



STAY
HEALTHY



Metro Nashville

2027 BENEFITS

FOR ACTIVE EMPLOYEES



LIVE
WELL

SAVE
MONEY



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This guide provides an overview of your benefits. If you need more detail than this guide provides, contact Metro Human Resources at **(615) 862-6700** or visit **nashville.gov/hr**.



2027 Benefit Plan Rates Per Pay Period

	General Government			MNPS Employees	
Coverage Level	12-Month Bi-Weekly	12-Month Semi-Monthly	9-Month Semi-Monthly	12-Month Bi-Weekly	10-Month Bi-Weekly
MEDICAL					
PPO Plan Employee only	\$129.23	\$140.00	\$186.67	\$129.23	\$168.00
PPO Plan Employee + child(ren)	\$184.62	\$200.00	\$266.67	\$184.62	\$240.00
PPO Plan Employee + family	\$337.85	\$366.00	\$488.00	\$337.85	\$439.20
HRA Plan Employee only	\$126.46	\$137.00	\$182.67	\$126.46	\$164.40
HRA Plan Employee + child(ren)	\$180.92	\$196.00	\$261.33	\$180.92	\$235.20
HRA Plan Employee + family	\$331.38	\$359.00	\$478.67	\$331.38	\$430.80
DENTAL					
Flexible Plan Employee only	\$0	\$0	\$0	\$0	\$0
Flexible Plan Employee + family	\$18.84	\$20.42	\$27.22	\$18.84	\$24.50
Limited Plan Employee only	\$0	\$0	\$0	\$0	\$0
Limited Plan Employee + family	\$23.99	\$25.99	\$34.65	\$23.99	\$31.19
VISION					
Basic Plan Employee only	\$1.28	\$1.39	\$1.85	\$1.28	\$1.67
Basic Plan Employee + family	\$3.93	\$4.26	\$5.68	\$3.93	\$5.11
Enhanced Plan Employee only	\$2.03	\$2.20	\$2.93	\$2.03	\$2.64
Enhanced Plan Employee + family	\$6.48	\$7.02	\$9.36	\$6.48	\$8.42

Note: Metro provides employee-only dental coverage at no cost to you.



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CONTACTS

PRINT



2027 Benefit Plan Rates Per Month

Disability

Short-Term Disability Rates

Monthly premium is .0261 times your weekly pay.

For example: \$750 weekly earnings x .0261 = \$19.58 per month

Long-Term Disability Rates

Monthly premium is .00264 times your monthly pay.

For example: \$3,000 monthly earnings x .00264 = \$7.92 per month

Life Insurance

Supplemental Life

Monthly premium is based on your age and amount of coverage elected.

If you are age:	Your monthly rate per \$10,000 in coverage is:
Less than 25	\$0.50
25 to 29	\$0.60
30 to 34	\$0.80
35 to 39	\$0.90
40 to 44	\$1.10
45 to 49	\$1.60
50 to 54	\$2.40
55 to 59	\$4.30
60 to 64	\$6.60
65 to 69	\$12.70
70 and over	\$20.60

Dependent Life

Monthly premium covers all children, regardless of how many; if you are electing dependent life for children only (no spouse/domestic partner coverage), the monthly rate is \$3.76.

\$5,000 per child plus spouse or domestic partner coverage amount of:	Your monthly rate per \$10,000 in coverage is:
\$10,000	\$3.76
\$20,000	\$7.12
\$30,000	\$10.48
\$40,000	\$13.84
\$50,000	\$17.70



Benefit Basics

Eligibility

Employee

Metro employees who are regularly and consistently working 20 or more hours per week are eligible to enroll in benefits.

Dependents

You may enroll your eligible dependents in medical, dental, vision and dependent life. Eligible dependents include your:

- » Legally recognized spouse, while not divorced or legally separated
- » Domestic partner (documentation will be required proving you've shared a primary residence for the last 365 days and you are financially interdependent upon one another)
- » Dependent child(ren) from birth up to age 26 if he/she is:
 - Your or your domestic partner's child by birth, legal adoption, legal guardianship or court order who may or may not reside in your home the majority of the time on an annual basis
 - Your stepchild
 - A foster child living in your residence in accordance with a "Foster Care Placement" which means and is defined as the supervised adoption period prior to final adoption, as approved by a court of competent jurisdiction
- » Dependent child(ren) over age 26, provided coverage under Metro benefits has been continuous and he/she is incapable of self-sustaining employment by reason of intellectual or physical disability (contact Human Resources for details)

The following are not eligible for Metro benefits:

- » Foster children (placed in the home for care, but not adoption)
- » Ex-spouses or ex-domestic partners, except as allowed under COBRA
- » Parents of the employee or spouse/domestic partner



Benefit Basics

Opting Out of Benefits

If You are Under Age 65

You may opt out of Metro's medical and/or dental coverage if you provide proof of other coverage. You must provide Metro Human Resources with either an insurance card in the employee's name or a letter from the other insurance company. If you opt out and later lose your other coverage or have an eligible change in status, you have 60 calendar days to re-enroll in Metro's medical and/or dental plan.

If You Continue Working for Metro Past Age 65

When you turn age 65, you are eligible for Medicare Parts A & B, regardless of your employment status. If you start working or are still working for Metro as a benefits-eligible active employee and you are age 65 or older, you may now opt out of Metro's medical insurance if you prefer to have Original Medicare Parts A & B, a Medicare Supplement or a Medicare Advantage plan rather than Metro's medical insurance.

This option is now available at the request of many older Metro employees who would rather have Medicare coverage than Metro's medical insurance since, in most cases, the monthly premium for Medicare is less expensive than Metro's premium.

Things to note:

- » If you choose to opt out of Metro's medical insurance, your dependents will no longer have medical insurance coverage with Metro.

- » You may only opt out of Metro's medical insurance within 60 days of enrolling in a Medicare plan, during Metro's Annual Enrollment while you are a benefits-eligible active employee or within 60 days of an eligible change in status.
- » You can re-enroll in Metro's medical insurance within 60 days of an eligible change in status or when you retire from Metro.



Benefit Basics

When Coverage Begins and Ends

Insurance and benefit coverage is effective the first of the month after you have worked 30 days. Your coverage will end when your employment ends or when you change to a part-time status working less than 20 hours per week.

Changing Your Benefits

The benefits you choose when you first become eligible or during Annual Enrollment remain in effect for the entire plan year, unless you have an eligible change in status, such as:

- » Marriage or divorce
- » Birth or adoption of a child
- » Change in job status for you or your dependent
- » Loss of coverage for you or your dependent
- » Death of a covered eligible dependent

You must notify Metro Human Resources and provide documentation within 60 calendar days of an eligible change in status to make a change in your benefit elections. Not notifying Metro Human Resources timely may prevent you from adding a dependent until the next Annual Enrollment or may require you to pay family premiums for the remainder of the plan year when a dependent is no longer eligible.

For a complete list of eligible changes in status and instructions on changing your benefit elections, contact your departmental HR Representative or Metro Human Resources.



Turning Age 65 in 2027?

Read this [important message](#).

Planning to Retire from Metro Soon?

Here are some important steps you must take to have Metro pensioner coverage upon your retirement.



Medical

Metro offers you two medical options, both administered by Cigna:

