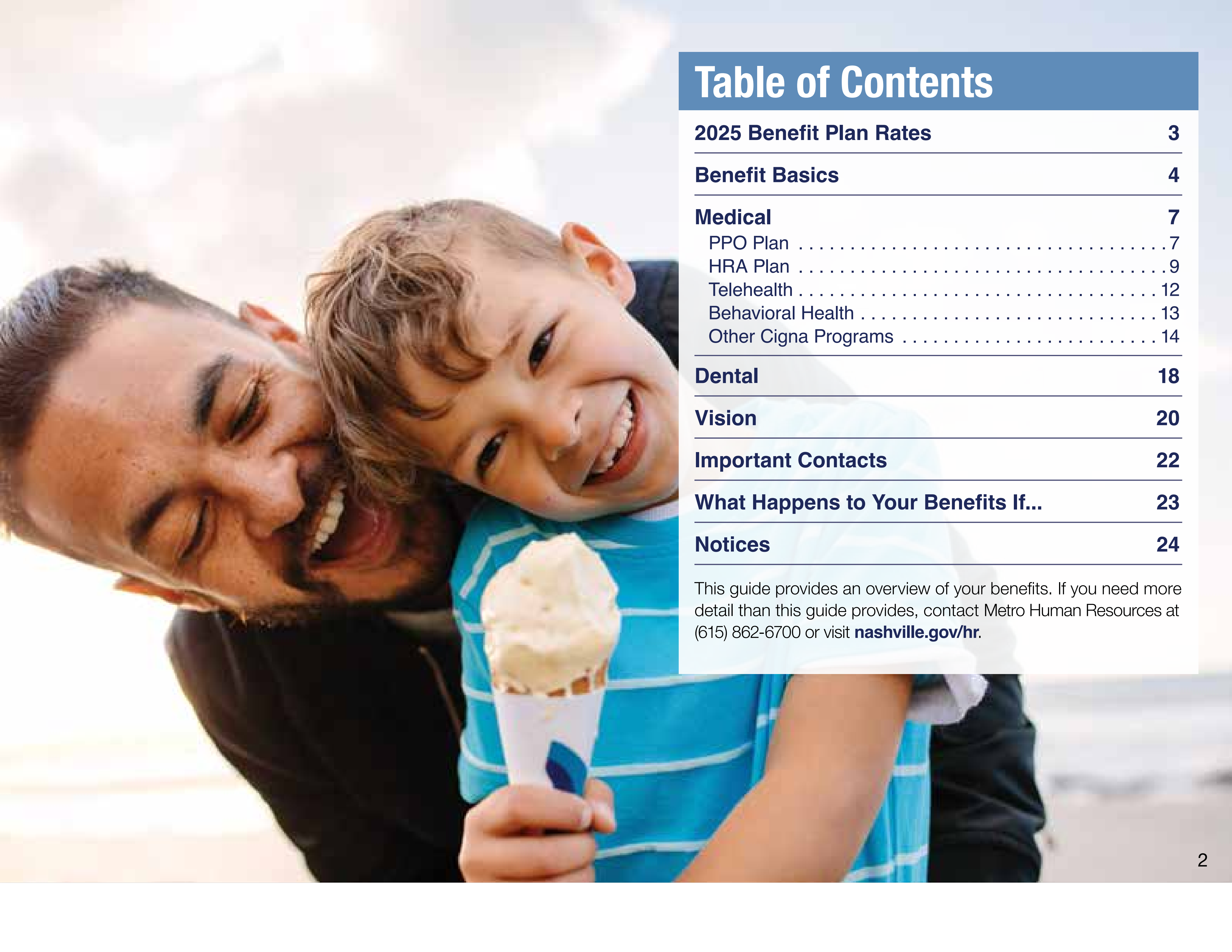
2025 BENEFITS

FOR COUNCIL MEMBERS

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

	Coverage Level	GENERAL GOVERNMENT 12-month Bi-Weekly	GENERAL GOVERNMENT 12-month Semi-Monthly	GENERAL GOVERNMENT 9-month Semi-Monthly	MNPS EMPLOYEES 12-month Bi-Weekly	MNPS EMPLOYEES 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

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

Opting Out of Benefits

If you are a Council member past age 65

When you turn age 65, you are eligible for Medicare Parts A & B, regardless of your employment status. If you are a Council member after you've reached age 65, 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 Council member 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.

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.

