2025 BENEFITS

FOR ACTIVE EMPLOYEES

Metro Nashville

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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**.

2025 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	$103.38	$112.00	$149.33	$103.38	$134.40
	Employee + child(ren)	$144.92	$157.00	$209.33	$144.92	$188.40
	Employee + family	$265.38	$287.50	$383.33	$265.38	$345.00
HRA Plan	Employee only	$104.31	$113.00	$150.67	$104.31	$135.60
	Employee + child(ren)	$149.08	$161.50	$215.33	$149.08	$193.80
	Employee + family	$273.23	$296.00	$394.67	$273.23	$355.20
DENTAL						
Flexible Plan	Employee only	Metro provides employee only dental coverage at no cost to you				
	Employee + family	$18.84	$20.42	$27.22	$18.84	$24.50
Limited Plan	Employee only	Metro provides employee only dental coverage at no cost to you				
	Employee + family	$23.99	$25.99	$34.65	$23.99	$31.19
VISION						
Basic Plan	Employee only	$1.36	$1.48	$1.97	$1.36	$1.77
	Employee + family	$4.16	$4.51	$6.01	$4.16	$5.41
Enhanced Plan	Employee only	$2.15	$2.33	$3.11	$2.15	$2.80
	Employee + family	$6.87	$7.44	$9.92	$6.87	$8.93

2025 Benefit Plan Rates

Per pay period

DISABILITY INSURANCE	
Short-Term Disability	Monthly premium is .0261 times your **weekly** pay Example: $750 weekly earnings x .0261 = $19.58 per month
Long-Term Disability	Monthly premium is .00264 times your **monthly** pay Example: $3,000 monthly earnings x .00264 = $7.92 per month

LIFE INSURANCE	Age	Monthly Rate Per $10,000 in Coverage
Supplemental Life	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	**$5,000 per Child Plus Spouse/Domestic Partner Coverage Amount of:**	**Monthly Rate[1]**
	$10,000	$3.76
	$20,000	$7.12
	$30,000	$10.48
	$40,000	$13.84
	$50,000	$17.20

[1] Monthly rates cover 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.

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. Metro pensioners may not add dependents during Annual Enrollment and may only add dependents within 60 days of an eligible change in status.

Turning age 65 in 2025?

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

Under either option, you can go to any provider you choose, but benefits are highest when you see an in-network provider. Cigna negotiates with its network providers to get you discounted rates for medical services, supplies and prescription drugs. This helps lower your out-of-pocket expenses when you use network providers.

Find network providers

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

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**.

How the PPO Plan works

The PPO Plan is an 80/20 coinsurance plan, which means most non-preventive services are covered at 80% when you use network providers. Additionally:

- Limited preventive care is covered at 100% (up to $750 per year) for enrollees ages 7 and older; for enrollees under age 7, the coverage is 80%. See **page 9** for what is covered and not covered as preventive care.
- Office visits are covered at 80% after a $20 (PCP) or $30 (specialist) copay.
- There is no deductible if you use network providers.
- Out-of-network care is covered at a lower benefit amount, as shown in the chart on **page 16**.
- If you reach the out-of-pocket maximum, you continue to pay copays but no coinsurance for the rest of the year.

Medical

How the PPO Plan works continued

Preventive Care

Under the PPO Plan, the following are covered preventive care services:

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

The following services are **NOT covered** as preventive care services but instead covered at the normal benefit level of 80% in-network or 60% 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 is 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 2025 Annual Enrollment).

Turn to **page 10** to learn about the HRA Plan and **page 16** to compare the two medical options.

Telehealth

Cigna offers a variety of ways to connect with a doctor through your phone or computer. See **page 13** for details.

Behavioral Health

Challenges to mental well-being come in many forms, and so do the ways you can get help. See **page 14** 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.

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.

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 drugs 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).

→ If you don't use all your HRA Fund during the year, remaining funds will roll over to your 2026 HRA Fund and reduce your share of your 2026 deductible. This money is yours to spend on future eligible expenses as long as you remain enrolled in the HRA Plan.

↓

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 16**.

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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 2025.

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 15**.

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 Babies℠ 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/per person per calendar year.

How the HRA Plan Works continued

Preventive Care

Under the HRA Plan, all of the following preventive care services are covered at 100%, with no copay or coinsurance:

- Annual preventive health exam
- Childhood immunizations
- Blood pressure screening
- Flu and pneumonia shots
- Tetanus-diphtheria (Td) booster
- Other recommended adult immunizations and immunizations not completed in childhood
- X-rays and lab services associated with preventive care
- Vision and hearing screenings performed by the physician during the preventive health exam
- Prostate screening
- Routine Pap smears
- Well-woman exams
- Mammograms (preventive and diagnostic)
- 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 16**.