- » PPO Plan
- » HRA Plan

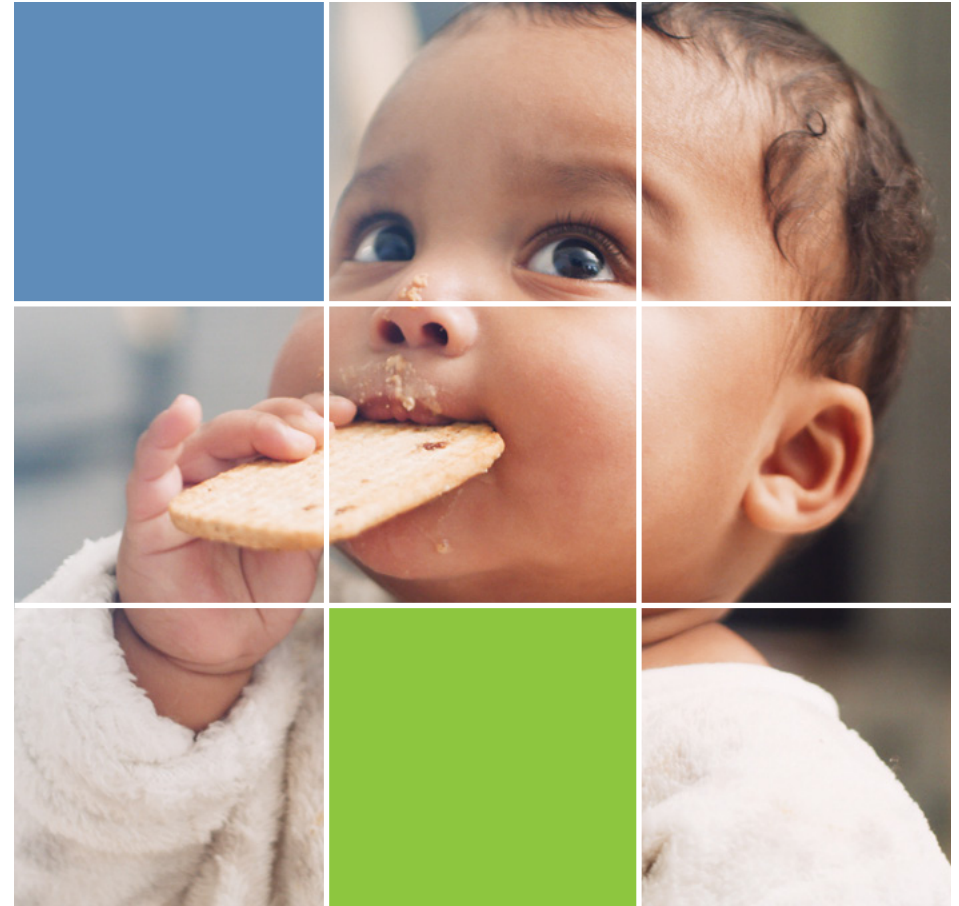
How the PPO and HRA Plans are ALIKE

Both plans:

- » Have the same network of providers and facilities
- » Use the same drug formulary, meaning they cover the same medications
- » Offer the same behavioral health services (see [page 18](#))
- » Offer these programs (see [page 19](#)):
 - Diabetes and hypertension prevention and management (Omada)
 - Bone and joint health benefit
 - Hearing aids
 - Virtual women's health clinic (Visana)
 - Virtual physical therapy (Airrosti)
- » Have similar premiums (paycheck deductions)

How the PPO and HRA Plans DIFFER

- » How medical services and prescription drugs are covered
- » Benefit levels
- » The HRA Plan has a Metro-funded Health Reimbursement Account (HRA) Fund to help you pay eligible medical and prescription drug expenses; the PPO Plan does not.
- » The HRA Plan lets you earn additional HRA dollars when you participate in certain wellness programs; PPO Plan enrollees can participate in these programs but do not earn incentives.



Learn More

- » About the PPO Plan on [pages 9-10](#)
- » About the HRA Plan on [pages 11-13](#)



Medical

How the PPO Plan Works

The PPO Plan is an 80/20 coinsurance plan. This means that for many medical services, the plan pays 80% and you pay 20% of the cost of care when you use network providers.

Below are some terms that can help you better understand how the PPO Plan works.

Deductible

A deductible is the amount you must pay out of pocket for covered health care services before your insurance plan starts to pay benefits. Under the PPO Plan, there is no deductible if you use network providers. However, if you use a provider or facility that is not in the network, the deductible applies, and you will pay more out of pocket.

Copay

A copayment (or copay for short) is a dollar amount you pay for a given service (like an office visit) or prescription drug at the time you receive it.

Coinsurance

Coinsurance is your share of the cost for a covered service. It's calculated as a percentage of the cost, rather than a fixed amount, and generally applies after you've met the deductible if applicable.

Out-of-Pocket Maximum

An out-of-pocket (OOP) maximum helps to limit how much you pay out of pocket for covered services each year.

Under the PPO Plan, if the amount of coinsurance you pay during the year reaches the OOP maximum, you will pay no more coinsurance for the rest of that year. However, copays for medical services and prescription drugs DO NOT count toward the plan's OOP maximum, AND copays DO NOT stop when you do meet your OOP maximum.

In other words, the following counts toward the OOP maximum:

- » Amounts paid toward the out-of-network deductible
- » Coinsurance

These do NOT count toward the OOP maximum:

- » Contributions (per-paycheck deductions)
- » Copays
- » Services not covered by the plan

Find Network Providers

For a list of network providers and other plan details, contact Cigna at the websites or phone number listed on the **Important Contacts** page. To view a complete copy of the plan documents and provisions, go to nashville.gov/hr.



Medical

How the PPO Plan Works ... continued

Preventive Care

Under the PPO Plan, the following preventive care services are covered at 100% up to \$750/year, then 80% for ages 7+. For children under age 7, they are covered at 80%:

- » Annual preventive health exam
- » X-rays and labs associated with preventive care
- » Childhood immunizations
- » Flu and pneumonia shots
- » Tetanus-diphtheria (Td) booster
- » Other recommended adult immunizations and immunizations not completed in childhood
- » Vision and hearing screenings performed by the physician during the preventive health exam
- » Blood pressure screening
- » Mammograms (preventive and diagnostic)

The following services are NOT covered as preventive care services and not included in the \$750/year limit; instead they are covered with an office visit copay plus 20% (in-network) or an office visit copay plus 40% (out-of-network):

- » Prostate screening
- » Routine Pap smears
- » Well-woman exams
- » Colorectal cancer screening

Prescription Drugs

Under the PPO Plan, you may purchase a one-month supply at any network pharmacy (Kroger is not a network pharmacy).

If you take medication for an ongoing condition, you can save money by asking your provider to write your prescription for a three-month (90-day) supply. To fill 90-day prescriptions, you must use either an approved retail pharmacy (Kroger and CVS are not approved) or Cigna's mail order program. The good news is you will only pay two copays (instead of three).

Cigna's maintenance medication program includes most retail chain, big box and grocery store pharmacies, but does NOT include Kroger or CVS. View a list of Cigna network pharmacies at nashville.gov/hr (click 2027 Annual Enrollment).

Telehealth

Cigna offers a variety of ways to connect with a doctor through your phone or computer. See [page 17](#) for details.

Behavioral Health

Challenges to mental well-being come in many forms, and so do the ways you can get help. See [page 18](#) for details.



Medical

How the HRA Plan Works

The HRA Plan combines traditional medical coverage with a Metro-funded Health Reimbursement Account (HRA) Fund. Under the plan, most preventive care is covered at 100% with no benefit limit, regardless of age, when you use network providers.

HRA Fund: Each year you are enrolled in the plan, Metro puts money in a Health Reimbursement Account (HRA) Fund to help you pay eligible medical and prescription drug expenses: \$1,100/employee only, \$2,200/employee + child(ren) or \$2,200/employee + family. You use your HRA Fund first during the year to pay for medical and prescription drug costs. There are no copays; you pay the full discounted cost of the product or service using your HRA Fund.



Deductible: If you use all your HRA Fund during the year, you are responsible for paying the full discounted costs of your medical and prescription drug claims until you have met your share of the deductible (\$450/employee only, \$900/employee + child(ren) or \$900/employee + family).



Coinsurance: Once you have met your share of the deductible, the plan begins to pay a percentage of the cost, as shown in the chart on [page 14](#).



Out-of-Pocket Maximum: If you reach the annual out-of-pocket maximum, which includes amounts paid toward the deductible and coinsurance, the plan pays 100% — and you pay nothing — for covered services for the rest of 2027.



If you don't use all your HRA Fund during the year, remaining funds will roll over to your 2028 HRA Fund and reduce your share of your 2028 deductible. This money is yours to spend on future eligible expenses as long as you remain enrolled in the HRA Plan.

Note: Pensioners with Medicare A & B can enroll in the HRA Plan but are not eligible to receive the HRA Fund.



Medical

How the HRA Plan Works ... continued

Preventive Care

Under the HRA Plan, the following preventive care services are covered in-network at 100%, with no copay, coinsurance or benefit limit:

- » Annual preventive health exam
- » X-rays and labs associated with preventive care
- » Childhood immunizations
- » Flu and pneumonia shots
- » Tetanus-diphtheria (Td) booster
- » Other recommended adult immunizations and immunizations not completed in childhood
- » Vision and hearing screenings performed by the physician during the preventive health exam
- » Blood pressure screening
- » Mammograms (preventive and diagnostic)
- » Prostate screening
- » Routine Pap smear
- » Well-woman exam
- » Colorectal cancer screening

Prescription Drugs

Under the HRA Plan, there are no copays. You will use your HRA Fund to pay the full discounted cost of your prescriptions. If you use all your HRA Fund, you are responsible for paying the full cost of your prescriptions until you meet the plan's deductible, as shown on **page 14**.

