



Metro Nashville Employee Benefit Handbook



YOU SERVE METRO. WE SERVE YOU.

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Introduction

Accessing your Benefits Information

Visit Human Resources on the web at www.nashville.gov to get answers regarding your benefit questions and to access insurance carriers, summary plan descriptions, online health and retirement tools as well as the latest news concerning your benefits.

Hospital Authority Employees

Hospital Authority employees hired or rehired after November 1, 2010 are not eligible to participate in Metro's pension benefits or retiree medical benefits. For more information, please contact the Hospital Authority.

This Document...

This document presents an overview of Metro benefits and is intended for informational purposes only. If there is a difference between this overview and the official plan documents or provider contracts, the official plan documents and provider contracts will govern. For more detailed information, please refer to Metro Human Resources' website or your insurance carrier's website.

HIPAA Compliance

The Health Insurance Portability and Accountability Act (HIPAA) requires that your health insurance plan limit the release of your health information to the minimum necessary required for your care, or as outlined in the Metro Human Resources – Notice of Privacy Practice found on Human Resources' website at www.nashville.gov. If you have questions about your claims please contact your insurance carrier first. If, after contacting the carrier, you need Metro to assist you with any claim issues, you may be required to

provide Metro with written authorization to release information related to your claim.

Disclosure of Grandfather Status under the Patient Protection and Affordable Care Act

Metro Nashville Government believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on essential benefits. Annual lifetime limits continue to apply to custom built shoes and travel expenses for organ transplants. Metro Nashville Government has determined that these are not essential benefits for purposes of the Affordable Care Act.

Questions regarding which protections apply and which protections do not apply to a grandfathered plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Metro Human Resources (615) 862-6640. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Benefit Carrier Contact Information

Benefit	Carrier	Website	Phone
Medical	BCBS PPO	www.bcbst.com/members/metro-gov/	(800) 367-7790
	CIGNA Choice Fund	If Not yet enrolled: www.mycignaplans.com ID - metro2012; password – cigna	(800) 401-4041
		If already enrolled: www.mycigna.com	(800) 244-6224
Dental	Delta Dental	www.metro.deltadentaltn.com	(800) 223-3104
Vision	UnitedHealthcare Vision	www.myuhcvision.com	(800) 638-3120
Life	Prudential	www.prudential.com/gi	(877) 232-3619
Short-Term Disability	The Standard	www.standard.com	(888) 494-9491
Long-Term Disability	The Standard	www.standard.com	(888) 494-9491
Long-Term Care	Prudential	www.prudential.com/gltcweb group name = metroltc; access code = nashville	(800) 732-0416
Flexible Spending Accounts	FBMC	www.myfbmc.com	(800) 342-8017
COBRA	COBRAGuard	www.cobraguard.net	(866) 442-6272
IOD Network Program	ASC	Link through www.nashville.gov	(615) 360-2800
MetroMax 457 Deferred Compensation	ING	www.nashville.gov/metromax	(615) 627-1500
Metro Human Resources	www.nashville.gov/hr_benefits/		(615) 862-6700

2012 Benefit Plan Rates (per pay period¹)

Plan	Coverage Level	General Government		MNPS Employees	
		12-month Semi-Monthly ¹	9-month Semi-Monthly	12-month Bi-Weekly	10-month Bi-Weekly
BCBS	Single	\$75.50	\$100.67	\$69.69	\$86.29
	Family	\$181.00	\$241.33	\$167.08	\$206.86
CIGNA	Single	\$73.00	\$97.33	\$67.38	\$83.43
	Family	\$174.50	\$232.67	\$161.08	\$199.43
Dental	Single	Metro provides Single Coverage at No Cost to You			
	Family	\$18.86	\$25.16	\$17.42	\$21.56
Vision	Basic Plan				
	Single	\$1.55	\$2.07	\$1.43	\$1.77
	Family	\$4.74	\$6.32	\$4.38	\$5.42
	Enhanced Plan				
	Single	\$2.12	\$2.83	\$1.96	\$2.42
	Family	\$6.79	\$9.05	\$6.27	\$7.76
Short-Term Disability	Monthly premium is .032 times your weekly pay. Example: \$400 weekly earnings x .032 = \$12.80 per month				
Long-Term Disability	Monthly premium is .0035 times your monthly pay. Example: \$1,600 monthly earnings x .0035 = \$5.60 per month				
Long-Term Care	Contact Prudential for rates.				
Supplemental Life	Age		Monthly Rate per \$10,000 in coverage		
	0 to 29		\$0.30		
	30 to 34		\$0.50		
	35 to 39		\$0.60		
	40 to 44		\$0.90		
	45 to 49		\$1.50		
	50 to 54		\$2.20		
	55 to 59		\$3.80		
	60 to 64		\$5.00		
	65 to 69		\$6.80		
70 and over		\$8.20			
Dependent Life	\$2.18 per month for spouse and eligible dependent children				

¹ General Government employees paid bi-weekly (26 pay periods) will have premiums deducted from 24 pay periods.