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 13** for details.

Behavioral Health

Challenges to mental well-being come in many forms, and so do the ways you can get help. See **page 14** for details.

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 14**.

MDLIVE

New for 2025! MDLIVE urgent care visits are covered at 100% — you pay $0.

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 14** 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

Both the PPO Plan and HRA Plan offer a wide range of 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 at no additional cost:

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 it
- 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**.

Health Coaching Programs

Cigna offers a variety of health coaching programs at no additional cost to you. See **page 11**. (Note: Only HRA Plan enrollees are eligible for health coaching incentives.)

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, offered through a collaboration with Ascension St. Thomas, 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 arthroplasty, 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 Amplifon network providers. There are no out-of-network benefits. Visit **amplifonusa.com/cigna** for more details.

Follow these steps to get started:

- Call Amplifon at **(888) 901-0811** to select a hearing specialist near you.
- A Patient Care Advocate will explain the Amplifon process and help you make a hearing exam appointment.
- Amplifon will send information to you and the hearing specialist prior to the appointment; this will ensure your Cigna benefit is activated.

Medical

MEDICAL BENEFITS ... AT A GLANCE

	PPO PLAN		HRA PLAN	
	In-Network OPEN ACCESS PLUS NETWORK	**Out-of-Network**	**In-Network** OPEN ACCESS PLUS NETWORK	**Out-of-Network**
Health Reimbursement Account Fund (Metro funded)[1, 2]	N/A	N/A	$1,100/employee only $2,200/family	
Your Share of the Deductible[2]	$0	$200/employee only $600/family	$450/employee only $900/family	
Coinsurance Maximum[2]	$1,000/employee only $2,000/family	$5,000/employee only $10,000/family	$700/employee only $1,400/family	$4,550/employee only $9,100/family
Annual Out-of-Pocket Maximum[2] (includes deduct. & coins. but not copays)	$1,000/employee only $2,000/family	$5,000/employee only $10,000/family	$1,150/employee only $2,300/family	$5,000/employee only $10,000/family
MEDICAL SERVICES				
After deductible, plan pays… (unless otherwise noted)				
Well Care/Preventive Care				
» Age 7 and older	100% up to $750, then 80%[3]	60%[3]	100%	70%
» Under age 7	80%	60%	100%	70%
Office Visits				
» Primary Care Physician[4]	80% after $20 copay	60% after $20 copay	90%	70%
» Specialist	80% after $30 copay	60% after $30 copay	90%	70%
In-office Procedures (surgery, consultation, allergy injections)	80% after office visit copay	60% after office visit copay	90%	70%
Maternity				
» Prenatal Care	You pay $20 copay for initial visit		90%	70%
» Delivery	80%	60%	90%	70%
Hospital	80%	60%	90%	70%
Emergency Room	80% after $100 copay (copay waived if admitted)	80% after $100 copay (copay waived if admitted)	90%	90%
Mental Health/Substance Abuse				
» Outpatient	80% after $20 copay	60% after $20 copay	90%	70%
» Inpatient (pre-authorization required)	80%	60%	90%	70%

MEDICAL BENEFITS ... AT A GLANCE ...continued

	PPO PLAN	HRA PLAN
Prescription Drugs		
You pay…		
1-month supply		After deductible:
» Generic	$10 copay	10% of discounted cost
» Brand	$30 copay	30% of discounted cost
3-month supply (maintenance drugs)	2 times above copays through certain retail pharmacies and mail order; see **page 9**	Same as above through certain retail pharmacies and mail order; see **page 12**

[1] Pensioners with Medicare A & B are not eligible to receive the Health Reimbursement Account Fund.

[2] If you enroll in the employee + child(ren) coverage tier, Metro's HRA Fund contribution (HRA Plan), your share of the deductible, coinsurance maximum and annual out-of-pocket maximum are the same as the family coverage tier.

[3] Screening colonoscopies, PSA tests, well-woman exams and Pap exams are covered at 80% after office visit copay (in-network) and 60% after office visit copay (out-of-network), but are not included in the $750 well-care benefit limit.

[4] 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.

Note: To view a complete copy of the plan documents and provisions, go to **nashville.gov/hr**.

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 (between 46 and 86 degrees). This device allows you to take your insulin with you when you leave home and ensure it's stored at just the right temperature.

Here's how to take advantage of this new benefit:

1. Choose and purchase a device and pay for it out of your own pocket.
2. Submit a **claim form to Cigna**.
3. Your insurance provider will process your claim as durable medical equipment and reimburse you based on your plan's benefits.

