

January 1, 2015 – June 30, 2015



METRO EMPLOYEE
BENEFITS
HANDBOOK

TABLE OF CONTENTS

Introduction	3
Eligibility and benefit changes after enrollment	4
Health plans coverage levels	5
Cost for health insurance	8 - 10
Medical plan summary	11-20
Dental and vision plans summary charts	21
Life and accidental death and dismemberment (AD&D) insurance	22
Long term disability	24
Voluntary Short term disability.....	24
Flexible spending account	24-26
Employee assistance program	27
Travel Connect	28
Public Employees Retirement System (PERS)	29
401(k) and 457 retirement plans	30
Other benefits and e-Portal	31
Important benefit notices	33-36
Contact information	37

Forms

Medical and dental enrollment/change form (required for newly eligible employees or for current employees changing plans)

Health Savings Account Enrollment Form (required if enrolled in a High Deductible Health Plan)

Flexible Spending Account Enrollment Form

Lincoln Financial group life insurance and long-term disability Enrollment Form (required for newly eligible employees)

IMPORTANT NOTE

This handbook provides a summary of benefits. To learn about your specific benefits, refer to your labor contract and employment policies. You can find your complete contract on the Metro intranet or get a copy by contacting the benefits department at 503-797-1723 or benefitshelp@metro-region.org.

Welcome. Your Benefits Handbook is a general guide to the benefits you receive as a Metro employee. **Please keep this handbook available for your use as a convenient reference throughout the entire benefits year.**

When enrolling for benefits, whether during open enrollment or as a new employee, take ample time to educate yourself on what each plan provides and how the various plan provisions fit your needs. Your benefits package is part of your overall compensation package from Metro. Make sure that you are well informed with plenty of time to meet enrollment deadlines.

Important dates

Medical, Dental, and Vision benefits are offered on a fiscal year schedule and renew each July 1. You can enroll or make changes to your medical, dental and vision benefits each year during open enrollment with an effective date of July 1. Open enrollment for health benefits is during May – June each year.

The flexible spending account program is on a calendar year schedule and renews each January 1. Open enrollment for the FSA program is during November and December each year.

Changes to your 401(k) and your 457 plans can be made at any time.

If you have any questions, contact a benefits staff member or you may visit the Benefits Department in Human Resources at Metro Regional Center.

HR – Benefits Help

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BENEFITS ELIGIBILITY

Benefits for eligible employees become effective the first day of the month following or coinciding with 30 days of continuous employment. Please refer to your respective collective bargaining agreement or Metro policy for benefits eligibility and coverage.

You may enroll your dependents, which include:

- Your spouse or domestic partner. Domestic partner coverage is subject to federal and in some cases state income tax. A marriage license or domestic partnership registration affidavit is required when initially enrolling a spouse, domestic partner, or children of domestic partner.
- Dependent children until they reach the end of the month in which they turn 26.
- Dependent children of domestic partner until they reach the end of the month which they turn 26.

BENEFITS CHANGES AFTER ENROLLMENT

Your benefit elections and health flexible spending account plans cannot be changed outside of open enrollment unless you experience a family status change. Family status changes may include:

- marriage or domestic partner registration
- divorce, legal separation or annulment
- birth or adoption of an eligible child
- change in your or your spouse's health coverage attributable to your spouse's employment
- change in your child's eligibility for benefits

It is the employees' responsibility to notify the Benefits Department of family status changes within 30 days of a qualifying event. Proof of qualifying event is required.

You may participate or change your 401(k) and 457 plan elections at any time. Employees who elect the dependent care flexible spending account may participate or change their dependent care election during a calendar year as needed, which is different from the health flexible spending account.

COVERAGE LEVELS

Benefit eligible employees have four coverage levels to choose from for health insurance.

The amount that you pay depends on the health plan you choose and the number of people that you cover:

- employee only
- employee and spouse or domestic partner*
- employee and child or children up to age 26
- employee and family

To enroll your domestic partner or spouse, you are required to provide a marriage license or an affidavit confirming your domestic partnership. Benefits coverage for your domestic partner or your domestic partner's children may be taxable. To learn more, review the guidelines outlined on the domestic partner affidavit.