You may fill prescriptions for a one-month supply at any network pharmacy (Kroger is not a network pharmacy). You can only purchase a three-month supply at pharmacies in Cigna's maintenance medication program, which includes most retail chain, big box and grocery store pharmacies, but does NOT include Kroger or CVS.

Your cost is always based on a discounted (or prenegotiated) amount, saving you money. However, Cigna's maintenance medication and mail order programs offer greater discounts. Visit **myCigna.com** to see a list of participating pharmacies. You are encouraged to shop pharmacies to find the lowest cost on prescriptions.

Telehealth

Cigna offers a variety of ways to connect with a doctor through your phone or computer. See **page 17** for details.

Behavioral Health

Challenges to mental well-being come in many forms, and so do the ways you can get help. See **page 18** for details.



Medical

Attention HRA Plan Members:

Earn Additional HRA Dollars!

Want to reduce your share of the deductible and total out-of-pocket expenses? Participate in any of these programs each year and earn dollars to be added to your HRA Fund.* Only employees, pensioners and their spouses/domestic partners who are covered under the HRA Plan are eligible to earn incentive dollars. Contact **Cigna** for details.

PPO Plan enrollees can participate in all of these programs, but incentives don't apply.



Take a Health Risk Assessment earn \$100/person

This online questionnaire is short, confidential and provides you with a personalized health profile to help you take steps toward better health. Your individual answers will not be shared with anyone at Metro.



Complete One of Omada's 16-week Programs earn \$100/person

If you live with prediabetes, type 1 or type 2 diabetes, or hypertension, Omada's digital lifestyle change program can help you develop long-term healthy habits. See **page 19**.



Participate in a Chronic Health Condition Support Program earn \$100/person

If you live with a chronic condition, such as heart disease, diabetes, COPD, asthma, depression, low back pain, osteoarthritis or weight complications, Cigna health coaches help you better manage your condition.



Participate in a Lifestyle Management Program earn \$50/program up to \$100/person

Cigna health coaches provide personalized support for lifestyle behaviors such as tobacco cessation, stress management and weight loss.



Participate in the Healthy Pregnancies, Healthy BabiesSM Program earn up to \$150

This program helps you and your baby stay healthy during your pregnancy. Earn \$150 if you enroll by the end of your first trimester (\$75 by the end of your second trimester).

* Incentive dollars are limited to \$300/person per calendar year.



Medical

The chart summarizes what the plans cover when you use in-network providers. To view complete details, including out-of-network benefits, see the plan documents on Nashville.gov/hr.

Medical Benefits ... at a Glance	PPO Plan	HRA Plan
	In-network using Open Access Plus Network	In-network using Open Access Plus Network
Metro-Funded Health Reimbursement Account Fund	N/A	\$1,100/employee only or \$2,200/family
Your share of the deductible	\$0	\$450/employee only or \$900/family
Preventive care for ages 7 and older	You pay \$0 until charges reach \$750, then 20%	You pay \$0
Preventive care for ages 6 and under	You pay 20%	You pay \$0
Office visits – primary care	You pay \$20 copay plus 20%	You pay 10% after deductible is met
Office visits – specialist	You pay \$30 copay plus 20%	You pay 10% after deductible is met
In-office procedures such as surgery, consult, allergy injections	You pay office visit copay plus 20%	You pay 10% after deductible is met
Maternity - prenatal	You pay \$20 copay for initial visit only	You pay 10% after deductible is met
Maternity - delivery	You pay 20%	You pay 10% after deductible is met
Hospital care	You pay 20%	You pay 10% after deductible is met
Emergency room	You pay \$100 copay plus 20%; copay waived if admitted	You pay 10% after deductible is met
Mental health & substance use - outpatient	You pay \$20 copay plus 20%	You pay 10% after deductible is met
Mental health & substance use - inpatient	You pay 20%	You pay 10% after deductible is met
Coinsurance maximum	\$1,000/employee only or \$2,000/family	\$700/employee only or \$1,400/family
Annual out-of-pocket maximum	\$1,000/employee only or \$2,000/family (includes deductible & coinsurance only)	\$1,150/employee only or \$2,300/family
Out-of-network benefits	You generally pay 40% after out-of-network deductible is met	You generally pay 30% after out-of-network deductible is met



Medical

Prescription Drug Benefits ... at a Glance	PPO Plan	HRA Plan
1-month supply - generic	You pay \$10 copay	You pay 10% after deductible is met
1-month supply – brand name	You pay \$30 copay	You pay 30% after deductible is met
3-month supply - generic	You pay \$20 copay	You pay 10% after deductible is met
3-month supply - brand name	You pay \$60 copay	You pay 30% after deductible is met

Note: Primary care physicians include pediatricians, family and general practitioners, internists and OB/GYNs. Specialists include physicians highly trained in specific areas such as cardiology, dermatology, neurology, podiatry, oncology and specialized OB/GYNs.

Do You Use Insulin?

The PPO and HRA plans cover up to two temperature-controlled storage devices per calendar year to keep your insulin at the optimal temperature when you leave home. Simply purchase the device(s) and then submit a **claim form to Cigna**.

Need Care While Outside the U.S.?

If you're traveling outside the U.S. and need emergency or urgent care, Cigna provides emergency worldwide coverage. You must contact Cigna at **(866) 763-8442** within 24 hours of receiving care, pay for your care up front and submit a claim for reimbursement once you return home.



Medical

HELP ME CHOOSE

Need help choosing your medical plan? Here's how the PPO Plan and HRA Plan compare.

	PPO Plan	HRA Plan
Free preventive care (age 7+)?	Yes, but limited In-network, you pay \$0 until charges reach \$750/year; then you pay 20%	Yes In-network, you pay \$0
Free preventive care (under age 7)?	No You pay 20% in-network	Yes In-network, you pay \$0
Health Reimbursement Account (HRA) Fund?	No	Yes Each year, Metro puts \$1,100/employee only, \$2,200/employee + child(ren) or \$2,200/employee + family in an HRA Fund for you to spend on eligible medical and pharmacy expenses and help you meet your deductible
Deductible?	Out-of-network only: \$200/employee only, \$600/employee + child(ren) or \$600/employee + family	Your share after HRA Fund pays: \$450/employee only, \$900/employee + child(ren) or \$900/employee + family
Office visit copays?	Yes You pay copay + coinsurance	No HRA Fund pays first; then you pay full discounted cost until deductible is met, then you pay 10% in-network
Prescription drug copays?	Yes You pay flat copay per prescription	No HRA Fund pays first; then you pay full discounted cost until deductible is met, then you pay 10% (generic) or 30% (brand)
Coinsurance (in-network)?	You pay 20%; plan pays 80%	You pay 10%; plan pays 90%
Coinsurance (out-of-network)?	You pay 40%; plan pays 60%	You pay 30%; plan pays 70%
Pre-negotiated discounted rates?	Yes	Yes
Annual out-of-pocket maximum?	Once your coinsurance reaches \$1,000/employee only or \$2,000/employee + dependents, you pay \$0 coinsurance for the remainder of the year, but you continue to pay copays	Once you spend \$1,150/employee only, \$2,300/employee + child(ren) or \$2,300/employee + family (deductible + coinsurance), you pay \$0 for the remainder of the year
Incentives for healthy behaviors?	No	Yes See page 13



Medical

Telehealth

Both the PPO Plan and HRA Plan offer a variety of ways to connect with a doctor through your phone or computer.

Your Own Provider

If your provider is in Cigna's network and offers telehealth through their office, Cigna will cover these visits at the same cost as an in-person visit.

Cigna's Behavioral Health Network

You have access to a giant network of behavioral health providers. Simply visit myCigna.com to search for a provider. If you need care immediately, Cigna's network includes some providers who guarantee an initial appointment within five business days and a callback within one business day. Search results will say "Available within 5 days" if the provider offers that.

For more behavioral health resources, see [page 18](#).

MDLIVE

Cigna has partnered with MDLIVE to give you access to even more board-certified doctors for the following needs:

- » Primary care – routine and preventive care, receive orders for blood work and screenings at local facilities
- » Urgent care – a convenient alternative to urgent care centers and the emergency room (**This is the only MDLIVE service with \$0 cost.**)
- » Behavioral health – talk therapy for issues such as anxiety, stress, depression and grief (see [page 18](#) for more details)
- » Dermatology – care for common skin, hair and nail concerns



Log onto myCigna.com and click "Talk to a Doctor." Select the type of care you need, and your cost will be displayed.

Or call MDLIVE at **(888) 726-3171**.



Medical

Behavioral Health

The PPO Plan and HRA Plan offer the same support tools and services that range from mindfulness apps to text-based therapy to in-person and virtual counseling. Below is an overview of some of those services; more details and access are available by logging onto myCigna.com.