Benefits at a Glance

Eligible Metro employees have the option to enroll in the following benefit plans. You may make changes to your benefits within 60 days of an eligible change in status or during Annual Enrollment.

Core Benefit Options and Highlights

Medical	<p>Plan Options:</p> <ul style="list-style-type: none"> • BCBS PPO – 80/20% coinsurance plan with copays • CIGNA Choice Fund – HRA funded by Metro to pay first dollar claims before you pay a deductible
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Dental	<p>Plan Options:</p> <ul style="list-style-type: none"> • Premier – \$1,000 annual benefit max; may choose any dentist but higher benefits with an in-network dentist • Limited PPO – higher benefits but must choose dentist from list of providers
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Basic Life AD&D Insurance	<p>\$50,000 basic term life \$50,000 Accidental Death & Dismemberment insurance</p>
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Pension	<ul style="list-style-type: none"> • 5-year vesting with a future retirement benefit • 10-year eligibility requirement for medical disability • In-line-of-duty injury benefits available
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Optional Benefits and Highlights

Vision	<p>Plan Options:</p> <ul style="list-style-type: none"> • Basic – eye exam every 12 months; glasses or contacts every 24 months • Enhanced – eye exam every 12 months; glasses or contacts every 12 months
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Short-Term Disability	60% of weekly pay; benefit begins once disabled 7 days with maximum of 180 days
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Long-Term Disability	50% of monthly pay; benefit begins once disabled 180 days
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Supplemental Life	Guaranteed coverage for new hires up to \$200,000 with option to increase to \$500,000 with proof of good health during Annual Enrollment
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Dependent Life	<ul style="list-style-type: none"> • Must enroll in Supplemental life to purchase Dependent Life • \$10,000 spouse coverage; \$5,000 each eligible dependent child
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FSA	<ul style="list-style-type: none"> • Health Care FSA – annual election up to \$5,000 • Dependent Care FSA – annual election up to \$5,000
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Enrollment & Eligibility

Eligible Employees and Coverage Effective Date

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

Opting Out of Coverage

Employees who can enroll in other medical and/or dental coverage may opt out of Metro's insurance coverage. To opt out, you must provide proof of other coverage – 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 non-Metro medical or dental coverage or have an eligible change in status, you have 60 calendar days to re-enroll in Metro's medical or dental plan.

Coverage Levels

You may choose from two levels of medical, dental and vision coverage:

- Single – employee only coverage;
- Family – employee plus one or more dependents.

Eligible Dependents

You may elect family coverage and enroll your eligible dependents in your medical, dental, vision and dependent life insurance (life

insurance coverage up to age 24). Eligible dependents include your:

- spouse (as legally recognized by the State of Tennessee, while not divorced or legally separated); and
- dependent child(ren) from birth up to age 26 if he/she:
 - is your 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;
 - is your stepchild whose primary residence is with you and your spouse;
 - is 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;
 - and he/she is not eligible for their own employer-sponsored health plan; and
 - dependent child(ren) over age 26, if coverage under Metro benefits has been continuous and he/she is incapable of self-sustaining employment by reason of mental retardation or physical handicap (contact Human Resources for details).

The following are not eligible for Metro benefits:

- foster children (placed in the home for care, but not adoption);
- stepchildren whose primary residence is not with you and your

- spouse;
- ex-spouses, except as allowed under COBRA; or
- parents of the employee or spouse.

Eligible Changes in Status

The benefits you choose at your initial enrollment 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 spouse;
- Loss of coverage for you, your spouse or dependent; or
- 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.

Metro Pensioners may not add dependents during Annual Enrollment and may only add dependents within

60 days of an eligible change in status.

Pre-Tax Payroll Deductions

Medical, dental and vision insurance premiums are deducted from your pay in pre-tax dollars, which lowers your taxable income. You may make an election during Annual Enrollment to have your premiums deducted in after-tax dollars. Call Metro Human Resources for more information.

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 provisions. Your spouse and children 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; or
- 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.

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; or
- 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; and
- prostheses (artificial replacements) and physical complications at all stages of the

mastectomy, including lymphodemas.

Coordination of Benefits

Regardless of which medical plan you elect, you must be sure to notify your insurance carrier if your spouse or dependent receives health coverage outside of Metro's plan (for example, through your spouse'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.

Medicare Coverage

If you become eligible for Medicare while you are still actively employed by Metro, you are not required by Metro to take Medicare Parts A and B. However, once you are retired from Metro, you and your dependents are required to enroll in Medicare Parts A and B as soon as you first become eligible. If you do not enroll in Parts A and B, your medical claims will be coordinated as if you did have Medicare.