COST OF COVERAGE

You and Metro share in the cost of your health benefits. Your health care contributions are deducted on a pre-tax basis. This means that the money used to pay for these benefits is deducted from your pay before social security, federal, state and local taxes are withheld.

MEDICAL PLANS

You have a choice of four medical plans:

- Kaiser HMO
- Kaiser HMO High Deductible Health Plan (HDHP) with Health Savings Account (HSA)
- Added Choice Point-of-Service Plan (POS) provided by Kaiser
- Added Choice POS High Deductible Health Plan (HDHP) with Health Savings Account (HSA)

Selecting either the Added Choice Point-of-Service plan or the Added Choice POS High Deductible Plan gives you the freedom to see any provider that you prefer either in network or out of network; selecting in-network providers affords you a higher level of benefits. If selecting either Kaiser HMO or Kaiser HMO HDHP, you must select a Kaiser or Portland Clinic doctor to direct your care for either of these plans you choose.

Vision Service Plan (VSP) is the only vision plan available and is automatically included with all medical plan options.

HEALTH SAVINGS ACCOUNT

OVERVIEW

A Health Savings Account (H.S.A.) is a special account owned by an individual used to pay for current and future medical expenses. H.S.A. is used in conjunction with Qualified High-Deductible

Health Plans (HDHP): Kaiser HMO HDHP and Added Choice POS HDHP. A H.S.A. has the advantages of triple tax savings: contributions are tax deductible, the account grows tax free, and there will be no tax for distribution for a qualified expense. There is no “use it or lose it” rule or “irrevocable election” rule associated with a H.S.A. The individual employee is in control of the account. At age 65, distributions will be made at ordinary income with no penalty.

ELIGIBILITY

An individual has to meet the following requirements in order to be eligible for an H.S.A.:

- Is covered by an qualified HDHP
- Is not covered by other health insurance (with a limited number of exceptions)
- Is not enrolled in Medicare
- Is not enrolled in Tricare Coverage
- Cannot be claimed as a dependent on someone else’s tax return
- Cannot be currently enrolled in a Health Flexible Spending Account or a General Purpose Health Reimbursement Account (HRA)

CONTRIBUTIONS

Contributions to an H.S.A. can be made by the employer or the individual, or both. Metro contributes \$1,000 for individuals and \$2,000 for those enrolling as employees plus dependent(s) per 12 month period. Metro contributes the full amount of the H.S.A. contribution, per employee or family enrollment, upon initial and the first subsequent re-enrollment into the HDHP. Renewing/continuing enrollees beginning the 3rd consecutive enrollment will receive 50% of the H.S.A. contribution on January 1 and 50% on July 1 of any given plan year. In no circumstances will an employee receive more than the above stated H.S.A. contribution during an enrollment period.

The enrollment period is January 1, 2015 to June 30, 2015 and July 1 of each year thereafter.

All employees who enroll in the HDHP shall receive the same H.S.A. contribution, per employee or family enrollment, amount based on tier of enrollment regardless of their hours worked as long as they remain benefit eligible.

If an employee enrolled in the HDHP should experience a qualifying event that changes the deductible for their HDHP, the employer contribution to the H.S.A. shall change to the corresponding contribution at the time the employee changes their enrollment based on the qualifying event.

OPT OUT OPTION

Under a number of employment contracts and collective bargaining agreements, employees may Opt Out of employer paid health insurance if they have coverage from another group source. Metro will pay an amount of \$150 per month to full-time employees and a prorated amount equivalent to their FTE status for those in less than full-time positions, who provide proof of other medical coverage and who opt out of medical and dental coverage through Metro. To choose this option, complete and select the opt-out option in the medical and dental enrollment/change form. Proof of other insurance coverage is required.