Counseling for All Ages (adults and children)

Cigna offers in-person and virtual mental health support for you and your covered dependents featuring:

- » A broad network of board-certified licensed counselors and psychiatrists
- » A partnership with MDLIVE to give you access to even more providers (telehealth only)
- » 24/7/365 access to confidential care, even on weekends and holidays
- » Help for stress, anxiety, depression, grief, relationship conflict and more
- » Help with sleep, tantrums, ADHD, anxiety and other concerns faced by children and adolescents
- » Fast access (no long waitlists; some providers can guarantee an initial appointment within 5 business days)
- » Providers who can prescribe medication when appropriate
- » Video visits with therapists and coaches

To get started, log onto myCigna.com and click “Talk to a Doctor.” Select the type of care you need, and your cost will be displayed. Or call MDLIVE at **(888) 726-3171** or download the MDLIVE app.



Not Sure Which Behavioral Health Service You Need?

Here are two ways to find out:

1. Visit CignaBehavioralPrograms.com/ctbh to view an interactive digital guide.
2. Log onto myCigna.com. Under the Wellness dropdown, choose “Mental Health Support” and follow the prompts to take a brief quiz. Your answers will help identify the most appropriate care for your specific needs.



Medical

Other Cigna Programs

Enrollees in both the PPO Plan and HRA Plan have access to these programs and services:

- » Diabetes and hypertension prevention and management (Omada)
- » Bone and joint health benefit
- » Hearing aids
- » Virtual women's health clinic (Visana)
- » Virtual physical therapy (Airrosti)

Omada (diabetes and hypertension prevention and management)

If you live with diabetes and/or hypertension, or if you're at risk for developing diabetes, this personalized program combines real human support with the latest technology so you can make lasting changes, one step at a time. Participants in the interactive Omada programs receive no-cost wifi-connected devices to track progress, along with sessions with a professional health coach.

You can join Omada if you:

- » Are at risk for diabetes or heart disease and want to avoid developing either condition
- » Live with type 1 or type 2 diabetes and want a new way to get and stay healthy
- » Have high blood pressure and want help managing it

It only takes a few minutes to get started. Join at omadahealth.com/metronash.

Bone and Joint Health Benefit

If you suffer from back, knee, hip or shoulder pain, Cigna's Bone and Joint Health benefit can help you find relief. The program gives you:

- » Personalized support to help you find the best solution for your pain
- » 100% coverage for surgery, if required
- » High quality care through a select network of providers

The benefit covers low back disk surgery, hip replacement, knee replacement, laminectomy, spinal fusion and shoulder replacement.

To learn more, call **(855) 678-0042** or visit nashville.gov/hr and click Employee Benefit Plans > Medical Plan Benefits.

Hearing Aids

Both the PPO and HRA plans offer an allowance of up to \$2,000 toward the purchase of hearing aids every 36 months. The benefit also includes one hearing exam per year. This means there is no cost to you, up to plan limits, when you use Cigna network providers. There are no out-of-network benefits. Visit myCigna.com or call the number on the back of your ID card for more details.



Medical

Other Cigna Programs ... continued

Visana (virtual women's clinic)

Visana provides whole-person support for:

- » **Menopause and perimenopause** - Understand your symptoms, explore hormonal and non-hormonal treatment options
- » **Gynecological, sexual/reproductive health** - Heavy bleeding, painful periods, vaginal infections, fibroids, endometriosis
- » **Hormone and metabolic health** - Irregular periods, sudden weight gain or loss, polycystic ovary syndrome (PCOS), thyroid issues
- » **Preventive care** - Well-woman visits, fertility assessments, mental health assessments, preventive screenings, health coaching

Visana connects you with doctors, nurses and coaches, all highly trained in women's health. They'll listen to you, explain what's going on in your body and help you find relief from all your symptoms.

Schedule your first virtual visit at visanahealth.com/cigna and pay your in-network office visit cost-share. Most needs can be handled virtually, but Visana can refer you for in-person care if needed.

Airrosti (virtual recovery clinic for muscle and joint pain)

Airrosti Remote Recovery provides:

- » **Comprehensive muscle and joint care** - For knee, shoulder, foot/ankle, wrist and more
- » **Virtual care** - Orthopedic evaluation, accurate diagnosis, injury education
- » **Personalized recovery plan** - With app-based exercises, recovery kit
- » **Ongoing clinic support** - For 12 months per injury, including unlimited virtual visits, texting and app access

Visit airrosti.com/remoterecovery or call **(800) 404-6050** to get started. You'll pay your in-network office visit cost-share. You're only billed for the first four visits per injury.



Dental

Dental coverage, offered through BlueCross BlueShield of Tennessee (BCBS), covers a wide range of preventive and restorative services. You have two choices for coverage: the Flexible Plan or the Limited Plan.

How the Dental Plans Work

Under the Flexible Plan, you can see any dentist you choose, but benefits are highest when you use providers in the BCBS DentalBlue network. Network providers have agreed not to exceed reasonable and customary (R&C) limits, which are based on the usual fees charged by providers in your geographic area. You have the flexibility to see an out-of-network provider, but if the provider's charges exceed R&C limits, you will be responsible for paying the difference.

Under the Limited Plan, benefits are paid according to a schedule of benefits, which shows your cost per service when you see a network provider. If you use an out-of-network provider, no benefits are paid.

For a list of providers and other important plan details, including the Limited Plan schedule of benefits, visit bcbst.com/members/metro-gov, or call (800) 367-7790.

Pre-determination of Benefits

If your dentist recommends treatment that is expected to cost \$200 or more, your dentist can request a predetermination of benefits. This helps you avoid surprises by letting you know how much will be covered before you receive treatment.



HELP ME CHOOSE

Both plans use the same provider network, DentalBlue. Here's how the plans differ:

	Flexible Plan	Limited Plan
Family premiums (Metro pays for single coverage):	Lower than Limited Plan	Higher than Flexible Plan
Limit on benefits paid in a year (not including orthodontia, TMJ care):	Pays up to \$1,000/year	Unlimited
Coverage for implants:	Yes	No
Coverage for TMJ treatment:	Yes	No
Coverage out-of-network:	Yes	No



Dental

The chart summarizes what the plans cover when you use in-network providers. If there is no network provider within a 30-mile radius of your home, you may use an out-of-network provider and receive in-network benefits; contact BCBS for instructions.

Dental Benefits ... at a Glance	Flexible Plan	Limited Plan
	In-network	In-network only; no out-of-network benefits
Annual deductible	You pay \$75 per person or \$225 per family	None
Preventive and diagnostic services including 2 exams and cleanings every 12 months, x-rays, sealants, fluoride	You pay \$0	You pay \$0 for most services
Basic restorative services including fillings, extractions, oral surgery, root canals, periodontics	You pay 20% with no deductible required	You pay \$0 for some services, a flat fee for others
Major restorative services including crowns, bridges, dentures, implants	You pay annual deductible + 50%	You pay flat fee for most services; implants not covered
Orthodontia for children and adults	You pay annual deductible + one-time \$100 orthodontia deductible + 50%	You pay flat fee for most services
TMJ (temporomandibular joint) treatment	You pay annual deductible + one-time \$100 TMJ deductible + 50%	Not covered
Lifetime TMJ benefit maximum	Plan pays up to \$750 per person	Not applicable
Annual dental benefit maximum	Plan pays up to \$1,000 per person, excluding orthodontia and TMJ care	Not applicable
Lifetime orthodontia benefit maximum	Plan pays up to \$1,000 per person	See schedule of benefits
Out-of-network benefits	Out-of-network coverage is available	No benefits for out-of-network care



Vision

Vision coverage, offered through National Vision Administrators (NVA), covers eye exams, frames, lenses and contacts. You have two choices for vision coverage: the Basic Plan or the Enhanced Plan.

How the Vision Plans Work

You receive the highest benefits when you use NVA's network of providers. The network includes many independent optometrists, ophthalmologists and opticians, as well as national retail optical providers, such as Costco, Walmart and Visionworks. For a list of network providers, visit e-nva.com (user name: metro; password: vision1). You are responsible for any costs over the reimbursed or allowed amount shown in the chart on the **next page**. However, in many cases, NVA offers a discount on amounts exceeding the retail allowance. Ask your provider.

HELP ME CHOOSE

The Enhanced Plan has higher employee premiums but offers higher benefits for:

- » Standard progressive and polycarbonate lenses – covered at 100% (Basic Plan does not cover)
- » Contact lenses – pays up to \$140 with no copay (Basic Plan pays up to \$125 after a \$10 copay)



Vision

The chart summarizes what the plans cover when you use in-network providers. Under both plans, eye exams and contact lens fittings are covered every 12 months. Lenses and frames are covered every 24 months. And contacts are covered every 24 months in lieu of frames and lenses.