Medical

Help Me Choose

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

	PPO PLAN	HRA PLAN
Network providers	The PPO Plan and HRA Plan share the same network of providers and facilities.	
Free preventive care (age 7+)?	**Yes** In-network, plan pays 100% up to $750/year; then 80%	**Yes** In-network, plan pays 100%
Free preventive care (under age 7)?	**No** Plan pays 80% in-network	**Yes** In-network, plan pays 100%
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
Telehealth office visit covered?	If offered by your provider, cost same as in-person visit; also offered through MDLIVE, visit **myCigna.com**	
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)?	Plan pays 80%; you pay 20%	Plan pays 90%; you pay 10%
Coinsurance (out-of-network)?	Plan pays 60%; you pay 40%	Plan pays 70%; you pay 30%
Pre-negotiated discounted rates?	**Yes**	**Yes**
Annual out-of-pocket maximum?	Plan pays 100% after you spend $1,000/employee only, $2,000/employee + child(ren) or $2,000/employee + family; you continue to pay copays	Plan pays 100% after you spend $1,150/employee only, $2,300/employee + child(ren) or $2,300/employee + family (deductible + coinsurance)
Incentives for healthy behaviors?	**No**	**Yes** See **page 11**

* If you don't spend all your HRA Fund during the year, remaining funds roll over to the next year and are yours to use toward eligible expenses, as long as you remain enrolled in the HRA Plan.

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:	Pays up to $1,000/year[1]	Unlimited
Coverage for implants:	Yes	No
Coverage for TMJ treatment:	Yes	No
Coverage out-of-network:	Yes	No

[1] Not including orthodontia, TMJ care

Dental

DENTAL BENEFITS ... AT A GLANCE

	FLEXIBLE PLAN	LIMITED PLAN
	In-Network[1] (out-of-network coverage available)	In-Network Only[1] (no out-of-network coverage)
Annual Deductible	$75/person, $225/family	$0
Plan pays…		See schedule of benefits for cost by service[2]
Preventive/Diagnostic (2 exams/cleanings every 12 months, x-rays, sealants, fluoride)	100%; no deductible	100% for most services
Basic Restorative (fillings, extractions, oral surgery, root canals, periodontics)	80%; no deductible	100% for some services; you pay flat fee for other services
Major Restorative (crowns, bridges, dentures, implants)	50% after deductible	You pay flat fee for most services; implants not covered
Orthodontia (child and adult)	50% after annual deductible and one-time $100 orthodontia deductible	You pay flat fee for most services
Lifetime Orthodontia Maximum	$1,000/person	See schedule of benefits[2]
TMJ (temporomandibular joint) **Treatment**	50% after annual deductible and $100 annual TMJ deductible	Not covered
Lifetime TMJ Maximum	$750/person	N/A
Annual Benefit Maximum	$1,000/person (excludes orthodontia, TMJ)	N/A

[1] 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.

[2] View the Limited Plan schedule of benefits at **bcbst.com/members/metro-gov**.

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**.

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

VISION BENEFITS ... AT A GLANCE

	BASIC PLAN		ENHANCED PLAN	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$0		$0	
Exams	You pay $10 copay	Plan pays up to $45	You pay $10 copay	Plan pays up to $45
Lenses	**You pay:**	**Plan pays:**	**You pay:**	**Plan pays:**
» Single Vision	$10 copay	Up to $40	$25 copay	Up to $40
» Bifocals	$10 copay	Up to $60	$25 copay	Up to $60
» Trifocal	$10 copay	Up to $80	$25 copay	Up to $80
» Lenticular	$10 copay	Up to $80	$25 copay	Up to $80
Lens Options	**Plan pays:**		**Plan pays:**	
» Scratch-resistant Coating	100%	Up to $5	100%	Up to $5
» Standard Progressives	Not covered	Not covered	100%	Up to $35
» Polycarbonate	Not covered	Not covered	100%	Up to $10
Frames	Up to $130[1]	Up to $50	Up to $150[1]	Up to $50
Contacts (in lieu of frames/lenses)	**Plan pays:**		**Plan pays:**	
» Elective	Up to $125 after $10 copay[1]	Up to $125	Up to $140[1]	Up to $140
» Medically Necessary	100%	Up to $210	100%	Up to $210
Fit/Follow-up	**You pay:**	**Plan pays:**	**You pay:**	**Plan pays:**
» Standard Daily Wear	$20 copay	Up to $20	$20 copay	Up to $20
» Extended Daily Wear	$30 copay	Up to $30	$30 copay	Up to $30
Covers...	Exams, contact fit every 12 months; lenses, frames and contacts every 24 months		Exams, contact fit, lenses, frames and contacts every 12 months	

[1] In many cases, NVA offers a discount on amounts exceeding retail allowance; ask your network provider.