Subrogation

If you or your dependent receives benefits under Metro's health plan as a result of an injury or illness caused by another person, Metro has the right to recover payment from that person and his/her insurer. This

“subrogation right” applies to all payments made by Metro’s plan for related medical services.

You or your dependent may be asked to provide information and otherwise help in the recovery process. If you

fail to do so, or if you settle a claim without the written consent of Metro’s plan administrator, you will be responsible for paying any attorneys’ fees and court costs incurred in the recovery process.

Your Medical Plans

BlueCross BlueShield PPO

The BCBS PPO plan is an 80/20 coinsurance plan with copays that allow you the flexibility to select your physicians without referrals. After the annual out-of-pocket maximum has been met, you will continue to pay your copay, but your coinsurance level will be 100%. To receive the maximum benefits, you should use an in-network provider that participates in Network P. You may contact BCBS or visit their website for a list of in-network providers. If you choose to use an out-of-network provider, you will still receive benefits, but at a lower level (60/40) and you may be required to pay the entire bill up front and file a claim with BCBS for reimbursement.

Preventive Care

This plan provides each participant 100% preventive care coverage up to \$750 of in-network claims, then coverage is at 80% in-network. This means that your annual physical will be covered at 100% up to \$750 for each member covered under your plan with any expenses above \$750 covered at 80% as long as you use an in-network provider.

Please note that wellness screenings, such as the annual well-woman visit, mammogram, men’s PSA screening, and colonoscopy, will continue to be covered in-network at 80% and are not considered a part of the annual preventive benefit.

Pharmacy Benefits

Prescription drug coverage is provided by BCBS and is available through most retail and home delivery pharmacies. You may obtain a 34-day supply for the cost of one copay and a 35- to 102-day supply for the cost of two copays which may be filled at certain retail pharmacies or through home delivery and mail order programs. The generic drug copay is considerably less than the copay of a brand name drug.

If you take a maintenance prescription on a regular basis, you should talk with your doctor about writing your prescription so that you may take advantage of the two copays rather than three. A list of all participating pharmacies may be obtained by calling BCBS or by visiting their website.

CIGNA Choice Fund

Fund and Deductible

The CIGNA Choice Fund is a health reimbursement arrangement where traditional medical coverage is combined with a Fund of contributions made by Metro. The HRA Fund can be used to pay for eligible health care and pharmacy expenses during the plan year. CIGNA has negotiated discounts with providers in their Open Access Plus Network and to receive the maximum benefits you should select providers in this network. There are no copays with the CIGNA Choice Fund; the full cost of the negotiated discount is the amount that is owed to the provider. If you choose to use an out-of-network provider, you will still receive benefits, but at a lower level and you may be required to pay the entire bill up front and file a claim with CIGNA for reimbursement.

Any money you have remaining in your HRA Fund at the end of the plan year will roll over to the next plan year and lower the amount of your deductible for that year.

Once the Fund has been exhausted, there is a deductible that you must meet before the plan begins paying at the coinsurance level. When your annual out-of-pocket maximum has been met, you have 100% coverage for the remainder of the plan year. If you become enrolled with a coverage effective date of April 1 or later, your HRA Fund and deductible will be prorated based upon the quarter in which your coverage becomes effective. If during the

same year that your coverage becomes effective, you add a dependent as a result of an eligible change in status, the HRA Fund and deductible will be increased as if you had family coverage on your insurance effective date. If you change from family coverage to single coverage at any point during the year, the HRA Fund and deductible will not be decreased or prorated.

Incentive Programs

You can earn incentive dollars that will be added to your Fund and thereby decrease your deductible by qualifying and participating in one of the incentive programs. These programs and incentives are available on an annual basis:

- Health Risk Assessment (online health questionnaire) – this questionnaire is short, simple and easy to use, and helps CIGNA provide you with a holistic view into your health risks and provides a personalized health profile.
 - \$100 per person 18 and older upon completion (\$200 maximum per family).
 - Available to employees, pensioners, spouses and Dependents age 18 or older.
- Disease Management for Cardiac, Diabetes and Chronic Obstructive Pulmonary Disease (COPD)
 - \$100 per person (\$200 maximum per family and up to two family members can qualify for one program per year).

- Active participation is defined as engaging in three (3) telephone sessions with a CIGNA Well Aware nurse.
- Tobacco Cessation Program
 - \$50 per person (\$200 maximum per family).
 - Active participation is defined as engaging in two (2) telephone sessions with a CIGNA coach within the 12 month duration of the program.
- Healthy Pregnancies, Healthy BabiesSM
 - \$150 if you enroll by the end of your first trimester, or
 - \$75 if you enroll by the end of your second trimester.
 - Participation in the program is designed to help you and your baby stay healthy during your pregnancy. This program encourages you to get prenatal care early in your pregnancy. When you complete the program and after your baby is born, you will receive the incentive dollars.