Out-of-network services are reimbursed up to certain retail allowances. Visit e-nva.com for details.

Vision Benefits ... at a Glance	Basic Plan	Enhanced Plan
	In-network	In-network
Annual deductible	None	None
Eye exams	You pay \$10 copay	You pay \$10 copay
Single vision lenses	You pay \$10 copay	You pay \$25 copay
Bifocal lenses	You pay \$10 copay	You pay \$25 copay
Trifocal lenses	You pay \$10 copay	You pay \$25 copay
Lenticular lenses	You pay \$10 copay	You pay \$25 copay
Standard progressive lenses	Not covered	You pay \$0
Polycarbonate lenses	Not covered	You pay \$0
Scratch-resistant coating	You pay \$0	You pay \$0
Frames	You pay \$0 up to \$130 retail allowance	You pay \$0 up to \$150 retail allowance
Elective contact lenses	You pay \$10 copay up to \$125 retail allowance	You pay \$0 up to \$140 retail allowance
Medically necessary contact lenses	You pay \$0	You pay \$0
Fit and follow-up for standard daily wear	You pay \$20 copay	You pay \$20 copay
Fit and follow-up for extended daily wear	You pay \$30 copay	You pay \$30 copay
Out-of-network benefits	Reimbursed up to certain retail allowances	Reimbursed up to certain retail allowances



Disability

Disability coverage replaces a portion of your paycheck if a serious illness (including mental illness), injury or pregnancy keeps you from working. Short-term and long-term disability coverage is administered by MetLife.

Short-Term Disability

Short-term disability (STD) benefits provide partial income replacement if you are unable to work due to a qualifying disability.

How Much the Plan Pays

The STD plan pays 60% of your eligible weekly pay, up to \$1,250 per week. Benefits are not taxable and are coordinated with other Metro benefits you may receive. Other plan limits may apply.

While you are receiving STD benefits, you may continue your medical and dental insurance coverage. You must choose how to pay your premiums during this time.

When Benefits Begin and End

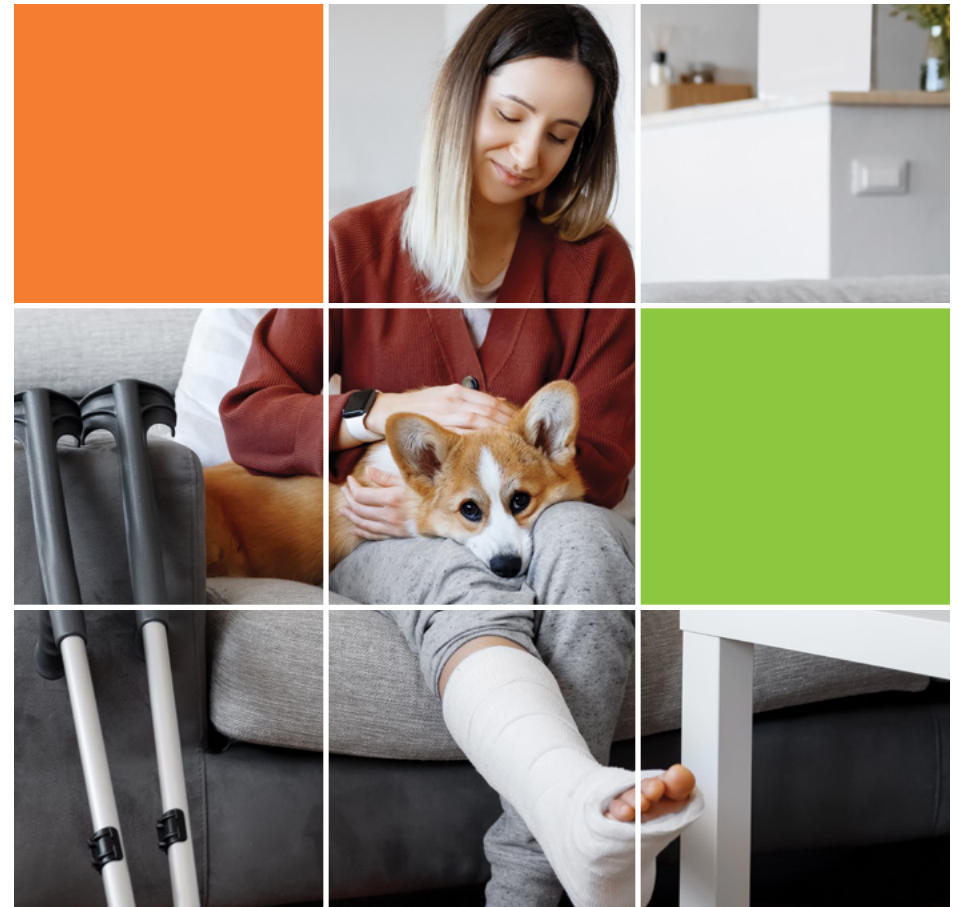
Benefits begin after a seven-day waiting period. During this waiting period, you may use sick leave or vacation leave.

If you are eligible for Family and Medical Leave Act (FMLA) leave, your short-term disability benefits and FMLA leave run at the same time. If pregnancy or childbirth is your disabling condition, benefits are paid only for the period your doctor and the insurance carrier determine you are disabled. This is typically six weeks after a normal delivery.

Benefits are payable for up to 180 consecutive days from the date your disability begins.

Late Enrollment Penalty

If you do not elect STD within 60 days of becoming eligible, you will be subject to the following late enrollment penalty: If you file a claim for anything other than an accidental injury in the first 12 months of coverage, benefits become payable after you have been continuously disabled for 60 consecutive days and remain disabled.



Disability

Long-Term Disability

Long-term disability (LTD) benefits provide income replacement if you are unable to work for an extended period due to a qualifying disability.

How Much the Plan Pays

The LTD plan pays 50% of your monthly earnings, up to \$7,500 per month. Benefits are not taxable and are coordinated with other benefits you may receive.

Once you begin receiving LTD benefits, you are no longer considered a Metro employee and must resign from employment. You may continue your medical, dental and vision insurance through COBRA if you elected these benefits as an active employee. Any vacation pay you receive at the end of your employment does not affect your long-term disability benefits.

When Benefits Begin and End

Benefits begin after a 180-day waiting period during which you are disabled. During the waiting period, you may use sick leave or vacation leave, in addition to any STD or Family and Medical Leave Act leave for which you are eligible.

Benefits generally continue until your disability ends or until you reach age 65. If you are age 62 or older when your covered disability begins, the maximum benefit duration is based on a sliding scale. Contact MetLife for details.

If you die while receiving LTD benefits, your eligible survivor may be entitled to a benefit based on your earnings while working.

Proof of Good Health

If you do not elect LTD benefits within 60 days of becoming eligible, you will be subject to proof of good health (also called evidence of insurability, or EOI) to enroll.

Pre-Existing Conditions

If you have a pre-existing condition in the 90 days before your LTD coverage becomes effective, you may not be eligible for benefits for that condition for 12 months after the effective date of your coverage. View the disability plan documents at nashville.gov/hr.

HELP ME CHOOSE

- » Imagine being sidelined from work for several months with no paycheck because of an illness or injury.
- » If you do not have 10 years of credited service with Metro, consider enrolling in both disability plans to protect your income and preserve your sick days.
- » If you are a Health Department or Hospital Authority employee, check your department's rules on sick leave and STD benefits.
- » You are not required to enroll in STD to enroll in LTD — you may enroll in one or the other, or both.



Flexible Spending Accounts (FSAs)

Metro offers two flexible spending accounts (FSAs) — a Health Care FSA and a Dependent Care FSA. The FSAs are administered by TASC.

How FSAs Work

With FSAs, you can set aside tax-free money from your paycheck to pay for out-of-pocket expenses like deductibles, copays, coinsurance, childcare and adult daycare. You pay less for these expenses because the money is not taxed when it is deducted from your paycheck or when you use it to pay for eligible expenses. You can contribute to one or both of the FSAs. You do not have to be enrolled in medical coverage to participate.

Contribution Limits

Each year, you choose how much to contribute to each FSA — as little as \$240/year or up to IRS annual contribution limits:

- » **The Health Care FSA contribution limit for 2027 is \$3,400.** If two Metro employees are married to each other, each spouse may contribute up to \$3,400 per year, for a combined total of \$6,800.
- » **The Dependent Care FSA contribution limit for 2027 is \$7,500.** If you are married and file separate tax returns, the maximum you may contribute is \$3,750 per year.

