

An Independent Licensee of the BlueCross BlueShield Association

# EHB Medical Renewal

Composite Rates
Issued For Larry R. Sprouse
Effective March 1, 2023

Group: Van Buren County Government — Group ID: 130393

## Plan Information

Effective Date: 03/01/2023
Benefit Date: 03/01/2023
Network: Blue Network S

Business Location: Van buren County
Rep Name: David Lawson III
COBRA: Yes with INL

Rating Area: 7
Employees: 14
Members: 14

| Renewal Plan | Plan Description | Office Visit | Teladoc Health |
|---|---|---|---|
| Gold 109 | $2,500/$7,000/80% | $35 OV / $55 Spec | $0 Copay |
| Urgent Care | IP Hospital | Emergency Room | |
| $55 | $600 | $750 then Ded/Coin | |
| Pharmacy | Rx Formulary | | Monthly Premium |
| $5/20%/40% | Essential | | $9,017.34 |

## Composite Rate Information

| Tier | Counts | Medical Rate | Cobra Admin | Total Rate |
|---|---|---|---|---|
| Employee Only | 14 | $643.77 | $0.33 | $644.10 |
| Employee/Spouse | 0 | $1,287.53 | $0.66 | $1,288.19 |
| Employee/Child | 0 | $1,190.97 | $0.61 | $1,191.58 |
| Family | 0 | $1,834.73 | $0.94 | $1,835.67 |
| | | | **Monthly Premium :** | **$9,017.40** |

Employer 322.05 monthly | Employee 161.03 per check

Commission Disclosure: The rates presented in this proposal include standard commissions, and may include additional compensation. If you have questions, please contact your broker or BCBST representative.

- EHB composite rate quotes should be submitted to the home office prior to the effective/renewal date. Composite rating may not be available for late submissions.
- Rates are not final until confirmed by BCBST home office.
- COBRA Admin charge of $0.33 is included in the member rate.
- Benefit Administration Period is from January through December.
- This is not a grandfathered health plan, as permitted by the ACA.
- 50% of net eligible employees must be enrolled (employees w/ other coverage are excluded from the calculation)
- No minimum employer contribution required.
- Rates and benefits offered are based on employer attestation of group size, if provided. If employer attestation not provided, rates and benefits are based on the information provided during the prior calendar year.
- MLR Survey Results: Small.
- BlueCross BlueShield of Tennessee assumes that your plan meets the requirements to be considered Minimum Essential Coverage. If this is not accurate, please inform us immediately. The Minimum Value (MV) statement included on this plan's SBC is based on proposed rules, the MV calculator on the CMS website, and benefits administered by BCBST. The determination of MV is ultimately an employer or plan sponsor responsibility. You may contact a third party such as an actuarial consulting firm for a review if you disagree with our indication.
- BLUECROSS BLUESHIELD OF TENNESSEE DOES NOT CONDUCT NONDISCRIMINATION TESTING REQUIRED PURSUANT TO IRS RULES.

Essential Health Benefits: Yes | Minimum Essential Coverage: Yes | Minimum Value: Yes | Status / Quote: Pending / 107

**Approve/Disapprove Old Solid Waste Truck Repair**

The Solid Waste 2001 Freightliner rollback needs work done and a new transmission. The full Commission was presented a bid but did not have the total amount included. After discussion on this matter, Cale Crain made a motion, second by Dusty Madewell to push this matter back to Committee A when we have more numbers from the mechanic. All agreed by voice vote. No opposed. Motion passed.

**Approve/Disapprove Solid Waste Budget Amendment**

Financial Director Heather Woodlee was present to explain to the Full Commission the need for a budget amendment in Solid Waste. Mrs. Woodlee stated, “We have two more pay periods left and not enough funds to cover till June 30, 2023.” The 2021/2022 budget did not have enough put into this line item for employees, Medicare and social security so she is needing an amendment from the Fund Balance to Solid Waste. Cale Crain made a motion, second by Michael Chandler to approve this budget amendment as presented.