Full-time Employee Health Insurance Contribution Rates (Effective 01/01/2015)

	Non-Represented, IUOE 701, ILWU 28, IATSE 28				AFSCME 3580, 3580-1, IUOE 701-1, LIUNA 483			
	Per Month		Per Pay Period		Per Month		Per Pay Period	
	Employee	Metro	Employee	Metro	Employee	Metro	Employee	Metro
Kaiser Added Choice POS								
Employee Only	\$61.76	\$710.24	\$30.88	\$355.12	\$46.32	\$725.68	\$23.16	\$362.84
Employee and Spouse/Domestic Partner	\$123.52	\$1,420.48	\$61.76	\$710.24	\$92.64	\$1,451.36	\$46.32	\$725.68
Employee and Child(ren)	\$111.17	\$1,278.43	\$55.58	\$639.22	\$83.38	\$1,306.22	\$41.69	\$653.11
Family	\$160.58	\$1,846.62	\$80.29	\$923.31	\$120.43	\$1,886.77	\$60.22	\$943.38
Kaiser Added Choice HDHP*								
Employee Only	\$41.52	\$477.48	\$20.76	\$238.74	\$31.14	\$487.86	\$15.57	\$243.93
Employee and Spouse/Domestic Partner	\$83.04	\$954.94	\$41.52	\$477.47	\$62.28	\$975.70	\$31.14	\$487.85
Employee and Child(ren)	\$74.73	\$859.45	\$37.37	\$429.72	\$56.05	\$878.13	\$28.03	\$439.06
Family	\$107.95	\$1,241.41	\$53.97	\$620.71	\$80.96	\$1,268.40	\$40.48	\$634.20
Kaiser \$10 HMO								
Employee Only	\$45.10	\$518.60	\$22.55	\$259.30	\$33.82	\$529.88	\$16.91	\$264.94
Employee and Spouse/Domestic Partner	\$90.19	\$1,037.19	\$45.10	\$518.59	\$67.64	\$1,059.74	\$33.82	\$529.87
Employee and Child(ren)	\$81.17	\$933.47	\$40.59	\$466.73	\$60.88	\$953.76	\$30.44	\$476.88
Family	\$117.25	\$1,348.35	\$58.62	\$674.18	\$87.94	\$1,377.66	\$43.97	\$688.83
Kaiser HDHP \$1500*								
Employee Only	\$29.42	\$338.32	\$14.71	\$169.16	\$22.06	\$345.68	\$11.03	\$172.84
Employee and Spouse/Domestic Partner	\$58.84	\$676.60	\$29.42	\$338.30	\$44.13	\$691.31	\$22.06	\$345.66
Employee and Child(ren)	\$52.95	\$608.95	\$26.48	\$304.47	\$39.71	\$622.19	\$19.86	\$311.09
Family	\$76.49	\$879.59	\$38.24	\$439.80	\$57.36	\$898.72	\$28.68	\$449.36
MODA Dental								
Employee Only	\$4.91	\$56.45	\$2.45	\$28.23	\$3.68	\$57.68	\$1.84	\$28.84
Employee and Spouse/Domestic Partner	\$9.72	\$111.82	\$4.86	\$55.91	\$7.29	\$114.25	\$3.65	\$57.12
Employee and Child(ren)	\$9.87	\$113.49	\$4.93	\$56.75	\$7.40	\$115.96	\$3.70	\$57.98
Family	\$15.08	\$173.36	\$7.54	\$86.68	\$11.31	\$177.13	\$5.65	\$88.57
Kaiser Dental								
Employee Only	\$4.94	\$56.84	\$2.47	\$28.42	\$3.71	\$58.07	\$1.85	\$29.04
Employee and Spouse/Domestic Partner	\$9.88	\$113.62	\$4.94	\$56.81	\$7.41	\$116.09	\$3.71	\$58.05
Employee and Child(ren)	\$8.89	\$102.29	\$4.45	\$51.14	\$6.67	\$104.51	\$3.34	\$52.25
Family	\$14.82	\$170.46	\$7.41	\$85.23	\$11.12	\$174.16	\$5.56	\$87.08
Vision Service Plan								
Employee Only	\$0.47	\$5.37	\$0.23	\$2.69	\$0.35	\$5.49	\$0.18	\$2.74
Employee and Spouse/Domestic Partner	\$0.75	\$8.59	\$0.37	\$4.30	\$0.56	\$8.78	\$0.28	\$4.39
Employee and Child(ren)	\$0.76	\$8.76	\$0.38	\$4.38	\$0.57	\$8.95	\$0.29	\$4.47
Family	\$1.23	\$14.13	\$0.61	\$7.07	\$0.92	\$14.44	\$0.46	\$7.22

NOTE: The Employer will contribute \$1,000 for employee only and \$2,000 for employee and dependent(s) per year into a Health Savings Account (H.S.A.) for those who select either of the two High Deductible plans.