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 (STD) and long-term disability (LTD) coverage is administered by MetLife.

Short-Term Disability

Benefits begin...	After 7 days of disability (waiting period)
Plan pays…	60% of your eligible weekly pay, up to $1,250/week; limits may apply
Benefits generally continue…	For up to 180 days of disability

- STD benefits are payable for up to 180 consecutive days from the date 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 your medical and dental insurance and must make an election as to how to pay your premiums.
- If you are also eligible for Family Medical Leave (FMLA), your STD and FMLA time will run concurrently. If pregnancy and childbirth is your disabling condition, 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.

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

Benefits begin...	After 180 days of disability (waiting period)
Plan pays...	50% of your monthly earnings, up to $7,500/month; limits may apply
Benefits generally continue...	Until your disability ends or you reach age 65[1]

[1] If you are age 62 or older when your covered disability occurs, maximum benefit duration is based on a sliding scale. Contact **MetLife** for details.

- 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 you reach age 65. If you become disabled after age 62 or older, the length of your payments vary based 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.

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.

	HEALTH CARE FSA	DEPENDENT CARE FSA
You can contribute…	As little as $240 or as much as $3,200/year[1] — tax-free	As little as $240 or as much as $5,000/year[2] — tax-free
To reimburse yourself for…	Eligible health care expenses paid out of your pocket (certain rules apply)	Day care expenses for your eligible dependents (certain rules apply)

[1] Two Metro employees married to one another may each contribute 3,200, for a total of $6,400.

[2] If you're married and file separate tax returns, the maximum you can contribute is $2,500/year.

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, 2026, and submit claims until June 15, 2026. So if you overestimate the amount you put in your Health Care FSA, you can use the funds in 2026, 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 2025.

Flexible Spending Accounts (FSAs)

Tax-saving Example:

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 2025. Look how much he can save in one year.

	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 tax (7.65%)	- 318.78	- 248.01
Pay after taxes	**$3,223.17**	**$2,507.69**
After-tax monthly expenses	- 925	- 0
Net take-home pay after FSA reimbursement	**$2,298.17**	**$2,507.69**
Monthly savings	**$0**	**$209.52**

[1] 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 the next column. Proof of good health is not required for child coverage.

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

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

Continued on next page

Life Insurance

Additional Benefits continued

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 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.

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.

It's pre-tax.

Your contributions and their earnings are not taxed until money is withdrawn, so your money has more time to compound. And when you do pay taxes on the money later, you may be in a lower tax bracket.

Enroll Today

Whether you're coming from another employer or just starting your career, your local MetroMax (Voya) representatives are available to answer any questions you may have about the MetroMax 457(b). Give them a call 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.

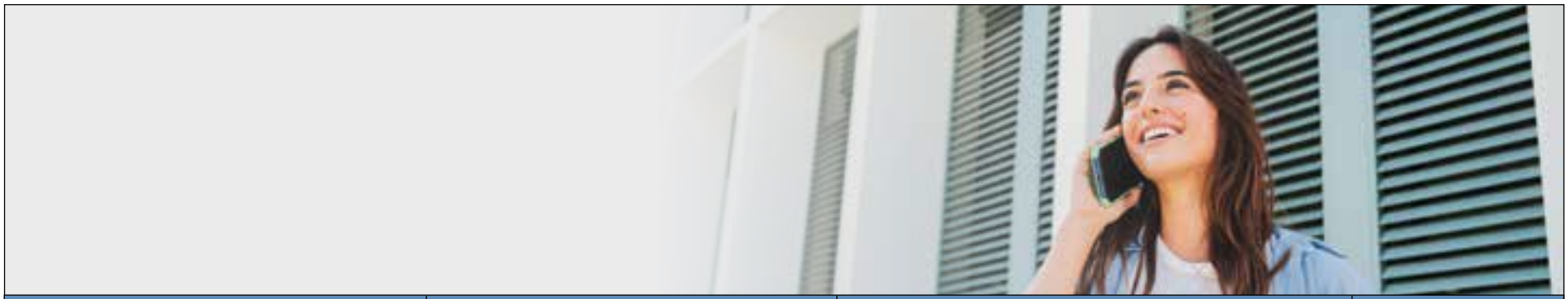
It probably costs less than you think.

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. You should consider your financial ability to consistently invest in up as well as down markets.

Important Contacts



PLAN	CARRIER	WEBSITE	PHONE
PPO Plan	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
HRA Plan			
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

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
- 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.

Continued on next page

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.

Continued on next page

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.

Continued on next page

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 direct 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.

Continued on next page

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 Plan 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.

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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.