Upon roll call: Michael Chandler, Cale Crain, Jordan Delong, Tabitha Denney, Terry Hickey, Terry Hodges, Dusty Madewell, Kenny Smith, Brick Wall, and Michael Woodlee voted yes. No changes to any yes vote. Motion passed**. Budget Amendment as following:**

**Van Buren Co. Executive** **General Fund**

**2022-2023** **BUDGET AMENDMENT** **FUND 116**

| Function | Obj. | Description | Explanation | Debit | Credit |
|---|---|---|---|---|---|
| 55732 | 149 | LABORERS | TO COVER TILL JUNE 30 | | $ 26,550.00 |
| 39000 | | FUND BALANCE | | $ 26,550.00 | |
| 55732 | 201 | SOCIAL SECURITY | TO COVER TILL JUNE 30 | | $ 1,643.30 |
| 39000 | | FUND BALANCE | | $ 1,643.30 | |
| 55732 | 212 | MEDICARE | TO COVER TILL JUNE 30 | | $ 346.68 |
| 39000 | | FUND BALANCE | | $ 346.68 | |
| | | | Total | $ 28,539.98 | $ 28,539.98 |

**Approve/Disapprove General Fund Budget Amendment**

Financial Director Heather Woodlee present to the Full Commission a budget amendment that is needed in line item maintenance and repair. This is a $15,000.00 budget amendment to get through till June 30, 2023. All County Building maintenance and repair come out of this line item and the Mayor David Sullivan explained that the generator in the Jail needs fuel in case of an emergency. The generator needs to have fuel added so it will be at 660 gallon to be in safe mode. Two batteries were added today and the County has to pay the maintenance service agreement. Commissioner Michael Woodlee made a motion to approve this amendment as present. Commissioner Terry Hodges spoke up and wanted to take out for the fuel and send the rest of the amount back to Committee A and let them look and see where that amount is going. Commissioner Michael Woodlee rescind his motion that was on the floor. Terry Hodges made a motion, second by Michael Chandler to amend this by $7,500.00 for diesel and batteries and send the amount left back to Committee A to see where the rest of the money is going.

Upon roll call: Michael Chandler, Cale Crain, Jordan Delong, Tabitha Denney, Terry Hickey, Terry Hodges, Dusty Madewell, Brick Wall, and Michael Woodlee voted yes. Kenny Smith voted No. 9-Yes votes, 1-No vote. Motion passed. **Budget Amendment as following:**

Amend 7566.00 only

**Van Buren Co. Executive** **General Fund**

**2022-2023 BUDGET AMENDMENT FU Fund 101**

| Function | Obj. | Description | Explanation | Debit | Credit |
|---|---|---|---|---|---|
| 51800 | 335 | MTN AND REPAIR | TO COVER MTN REP. | | $ 15,000.00 |
| 39000 | | FUND BALANCE | | $ 15,000.00 | |
| | | | Total | $ 15,000.00 | $ 15,000.00 |

**Approve/Disapprove Setting Rules for Committee A & B**

Chairman Terry Hickey presented the minutes from the Special Called Meeting on Tuesday September 9, 2014 where the Full Commission voted in the duties for Committee A & B. Listed as following: Chairman Hickey believes no action needs to be taken on this matter.

| **Committee A (Commissioner Assignments)** | **Committee B (Commissioner Assignments)** |
|---|---|
| **Budget** | **Building & Grounds** |
| **Solid Waste** | **Jail & Law Enforcement** |
| **Ambulance Service** | **Parks & Recreation** |
| **Delinquent Tax** | **Highways** |
| **Schools** | **Veterans Affairs** |
| **Tourism** | **Agriculture** |
| **Insurance** | **Fire Protection/Safety & Rescue** |

Michael Chandler made a motion, second by Kenny Smith to leave this like it is. All approved by voice vote. 0-opposed. Motion passed.

**Adjournment**

Tabitha Denney made a motion, second by Michael Woodlee to adjourn. All agreed by voice vote. Motion passed. Meeting was adjourned at 6:59 p.m.

_____ _____

Chairman Terry Hickey County Clerk Lisa Rigsby