Preventive Care

In-network preventative care services are covered at 100% and are not

applied against the HRA Fund. Preventive services received from an out-of-network provider are covered at 70% and do reduce the dollars in your Fund.

Pharmacy Benefits

Prescription drug coverage is provided by CIGNA and is available through most pharmacies and by mail order. While you are in the Fund and deductible levels, you will pay the full price of the discounted cost of the generic or brand-name drug. Once you have moved into the coinsurance level, you will pay 10% of the discounted cost for generic drugs and 30% of the discounted cost for brand name drugs.

The pharmacy will determine the amount you owe, if any, for the prescription drug depending upon the fund balance in your HRA Fund and if you have met your deductible. If you have exhausted your fund but not yet met the deductible, you will pay the full price of the discounted cost of the drug at the time you pick up the drug.

A list of all participating pharmacies may be obtained by calling CIGNA or by visiting their website.

2012 Health Plan Comparison Highlights

Covered Benefit	BCBS PPO		CIGNA Choice Fund	
	In-Network ¹ (Blue Network P)	Out-of-Network ^{1,2}	In-Network ¹ (Open Access Plus)	Out-of-Network ^{1,2}
Health Reimbursement Account (funded by Metro) ³	n/a		\$1,100 Single \$2,200 Family	
Deductible	n/a	\$200 Single \$600 Family	\$450 Single \$900 Family	
Coinsurance	80%	60%	90%	70%
Annual Out-of-Pocket Maximum (deductible + coinsurance)	\$1,000 Single \$2,000 Family	\$5,000 Single \$10,000 Family	\$1,150 Single \$2,300 Family	\$5,000 Single \$10,000 Family
Hospital	80%	60%	90%	70%
Emergency Room	\$100 copay; copay waived if admitted		90%	90%; 70% if not true emergency
	80%	60%		
Office Visits Surgery Consultations Allergy Injections	Copay: \$20 for primary care physicians ⁴ \$30 specialists ⁴		90%	70%
	80% after copay	60% after copay		
Maternity	\$20 copay for initial visit		90%	70%
	80%	60%		
Well-Care / Preventive Care (age 7 and older)	100% up to \$750; then 80% ⁵	60% ⁵	100%	70% HRA Fund reduced
Well-Care / Preventive Care (age 6 and younger)	80%	60%	100%	70% HRA Fund reduced
Prescription Drugs ⁶ (shown as amount you pay)	Generic: \$10 copay Brand-Name: \$30 copay 35- to 102-day supply: 2 copays Mail Order Program available		You pay: Generic: 10% of discounted cost Brand-Name: 30% of discounted cost Mail Order Program available	
Mental Health Out-Patient Substance Abuse Out-Patient Group Therapy	No pre-authorization required; \$20 office visit copay		No pre-authorization required	
	80%	60%	90%	70%
Mental Health In-Patient Substance Abuse In-Patient	Pre-authorization required		Pre-authorization required	
	80%	60%	90%	70%
Temporomandibular Joint Syndrome (TMJ)	Non-surgical: 50% with a \$2,000 annual maximum		Non-surgical: \$2,000 annual maximum	
			Non-surgical: 70%	Non-surgical: 50%
	Surgical: 80%	Surgical: 60%	Surgical: 90%	Surgical: 70%

¹ In-Network and Out-of-Network benefits are paid at the maximum allowable charge after plan deductible you owe.

² If you choose an Out-of-Network provider you will pay any amount above the maximum allowable charge.

³ Pensioners with Medicare Parts A and B do not receive the HRA Fund.

⁴ Primary care physicians include pediatricians, family and general practitioners, internists, gynecologists and obstetricians. A specialist includes physicians highly trained in a specific area such as cardiology, dermatology, neurology, podiatry, oncology and specialized obstetricians and gynecologists.

⁵ Screening colonoscopies, mammograms, prostate exams and pap exams will be paid at 80% in-network with copay (60% out-of-network with copay) and are not included in the well-care benefit.

⁶ Certain Drugs may require pre-authorization and quantities of some drugs may be limited.