Enrolling in the FSAs

You must re-enroll in the FSAs every year to keep participating. Unlike many of your other benefits, your participation does not automatically continue with each new year. You do this during Annual Enrollment for the upcoming calendar year, even if you wish to keep your same contribution.

How to Get Started

- » **Estimate** your health care and dependent care expenses separately for the upcoming year.
- » **Decide** how much to contribute to each account. Your contributions will be deducted from your paycheck before taxes are taken out of your check and deposited into your account(s). Be careful not to overestimate your expenses. Unused money left in your account at year-end (or March 15 of the following year for the Health Care FSA) is forfeited.
- » **Get reimbursed.** TASC offers several convenient ways to get reimbursed for expenses you've already paid, including direct deposit to your bank account or a mailed check, an online payment feature, and a pharmacy debit card you can use like cash to purchase prescriptions (the debit card cannot be used for expenses other than pharmacy).



Flexible Spending Accounts (FSAs)

Eligible FSA Expenses

Here are some examples of eligible expenses:

Health Care FSA

- » Out-of-pocket medical, dental, vision, hearing and prescription drug expenses
- » Certain over-the-counter medicines if prescribed by a physician
- » Over-the-counter health-related supplies
- » Other out-of-pocket health expenses considered tax-deductible by the IRS

Dependent Care FSA

- » Day care fees and associated expenses for your children under age 13
- » Dependent care fees for a disabled spouse or child or a tax-dependent parent or elderly person

For a detailed list of eligible health care and dependent care expenses, visit tasconline.com (click Resources > Eligible Expenses).

Important IRS Rules

Because FSAs offer such favorable tax breaks, certain rules apply.

Use It or Lose It

It is important to estimate your expenses carefully. You must use all the money in your Dependent Care FSA by year-end. The IRS requires that any funds remaining after this date be forfeited.

Your Health Care FSA offers a grace period to help you avoid the IRS “use it or lose it” rule. You can continue to incur eligible health care expenses until March 15, 2028, and submit claims until June 15, 2028. So if you overestimate the amount you put in your Health Care FSA, you can use the funds in 2028, before they are forfeited.

No Contribution Changes

Once you decide how much to contribute to each account, you can't change it until the next Annual Enrollment, unless you experience an eligible change in status.

HELP ME CHOOSE

- » Do you pay for childcare or adult daycare? Why not do it tax-free with the Dependent Care FSA?
- » Do you have predictable health care expenses or ongoing prescriptions? Do you anticipate a large expense, like surgery or orthodontia, next year? Why not pay for it tax-free with the Health Care FSA?
- » You can use the Health Care FSA to pay for tax-dependent family members' expenses — even if they are not covered by Metro's benefits.
- » **Attention participants:** Your current contributions do not automatically continue. You must re-enroll to participate in the FSAs in 2027.



Flexible Spending Accounts (FSAs)

Tax-saving Example #1 on Earnings of \$50,000/year

Jesse earns \$50,000 annually (\$4,167/month), pays \$9,600 a year (\$800/month) for childcare and anticipates \$1,500 (\$125/month) in qualifying health care expenses in 2027. **By using the Health Care and Dependent Care FSAs, he can increase his take-home pay by \$2,514.**

	Without an FSA	With an FSA
Monthly pay	\$4,167	\$4,167
Pre-tax contributions to Dependent Care FSA	- \$0	- \$800
Pre-tax contributions to Health Care FSA	- \$0	- \$125
Taxable monthly pay	\$4,167	\$3,242
Federal income tax (15%)	- \$625.05	- \$486.30
Social Security and Medicare tax (7.65%)	- \$318.78	- \$248.01
Monthly pay after taxes	\$3,223.17	\$2,507.69
After-tax monthly health care and dependent care expenses	- \$925	- \$0
Net take-home pay after FSA reimbursement	\$2,298.17	\$2,507.69
Monthly savings	\$0	\$209.52
Annual savings	\$0	\$2,514.24

Note: Tax rates are estimated; example amounts are rounded to the nearest dollar.



Flexible Spending Accounts (FSAs)

Tax-saving Example #2 on Earnings of \$80,000/year

Molly earns \$80,000 annually (\$6,667/month), pays \$12,000/year (\$1,000/month) for childcare and anticipates \$1,500/year (\$125/month) in qualifying health care expenses in 2027. **By using the Health Care and Dependent Care FSAs, she can increase her annual take-home pay by more than \$4,000.**

	Without an FSA	With an FSA
Monthly pay	\$6,667	\$6,667
Pre-tax contributions to Dependent Care FSA	- \$0	- \$1,000
Pre-tax contributions to Health Care FSA	- \$0	- \$125
Taxable monthly pay	\$6,667	\$5,542
Federal income tax (22%)	- \$1,466.74	- \$1,219.24
Social Security and Medicare tax (7.65%)	- \$510.03	- \$423.96
Monthly pay after taxes	\$4,690.23	\$3,898.80
After-tax monthly health care and dependent care expenses	- \$1,125	- \$0
Net take-home pay after FSA reimbursement	\$3,565.23	\$3,898.80
Monthly savings	\$0	\$333.57
Annual savings	\$0	\$4,002.84

Note: Tax rates are estimated; example amounts are rounded to the nearest dollar.



Life Insurance

Metro provides basic life/AD&D insurance through The Hartford at no cost to you. You may add to this coverage by purchasing supplemental employee and dependent life.

Basic Employee AD&D Insurance

Metro provides you with basic life and AD&D coverage equal to \$50,000 (\$32,500 if you are age 65 or older), at no cost to you.

What is AD&D?

AD&D insurance pays a benefit above any other insurance benefits in the event of accidental death or dismemberment. If you die as a result of an accident, the full AD&D benefit plus the basic life insurance benefit will be paid. If you suffer a dismemberment accident (such as the loss of an eye or limb), the plan pays a percentage of the full benefit amount.

Supplemental Life

You may purchase supplemental life for yourself up to \$500,000, in increments of \$10,000. In certain cases, proof of good health may be required; see the next column.

Dependent Life

If you are enrolled in supplemental life, you may also enroll in dependent life, which provides up to \$50,000 (in increments of \$10,000) in coverage for your spouse/domestic partner and \$5,000 for each dependent child (up to age 26). If you are enrolling for the first time or increasing spouse/

domestic partner coverage, proof of good health is required; see below. Proof of good health is not required for child coverage.

Note: If you are married to another Metro employee, only one of you may enroll a dependent child in this insurance.

Your Beneficiary

It is important to designate a beneficiary for your coverage. It is also a good idea to review your beneficiary every year and update as you experience status changes (such as marriage, divorce or death). You may designate or update your beneficiary at any time by completing a form available online at nashville.gov/hr, or from Metro Human Resources.

Proof of Good Health

In certain cases, you (and/or your spouse/domestic partner) may be required to submit proof of good health (also called evidence of insurability, or EOI) to The Hartford and be approved before coverage becomes effective. Proof of good health is required if:

- » You declined supplemental life or dependent life for your spouse/ domestic partner when first eligible but wish to elect it at a later date
- » You wish to increase your current supplemental life coverage by more than \$10,000 or your total coverage exceeds \$400,000
- » You wish to increase dependent life for your spouse/domestic partner by any amount



Life Insurance

Additional Benefits

Additional benefits may be available if a covered individual becomes disabled (waiver of premium), becomes terminally ill or dies in the line of duty.

Waiver of Premium

If you are under the age of 60 and you become totally disabled according to the life insurance carrier's standards (not Metro's), you may apply for the waiver of premium for basic life, supplemental life and dependent life benefits and have your premiums waived as long as you continue to be disabled. You must apply within 12 months of the date you became disabled. If approved, your pre-retirement level of benefits may remain in effect until age 70 as long as you continue to meet the life insurance carrier's criteria.



If you qualify for the waiver of premium, this is a free benefit to you. If you are denied the waiver of premium benefit, you have 30 days from the date of the denial to appeal the insurance company's decision. If your appeal is denied, or you elect not to appeal the denial, you may convert to an individual policy; however, you must make written application and payment of premium within 31 days from the time the insurance company denies your waiver of premium application. To appeal or convert, you must contact the life insurance company directly.

Accelerated Death Benefit

If, as an active employee, you become terminally ill and are not expected to live more than twelve months, you may request 80% of your life insurance benefits not to exceed \$500,000 (for both basic and supplemental life) payable to you in one lump sum or equal monthly installments. A doctor must certify your condition in order to qualify for this benefit. Upon your death, the remaining benefit will be paid to your designated beneficiary.