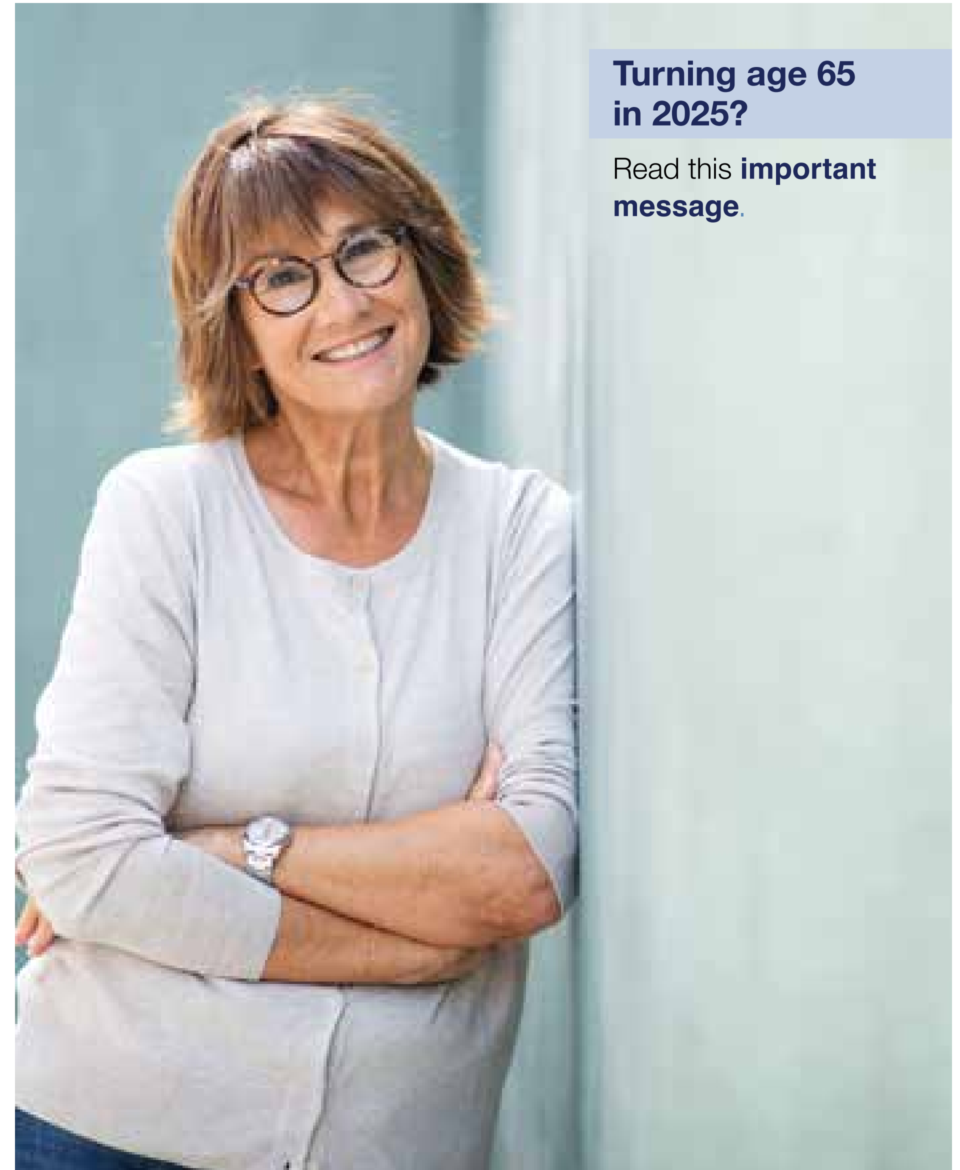
CHANGING YOUR BENEFITS

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.



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 8** 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 15**.
- If you reach the out-of-pocket maximum, you continue to pay copays but no coinsurance for the rest of the year.

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 9** to learn about the HRA Plan and **page 15** 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 12** for details.

Behavioral Health

Challenges to mental well-being come in many forms, and so do the ways you can get help. See **page 13** 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 15**.

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 14**.

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 15**.

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 12** for details.

Behavioral Health

Challenges to mental well-being come in many forms, and so do the ways you can get help. See **page 13** 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 13**.

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 13** 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**.

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.

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 10**. (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 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 11**

[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 10**

* 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.

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
General	Metro Human Resources	**nashville.gov/hr**	(615) 862-6700

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 Council member 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 Council member 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.

Continued on next page

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 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.

Continued on next page

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.