2012 Dental Plan Comparison Highlights

Covered Benefit	Delta Dental Premier ¹		Delta Dental Limited PPO ²
	In-Network	Out-of-Network	
Plan pays	Higher benefits with in-network care; out-of-network care is available		In-network care only
Cleanings	One cleaning within a 6-month period are covered at 100% of MPA ³		
Calendar Year Maximum	\$1,000 per person		No annual maximum
Calendar Year Deductible	\$75 per person; \$225 per family		No deductible
Class I – preventive and diagnostic care (initial and periodic exams, cleanings, routine x-rays)	100% no deductible	100% of MPA ³ ; no deductible	100% for most benefits (except space maintainer)
Class II – basic restorative care (fillings to include posterior composites, extractions, root canal, periodontal treatment)	80% no deductible	80% of MPA ³ ; no deductible	100% of some services; flat dollar amount set for other services
Class III – major restorative care (crowns, dentures, bridges)	50% after deductible	50% of MPA ³ ; after deductible	Flat dollar amount set for most services
Class IV – orthodontia (braces)	\$100 lifetime deductible ⁴ ; \$1,000 lifetime maximum		Flat dollar amount set for most services
	50% after deductible	50% of MPA ³ after deductible	
Class V – Temporomandibular Joint Syndrome (TMJ)	\$100 calendar year deductible ⁴ ; \$750 lifetime maximum		Not a covered benefit
	50% after deductible	50% of MPA ³ after deductible	
Pre-Determination of Benefits	Before starting treatment, your dentist may do a pre-determination with Delta Dental for any procedure over \$300. This will let you know if the procedure is covered and approximately how much the work will cost you. Pre-determination does not guarantee benefits.		
Optional Services	You are responsible for optional services that cost more than Delta Dental's normal coverage for that service. For example, if your plan allows for amalgams only, even though a metal or porcelain inlay is suggested by your dentist, Delta Dental will pay for only the cost of the amalgam.		

¹ If you are a member of the Premier Plan and your dentist participates in both the Delta Dental Premier and PPO networks, your claims will be processed at the PPO network discounted fee, subject to the Premier plan's calendar year maximums and deductibles.

² Under the Delta Dental Limited PPO, you must visit a dentist in the Delta Dental PPO network or you will not receive benefits; however, you do not need to choose a primary care dentist. There are no out-of-network benefits available with this plan.

³ You are not responsible for charges over the maximum plan allowance (MPA) if you go to a participating Delta Dental dentist. You are responsible for charges over the MPA if you go to a non-participating dentist.

⁴ These deductibles are in addition to the plan deductible.

Vision Comparison Highlights

Regardless of which vision plan you choose, you pay the full cost of the vision premiums at group rates. Both plans provide for an annual exam with a copay. The Enhanced Plan allows you to get glasses or contacts every year while the Basic Plan only gives you the option of glasses or contacts every 24 months. Before selecting a plan, decide how frequently you and your dependents need glasses or contacts.

Covered Benefit	Basic Plan		Enhanced Plan	
	In-Network	Out-of-Network ^{2,4}	In-Network	Out-of-Network ^{2,4}
Exam	Once every 12 months		Once every 12 months	
	100% with \$10 copay	Reimbursed up to \$45	100% with \$10 copay	Reimbursed up to \$45
Lenses ¹	Once every 24 months		Once every 12 months	
	\$10 copay (applied to lenses & frame); 100% coverage for single vision, lined bifocal, lined trifocal & lenticular lenses	Reimbursed up to: Single vision \$40 Lined bifocal: \$60 Lined trifocal: \$80 Lenticular: \$80	\$25 copay (applied to lenses & frame); 100% coverage for single vision, lined bifocal, lined trifocal & lenticular lenses	Reimbursed up to: Single vision \$40 Lined bifocal: \$60 Lined trifocal: \$80 Lenticular: \$80
Frames ^{1,2}	Once every 24 months		Once every 12 months	
	\$10 copay (applied to lenses & frame); \$130 frame allowance at retail chain providers and private practice providers	Reimbursed up to \$50	\$25 copay (applied to lenses & frame); \$130 frame allowance at retail chain providers and private practice providers	Reimbursed up to \$50
Contact Lenses ^{1,2,3}	Once every 24 months		Once every 12 months	
	Elective: \$10 copay; reimbursed up to \$125 Medically Necessary: \$10 copay	Elective: reimbursed up to \$125 Medically Necessary: reimbursed up to \$210	Elective: \$25 copay; reimbursed up to \$125 Medically Necessary: \$25 copay	Elective: reimbursed up to \$125 Medically Necessary: reimbursed up to \$210

¹ You may choose between contacts or eyeglasses. If you choose contacts, the benefit does not apply to eyeglasses (lenses and frame) during the same service period.

² You are responsible for any amount over the reimbursed or allowance amount.

³ The \$125 allowance covers exam, contact lens(es), fitting and evaluation. You are responsible for any amount over the reimbursed or allowance amount.

⁴ A limit of 2 out-of-network claims will be processed per year; therefore, it may be necessary for you to hold your receipts and submit with one or two claims per year.

Life Insurance

Basic Life and AD&D Insurance

Metro provides active employees – at no cost to you – with basic life insurance and accidental death and dismemberment (AD&D) insurance. Each employee is covered with \$50,000 in basic life and \$50,000 for AD&D. Active employees over the age of 65 are covered in the amount of \$32,500 for both basic life and AD&D. As a disability or service pensioner, Metro will provide you with \$10,000 in basic life insurance coverage.