In-Line-of-Duty Death Benefit

Employees who lose their life in the line of duty may be eligible for an additional \$100,000 death benefit payable to the employee's estate. This benefit is subject to approval by the Metropolitan Employee Benefit Board.

Conversion and Portability Rights

If you leave your job, your life insurance coverage will end. To convert and/or port all or part of your life insurance benefits to an individual policy, you must apply and pay for the first premium within 31 days after your coverage ends. For more information about your conversion and portability rights, contact the life insurance carrier.



MetroMax 457(b) Deferred Compensation Plan

Metro Government offers an easy and tax-smart way to save for retirement. Through the MetroMax 457(b) Deferred Compensation Plan, you can make automatic, pre-tax contributions each pay period, which can add up over time to help fund your retirement. Why participate? Read on for six reasons.

It's Easy

A local plan representative can enroll you over the phone or answer any questions you have.

It's Flexible

You choose the amount of pay you'd like to contribute, up to IRS maximum limits, and you can change or stop at any time.

It's Automatic

Your contributions are automatically deducted each pay period so you don't have to think about saving.

You Choose Pre-Tax or After-Tax (Roth) Contributions

Regardless of your choice, your contributions and their earnings have the ability to compound and grow tax-deferred.

Enroll Today

Whether you're coming from another employer or just starting your career, your local MetroMax (Voya) representatives can answer any questions you may have about the MetroMax 457(b). Call them at **(615) 627-5938** or visit **metromax.beready2retire.com** to learn more.

It's Important to Start Early

Waiting could impact how much you'll have for retirement. For example:

If you start saving \$50 per pay period at age:	You could have at age 65:
25	\$191,696
30	\$138,029
40	\$67,958

The accumulated amounts in this hypothetical example assume contributions over 24 pay periods per year, a 6% annual rate of return compounded monthly and a retirement age of 65.

It Probably Costs Less Than You Think

You can start with as little as \$10 per pay period. And because it's pre-tax, you'll feel it less in your take-home pay. The chart below shows the impact of a \$50 per pay period contribution:

	Without the 457(b)	With the 457(b)
Salary per pay period	\$2,083.33	\$2,083.33
457 contribution	- \$0	- \$50.00
Taxable salary	\$2,083.33	\$2,033.33
Federal tax withholding	- \$176.67	- \$170.67
FICA and Medicare	- \$159.37	- \$159.37
Take-home pay	\$1,747.29	\$1,703.29
Difference		+ \$44.00

This hypothetical example assumes a salary of \$50,000, a contribution of \$50 per pay period (24 pay periods) and a filing status of single with one dependent. Systematic investing does not ensure a profit nor guarantee against a loss in declining markets.



Important Contacts

Plan	Carrier	Website	Phone
Medical	Cigna	If currently enrolled, log onto myCigna.com If not yet enrolled, visit Cigna.com	Customer service: (800) 244-6224 Cigna One Guide: (888) 806-5042
Dental	BlueCross BlueShield of TN	bcbst.com/members/metro-gov	(800) 367-7790
Vision	NVA	e-nva.com (user name: metro; password: vision1)	(800) 672-7723
Disability	MetLife	mybenefits.metlife.com	(833) 622-0135
Flexible Spending Accounts (FSAs)	TASC	tasconline.com	(800) 422-4661
Life Insurance	The Hartford	thehartford.com	(888) 563-1124
COBRA	COBRAGuard, an iTedium solution	mycobra.info	(866) 442-6272
MetroMax 457(b) Deferred Compensation Plan	Voya Financial	metromax.beready2retire.com	(615) 627-5938
General	Metro Human Resources	nashville.gov/hr	(615) 862-6700

Need More Help?

Cigna One Guide® gives you access to a real, live person who can help you understand your health plan, find the best provider for your needs, find ways to lower your costs, resolve problems and more.

Download the One Guide app at **myCigna.com** or call **(888) 806-5042**.



What Happens to Your Benefits If...

...You are on Family Medical Leave (FMLA) or Short-Term Disability (STD)?

While you are on FMLA and/or STD, your medical, dental, basic life insurance and any optional benefits you are enrolled in will continue. As long as you are in a paid status (using sick or vacation leave), premiums will continue to be withheld from your paycheck.

If all or part of your FMLA or STD will be unpaid (and Metro is not paying you for sick or vacation leave), you must make an election as to how you will pay your premiums while you are on leave. Your options are to:

- » Pre-pay your premiums before taking leave
- » Pay premiums on a monthly basis directly to Metro on an after-tax basis
- » Hold your premiums in arrears until you return to work and then have premiums withheld from your paychecks over the same number of pay periods as the missed premiums would have been withheld

You may also cancel your participation in long-term disability, supplemental life or dependent life while you are on FMLA. If you re-enroll in these benefits within 31 days of returning from leave, you will not be required to provide evidence of insurability.

You may elect to stop your participation in the Health Care FSA for the remainder of the year (participation in the Dependent Care FSA will automatically stop when you go on leave). If you elect to continue your participation in the Health Care FSA, you may continue to incur claims and once you return from leave, arrears will be taken in the same plan year to catch up your contribution. If you stop participating, you may NOT incur claims past the end of the month in which you get your last active paycheck. You may re-enroll once you return to work.

If you do not return to work at the end of your FMLA or STD leave, your coverage will terminate on the actual paycheck issue date of your second missed premium, and you will be offered COBRA.



...You Take Leave Without Pay?

If you take a leave without pay (unpaid leave of absence), your coverage will terminate on the actual paycheck issue date of your second missed premium, and you will be offered COBRA.

If your leave is less than 30 days, your coverage will be reinstated when you return to work. If your leave is more than 30 days, your coverage will be reinstated effective the first of the month following 30 days from the date you returned from leave.

If you were enrolled in an FSA, your missed premiums will be collected in arrears and the premiums will be adjusted over the remaining pay periods in the same plan year to account for the missed premiums. Evidence of insurability for supplemental life, dependent life and long-term disability will be required when you return from leave.



What Happens to Your Benefits If...

...You Turn Age 65 During the Year?

When you turn age 65, you are eligible for Medicare Parts A & B, regardless of your employment status. If you start working or are still working for Metro as a benefits-eligible active employee and you are age 65 or older, you may now opt out of Metro's medical insurance if you prefer to have Original Medicare Parts A & B, a Medicare Supplement or a Medicare Advantage plan rather than Metro's medical insurance.

This option is now available at the request of many older Metro employees who would rather have Medicare coverage than Metro's medical insurance since, in most cases, the monthly premium for Medicare is less expensive than Metro's premium.

Things to note:

- » If you choose to opt out of Metro's medical insurance, your dependents will no longer have medical insurance coverage with Metro.
- » You may only opt out of Metro's medical insurance within 60 days of enrolling in a Medicare plan, during Metro's Annual Enrollment while you are a benefits-eligible active employee or within 60 days of an eligible change in status.
- » You can re-enroll in Metro's medical insurance within 60 days of an eligible change in status or when you retire from Metro.



What Happens to Your Benefits If...

...You Retire from Metro?

If you retire from Metro on or after age 65, you must also apply for Medicare Part B so it is effective by the same date your Metro retiree medical insurance is effective. This is important because a Metro retiree who is age 65 or older is only eligible for Metro's Medicare Advantage plans, and to be in one of Metro's Medicare Advantage plans, you must be enrolled in Medicare Parts A & B. Therefore, if you do not have Medicare Part B by the same date your retiree medical insurance is effective, you will no longer be eligible for any Metro medical insurance.

Metro requires all pensioners and dependents to enroll in Medicare Parts A & B when you first become eligible regardless of your employment or your spouse's employment status outside of Metro. If a pensioner or a dependent does not enroll in Medicare Parts A & B when they become eligible, they are no longer eligible for Metro medical insurance. When the pensioner and his/her covered dependents are all eligible for Medicare, they will no longer be eligible for Metro's medical insurance unless they are all enrolled in Medicare Parts A & B.

Once a pensioner and all dependents turn age 65 and become eligible for Medicare, then they are no longer eligible to be enrolled in Metro's PPO Plan or HRA Plan because their **only** medical plan option is to enroll in one of Metro's Medicare Advantage plans. To enroll in one of Metro's Medicare Advantage plans, a person must be enrolled in Medicare Parts A & B; therefore, it is imperative to apply for Medicare Parts A & B three months in advance of turning age 65. If you do not have Medicare Parts A & B when you turn age 65, you and your dependents will no longer be eligible for any Metro medical insurance.

Note: Pensioners enrolled in the HRA Plan will lose any remaining HRA funds when they are moved to one of Metro's Medicare Advantage plans.



What Happens to Your Benefits If...

...You Go on Military Leave?

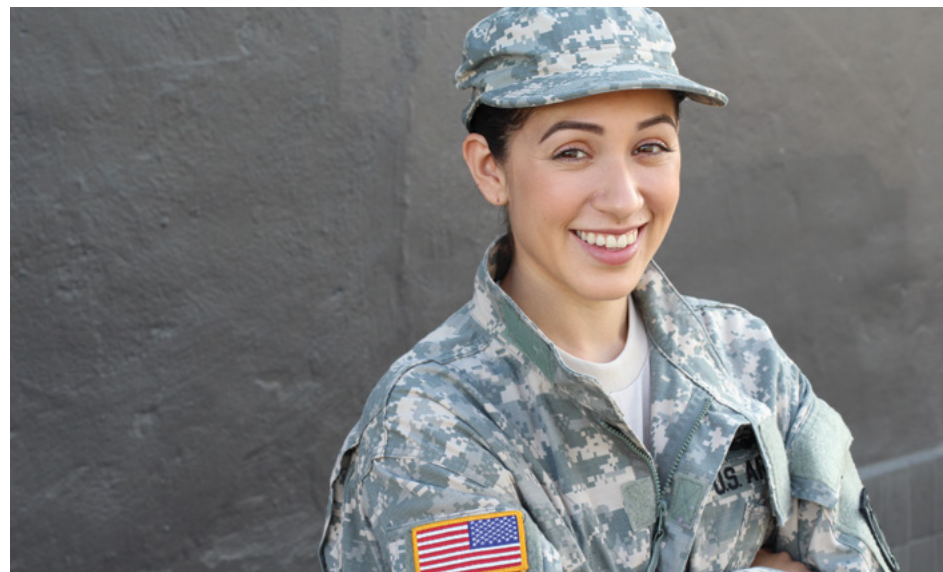
You must make an election to either discontinue or continue your medical and dental coverage for a maximum of 24 months while on active military duty (COBRA will not be offered at the end of the 24-month period). If you later decide to drop your coverage, you must notify Metro Human Resources in writing. Medical and dental premiums will be deducted from your regular earnings or any partial pay you receive. Your basic life insurance will continue to be paid by Metro while you are on active duty.

If you are enrolled in vision, supplemental life or dependent life, you may keep these benefits while you are on military leave, or you may elect to cancel these benefits and re-enroll when you return from leave. If you choose to cancel your supplemental life and/or dependent life while you are on leave, you will have 31 days from the date you return to work to re-enroll without providing evidence of insurability. Premiums for these benefits will NOT be deducted from any partial pay you receive so you must make an election below as to how you wish to pay these premiums. Your options are to:

- » Pre-pay your premiums before taking leave
- » Pay premiums on a monthly basis directly to Metro on an after-tax basis
- » Hold your premiums in arrears until you return to work and then have premiums withheld from your paychecks over the same number of pay periods as the missed premiums would have been withheld

You may also cancel your participation in vision, supplemental life or dependent life while you are on leave. If you re-enroll in these benefits within 31 days of returning from leave, you will not be required to provide evidence of insurability.

While on military leave, you are not eligible to maintain your short-term or long-term disability coverage. If you return to work within 90 days, your coverage is automatically reinstated. If you return to work after 90 days, you will be treated as a new employee without a late enrollment penalty.



You may elect to continue your Health Care FSA while on military leave; however, you must pay your premiums direct on an after-tax basis. You must file any Health Care FSA claims by June 15 following the year end. You may not continue to participate in the Dependent Care FSA while on military leave and you must be sure to file any claims within 90 days of the plan year end.

If you are a qualified reservist called to active duty for 180 days or more, you may request a distribution of all or a portion of the balance in your Health Care FSA. For more information about this distribution, contact Metro Human Resources.



What Happens to Your Benefits If...

...Your Metro Employment Ends?

Your benefits coverage will terminate at the end of the month of your last day on payroll, but premiums will continue to be deducted through your last paycheck.

If your employment ends with Metro for any reason other than gross misconduct, you will be offered COBRA, and Metro's COBRA administrator will contact you by mail with information and premium rates.

As a member of the benefit system, you were enrolled in a Basic Term Life Group Insurance policy, and you may have several options available to you and your eligible dependents to continue all or part of your current life insurance benefits. You must elect this coverage and make premium payment to the insurance carrier within 31 days of your employment end date. If your employment is ending due to your disability, you may be eligible for the waiver of premium life insurance benefit. If enrolled, your supplemental life insurance policy is portable at group insurance rates (you must apply and make payment within 31 days of your employment end date). To continue your basic term life and/or supplemental life policy, contact the insurance carrier immediately.

If you participated in Metro's flexible spending account(s), contributions to your account(s) will stop at the end of the month in which you get your last paycheck, and you will be able to incur expenses up to your insurance termination date. You will be allowed up to 90 days from your insurance termination date to submit claims for expenses that you incurred *prior* to your insurance termination date. Claims submitted after 90 days will not be reimbursed. You may also use COBRA to continue use of your Healthcare FSA up to the amount of the initial declaration. If you are rehired by Metro within 30 days in the same calendar year, you will re-enter the flexible spending program with the same elections you had when you left.

If you have vested, you are entitled to receive a future retirement benefit. You may be eligible for this benefit as early as age 60 and no later than age 65 (or as early as age 53 and no later than age 60 if in the Police & Fire plan), depending upon your total credited service with Metro.

If eligible, it is your responsibility to contact Metro Human Resources in advance of your retirement age to begin this process. If you die before your retirement benefits begin, your legal spouse, domestic partner (who has a Declaration of Domestic Partnership already on file with Metro Human Resources) or minor dependent child(ren) may be entitled to receive pension benefits immediately.



Notices

If the information in the guide differs from the official plan documents, the plan documents will govern. This guide does not constitute an offer of employment or a promise to provide any particular benefit. Metro Nashville reserves the right to change its employee benefits program at any time. For more information, call Metro Human Resources at **(615) 862-6700**.

Summary of Benefits and Coverage

In accordance with the Affordable Care Act, you can find the Summaries of Benefits and Coverage (SBC) for both the PPO and HRA plans on Human Resources' website at nashville.gov/hr.

HIPAA Notice of Privacy Practices

This notice governs Metro's privacy practices for Metro's medical plans and the flexible spending accounts and can be found at nashville.gov/hr. For copies of the other carriers' privacy notices, contact the carrier directly.

Grandfathered Plan Status

Metro's medical plans are considered "grandfathered health plans" under the Affordable Care Act. A grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted, and your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans.

COBRA Continuation Coverage

If you or your dependents lose your eligibility for health care coverage for certain reasons, you will be allowed to continue coverage for a certain period of time under COBRA. Your dependents have the right to continue coverage even if you do not elect to continue your own coverage. Metro does not pay for coverage under COBRA; you or your dependent will pay 100% of the cost plus a 2% administration fee.



You or your dependents are eligible for COBRA continuation if coverage ends because:

- » Your employment ends for reasons other than gross misconduct
- » Your work hours are reduced so that you no longer qualify for coverage
- » You die
- » You get divorced or legally separated
- » Your dependent child becomes ineligible for coverage

If you or your dependents qualify for COBRA, you will be mailed a packet with rate information and payment instructions from Metro's COBRA administrator.



Notices

Women's Health Provisions

No matter which medical plan option you choose, your hospital coverage for childbirth will be for the same minimum number of days, as required by federal law:

- » If your baby is delivered vaginally, you may stay in the hospital at least 48 hours (two days) after the birth
- » If you have a cesarean section, you may stay in the hospital at least 96 hours (four days) after the birth
- » If the attending physician believes you need a longer stay, you may receive benefits for additional days if your doctor obtains pre-authorization from the insurance company. On the other hand, if you and your doctor agree that, in your case, the minimum number of days is not necessary, you may be released from the hospital earlier.

Under the Women's Health and Cancer Rights Act of 1998, all health plans that provide mastectomy coverage are also required to provide coverage for:

- » Reconstruction of the breast on which the mastectomy has been performed
- » Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance
- » Prostheses (artificial replacements) and physical complications at all stages of the mastectomy, including lymphedemas

Coordination of Benefits

Regardless of which medical plan you elect, you must be sure to notify Cigna if your dependents receive health coverage outside of Metro's plan (for example, through your spouse/domestic partner's insurance plan at work or by qualifying for Medicare).

If your dependent has coverage elsewhere, a process called coordination of benefits (COB) comes into play. COB simply means that benefits are coordinated between your dependent's coverage under your Metro plan and another plan. This process ensures that benefit payments are not duplicated and helps hold down the rising cost of health insurance.