Accidental death and dismemberment insurance provides you or your beneficiary with a benefit if you suffer certain accidental injuries or if you die from an accident. The amount of AD&D injury benefit is based on the type of injury while the amount of the AD&D death benefit is based on the amount of your coverage at the time of your death.

Please refer to the life insurance policy located on Metro Human Resources' website for more information concerning your life insurance benefits.

Supplemental Life

As a new employee, you may elect to purchase additional life insurance in \$10,000 increments up to a maximum of \$200,000 without proof of good health. If you have a known condition that might preclude you from being approved by the insurance company, you should strongly consider enrolling when you first become eligible. If you decide to

wait and enroll later, you will be required to provide proof of good health.

If you are already an employee or enrolled in supplemental life, you may increase your coverage in increments of \$10,000 to a maximum of \$500,000 with proof of good health (or evidence of insurability – EOI) at Annual Enrollment or if you have certain eligible changes in status. If you are already enrolled, you may increase your coverage by \$10,000 at Annual Enrollment without proof of good health (as long as the increase does not take you above \$200,000).

Dependent Life

If you are enrolled in supplemental life insurance, you may also enroll in dependent life which provides \$10,000 in coverage on your spouse and \$5,000 for each dependent child (up to age 24) regardless of the number of dependents. The employee is automatically the beneficiary for dependent life claims.

You may enroll your spouse without proof of good health (EOI) if you enroll when you first become eligible – either at benefit eligibility or within 60 days of your marriage. Dependent children are not subject to proof of good health.

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.

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 your 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 for 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.

Beneficiary

You may change your beneficiary at any time by completing a new form with Metro Human Resources. When you experience an eligible change in status (such as with a marriage, divorce or death) you should consider updating your beneficiary at that time. You may also name different beneficiaries to receive your basic life and supplemental life benefits.

Conversion & 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.

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.

Short-Term Disability

Short-Term Disability (STD) is an optional benefit and replaces a portion of your Metro pay for up to 180 days if you become disabled by an injury, illness, or medical condition – including pregnancy and mental illness – cannot work and suffer a loss of income. After a seven day waiting period, benefits are payable at 60% of your weekly earnings up to a maximum weekly benefit of \$2,076.

If you do not have 10 years of credited service with Metro, you should consider enrolling in this benefit to protect your income and preserve any sick days you might have. If you are an employee of the Health Department or Hospital Authority, please check you're your department regarding their rules as they relate to sick leave and STD benefits.

Pre-existing Condition

If you have a pre-existing condition in the 90 days before you enroll in STD insurance, you may not be eligible for benefits for that condition for 12 months after the effective date of your coverage. After 12 months of continuous coverage, the pre-existing condition is waived.

Late Enrollment Penalty

If you do not enroll in this benefit 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 during the first 12 months after your coverage takes effect, your benefits will become

payable after you have been continuously disabled for 60 consecutive days and remain disabled.

Your Benefit

STD benefits are payable for up to 180 consecutive days from the date of your disability begins. Actual payments will begin at the end of a seven day waiting period. During this waiting period, you may use sick or vacation leave. The STD benefits you receive are not taxable but are coordinated with other Metro benefits you may receive. While you receive STD benefits, you will be eligible to continue to your medical and dental insurance and must make an election as to how to pay your premiums during this time.

If you are also eligible for Family Medical Leave (FMLA), your STD and FMLA time will run concurrently with each other. If pregnancy and childbirth is your disabling condition, please keep in mind that you will only receive STD benefits for the period of time your doctor and the insurance carrier deem you disabled – typically six weeks after a normal delivery.

Applying for STD Benefits

To apply for STD benefits, you should contact your department's HR Representative who will assist you in completing an application. You will also be required to provide medical documentation to support your claim. The insurance company will notify you when and if you are approved.

Long-Term Disability

Long-Term Disability (LTD) is an optional benefit and replaces a portion of your Metro pay if you become disabled by an injury, illness, or medical condition and cannot work. After a 180-day waiting period (typically after short-term disability benefits end), benefits are payable at 50% of your monthly earnings up to a maximum monthly benefit of \$7,500.

You are not required to enroll in short-term disability (STD) to enroll in LTD benefits – you may enroll in one or the other or both. If you do not have 10 years of credited service with Metro, you should consider enrolling in this benefit.

Proof of Good Health

If you do not enroll in LTD benefits within 60 days of becoming eligible, proof of your good health (evidence of insurability – EOI) will be required to enroll.

Pre-existing Condition

If you have a pre-existing condition in the 90 days before you enroll in LTD insurance, you may not be eligible for benefits for that condition for 12 months after the effective date of your coverage. After 12 months of continuous coverage, the pre-existing condition is waived.

Your Benefit

LTD benefits are payable monthly after you have been disabled for 180 consecutive days. During this waiting period, you may use sick or vacation leave in addition to any STD or FMLA for which you may be eligible. The

LTD benefits you receive are not taxable but are coordinated with other benefits you may receive. If you become disabled before age 62, benefits may continue during disability until your age 65. If you become disabled after age 62 or older, the length of your payments vary upon when your disability begins. Contact the insurance carrier for more information.

Once you begin receiving LTD benefits, you will no longer be a Metro employee and will need to resign from employment. You will be eligible to continue to 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 will not affect your LTD benefits.

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

Applying for LTD Benefits

To apply for LTD benefits, you should contact your department's HR Representative who will assist you in completing an application. You will also be required to provide medical documentation to support your claim. If you are transitioning from STD to LTD, you will not be required to file a new claim form. The insurance company will notify you when and if you are approved.

Long-Term Care Insurance

Long-Term Care coverage is optional and provides help or supervision needed for someone with severe cognitive impairment or the inability to perform two of the normal activities of daily living such as bathing, dressing, eating, toileting, transferring and continence. Services may be provided at home or in a facility – and care may be provided by a professional caregiver, friend or family member.

Long-Term Care coverage may be purchased for yourself, your spouse, children over the age of 18 and their spouses, and even for your parents, grandparents and in-laws. If you elect coverage for yourself when first eligible, you will not be required to provide proof of good health (evidence of insurability – EOI);

however, pensioners and other eligible dependents will be required to provide EOI.

Please do not confuse Long-Term Care with Long-Term Disability. Long-Term Disability is designed to cover employees during injuries and illness that prevent them from working and Long-Term Care is for those that have trouble with the activities of daily living.

Contact the insurance carrier for more information about the different levels of coverage and the group-rate premiums. If you enroll, the insurance carrier will bill you directly for the premiums rather than premiums being withheld from your paycheck.

Flexible Spending Accounts

A Flexible Spending Account (FSA) is an account you set up to pre-fund your anticipated eligible medical expenses and dependent care expenses on a tax-free basis. Your participation in these accounts does not automatically continue from year to year – you must set up FSAs each year. Your FSA funds are evenly deducted from your paychecks before taxes are calculated which lowers your taxable income and saves you tax dollars on money you plan to spend anyway. You may choose from two accounts – Health Care FSA and a Dependent Care FSA and may

contribute as little as \$240 or as much as \$5,000 per year to each account.

Important FSA Information

FSAs are easy to set up and use once you understand how they work. Here are a few simple guidelines you should know:

- When determining an amount to contribute toward your FSAs, you should estimate your expenses carefully since any funds left over at the end of the year (March 15 for the Health Care FSAs) will be

forfeited and cannot be rolled into the next plan year.

- For FSA purposes, an eligible expense is incurred when the health care or dependent care service is received, not when the bill is received or paid.
- You have until June 15 of the following year to file for reimbursement of health care expenses and until March 15 to file claims for dependent care expenses incurred in the previous year.
- FSAs do not automatically continue the next plan year – you must elect to participate annually during Annual Enrollment.
- Once you make the election to participate in an FSA, you are “in” for the entire year and cannot increase or decrease your election amount unless you have certain eligible changes in status.
- If you leave Metro, you may incur claims up to the end of the month in which you get your last paycheck and you have 90 days from that date to submit claims for reimbursement.

For more information concerning FSAs, eligible expenses and information regarding reimbursements visit the FSA administrator’s website.

Health Care FSA

Health Care FSAs cover most healthcare expenses that are not already covered by your medical, dental and vision plans, including deductibles, copays, coinsurance, expenses above “maximum allowable charge” insurance limits, prescriptions and limited over-the-

counter items prescribed by your physician (for a complete list of eligible expenses, log on to the FSA vendor’s website). You can even use your FSA to pay healthcare expenses for dependents who are not covered by Metro benefits, such as a spouse who has coverage where he/she works, as long as you claim the individual on your federal tax return.

The Health Care FSA allows you to receive reimbursement for eligible expenses as you incur the expense even if your account balance is below the amount of reimbursement being requested. To receive reimbursement, you must provide a receipt or other proof of purchase from the provider and submit a claim form to the FSA administrator.

You may use the FSA Debit Card to cover the cost of your prescription drugs (but not over-the-counter items). Simply swipe the stored-value card at the time you are paying for the eligible items and the cost will be automatically deducted from your healthcare FSA account without the need to send receipts to Metro’s FSA administrator. If you are using the FSA debit card at a pharmacy other than one of the national chain stores, you will be required to submit a claim form along with your pharmacy receipt. For a complete list of where the FSA debit card may be used, please visit the FSA administrator’s. The FSA debit card cannot be used for physician, dental or other medical services.

Grace Period

If you enroll in a Health Care FSA and you have funds left over at the end of

the year, you have a grace period of an additional 2 ½ months (through March 15) in which you can incur eligible expenses. Any remaining funds at the end of the grace period will be forfeited and cannot be rolled over to the following year.

Dependent Care FSA

The Dependent Care FSA is a great way to pay for eligible dependent care expenses such as daycare services, after-school care, nursery and pre-school, summer day camps and senior centers. Eligible dependents include your qualifying child under age 13, a disabled spouse, parent or child age 13 and

older who is physically or mentally incapable of caring for himself or herself, spends at least 8 hours a day in your home and is a dependent on your federal tax return.

The caregiver can even be a relative of yours as long as he/she is not one of your dependents for tax purposes and you are able to provide a Social Security number or employer ID number for the individual or company providing the services.

You may only be reimbursed for the balance in your Dependent Care account.

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 (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 direct to Metro on an after-tax

basis; or

- 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 reenroll 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 reenroll 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.

If 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 LTD will be required when you return from leave.

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 reenroll 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 reenroll 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 direct to Metro on an after-tax basis; or
- 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 reenroll 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 a post-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.

If your Metro employment ends?

Your benefit coverage will terminate at the end of the month in which you receive your last paycheck. If premiums were deducted from the second paycheck in the month that you terminate, that last premium will

be refunded to you. If you are a MNPS employee, contact the MNPS Benefit Office for your coverage termination date.

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.

If you were enrolled in medical insurance, you will receive a Certificate of Creditable Coverage from your insurance company within 14 days from the date your insurance coverage ends. This letter may be given to your next employer to show that you had prior insurance coverage.

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 flexible spending account 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 at least 5 years of credited service with Metro, 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 or minor dependent child(ren) may be entitled to receive pension benefits immediately.

In-Line-of-Duty Injury Network Program

Metro's Injured on Duty (IOD) program provides quality medical treatment – at no cost – to Metro employees who are injured on the job. Metro's IOD program is administered by Alternative Service Concepts (ASC) whose role is to manage the IOD injury claim process, assist you in coordinating your medical care while ensuring your successful return to work. Full and rapid recovery is the goal for any Metro employee who is injured on the job.

If you are injured on the job, you should report your injury to your supervisor and/or department safety representative immediately. If your injury is urgent or life-threatening, seek treatment immediately from the

nearest hospital.

Under Metro's IOD program, you have the choice of using the IOD program's Network of providers or your own Metro health plan (provided you are enrolled in one of Metro's health plans). The IOD Network of providers is the same network used by Metro's BCBS PPO medical plan (Network P). If you choose to use your own medical care provider, you will be responsible for copays and deductibles at time of treatment and may later file claim forms for reimbursement of your verified out-of-pocket expenses with ASC.

For more information about Metro's IOD Network Program, contact the IOD program administrator.

Pension Benefits

Service Retirement Pension

After you have earned five years of credited service, Metro offers – at no cost to you – a monthly service retirement benefit. If you are vested and die, survivor benefits will be payable to your legal spouse or eligible dependent child(ren).

There are two types of retirement pensions – a normal service pension or an early reduced pension benefit.

If you elect an early service pension, you will receive a 4% reduction per year for each of the first five years you retire early and an 8% reduction for each year over five years with a maximum reduction of 60%.

You may estimate your retirement benefit using the online pension estimator on Metro Human Resources' website.

General Government Pension Plan

Normal Retirement

Benefits begin at age 60 once your age plus your years of service equal 85 points or at age 65 with 5 years of service.

Early Retirement

Reduced benefits begin at age 50 once you have 10 years of service

Police & Fire Pension Plan

Normal Retirement

Benefits begin at age 53 once your age plus your years of service equal 75 points or at age 60 with 5 years of service.

Early Retirement

Reduced benefits begin at age 45 once you have 10 years of service

Disability Pension

Metro offers two types of disability pension benefits – 100% paid for by Metro with no employee contribution.

- Medical Disability – must have 10 years of credited service to be eligible
- In-Line-of-Duty (IOD) –

immediate coverage for work-related injuries

- Your monthly benefit is 50% of your last 12 months earnings

Applying for Pension Benefits

You must apply for retirement or disability benefits with Metro Human Resources and provide certain documents such as birth certificates, Social Security cards, marriage license or divorce decree at the time of your application. Contact Metro

Human Resources to apply.

* The pension benefits discussed in this document pertain to the Metro – Division B pension plan which covers employees hired July 1995 and later and employees who made an election to transfer to Division B.

MetroMax 457 Deferred Compensation Plan

Metro employees may elect to participate in the MetroMax 457 Deferred Compensation plan at any point. For more information or to enroll, contact ING, the plan administrator.