Dental and Vision only coverage is available as a package if an employee has other group medical insurance coverage.

Part-time Non-Represented Employee Health Insurance Contribution Rates
(Effective 01/01/2015)

	Non-Represented - 0.75 FTE				Non-Represented - 0.5 FTE			
	Per Month		Per Pay Period		Per Month		Per Pay Period	
Kaiser Added Choice POS	Employee	Metro	Employee	Metro	Employee	Metro	Employee	Metro
Employee Only	\$239.32	\$532.68	\$119.66	\$266.34	\$416.88	\$355.12	\$208.44	\$177.56
Employee and Spouse/Domestic Partner	\$478.64	\$1,065.36	\$239.32	\$532.68	\$833.76	\$710.24	\$416.88	\$355.12
Employee and Child(ren)	\$430.78	\$958.82	\$215.39	\$479.41	\$750.38	\$639.22	\$375.19	\$319.61
Family	\$622.23	\$1,384.97	\$311.12	\$692.48	\$1,083.89	\$923.31	\$541.94	\$461.66
Kaiser Added Choice HDHP*	Employee	Metro	Employee	Metro	Employee	Metro	Employee	Metro
Employee Only	\$160.89	\$358.11	\$80.45	\$179.06	\$280.26	\$238.74	\$140.13	\$119.37
Employee and Spouse/Domestic Partner	\$321.77	\$716.21	\$160.89	\$358.10	\$560.51	\$477.47	\$280.25	\$238.74
Employee and Child(ren)	\$289.60	\$644.58	\$144.80	\$322.29	\$504.46	\$429.72	\$252.23	\$214.86
Family	\$418.30	\$931.06	\$209.15	\$465.53	\$728.65	\$620.71	\$364.33	\$310.35
Kaiser \$10 HMO	Employee	Metro	Employee	Metro	Employee	Metro	Employee	Metro
Employee Only	\$174.75	\$388.95	\$87.37	\$194.48	\$304.40	\$259.30	\$152.20	\$129.65
Employee and Spouse/Domestic Partner	\$349.49	\$777.89	\$174.74	\$388.95	\$608.79	\$518.59	\$304.39	\$259.30
Employee and Child(ren)	\$314.54	\$700.10	\$157.27	\$350.05	\$547.91	\$466.73	\$273.95	\$233.37
Family	\$454.34	\$1,011.26	\$227.17	\$505.63	\$791.42	\$674.18	\$395.71	\$337.09
Kaiser HDHP \$1500*	Employee	Metro	Employee	Metro	Employee	Metro	Employee	Metro
Employee Only	\$114.00	\$253.74	\$57.00	\$126.87	\$198.58	\$169.16	\$99.29	\$84.58
Employee and Spouse/Domestic Partner	\$227.99	\$507.45	\$113.99	\$253.73	\$397.14	\$338.30	\$198.57	\$169.15
Employee and Child(ren)	\$205.19	\$456.71	\$102.59	\$228.36	\$357.43	\$304.47	\$178.71	\$152.24
Family	\$296.38	\$659.70	\$148.19	\$329.85	\$516.28	\$439.80	\$258.14	\$219.90
MODA Dental	Employee	Metro	Employee	Metro	Employee	Metro	Employee	Metro
Employee Only	\$19.02	\$42.34	\$9.51	\$21.17	\$33.13	\$28.23	\$16.57	\$14.11
Employee and Spouse/Domestic Partner	\$37.68	\$83.86	\$18.84	\$41.93	\$65.63	\$55.91	\$32.82	\$27.95
Employee and Child(ren)	\$38.24	\$85.12	\$19.12	\$42.56	\$66.61	\$56.75	\$33.31	\$28.37
Family	\$58.42	\$130.02	\$29.21	\$65.01	\$101.76	\$86.68	\$50.88	\$43.34
Kaiser Dental	Employee	Metro	Employee	Metro	Employee	Metro	Employee	Metro
Employee Only	\$19.15	\$42.63	\$9.58	\$21.31	\$33.36	\$28.42	\$16.68	\$14.21
Employee and Spouse/Domestic Partner	\$38.29	\$85.22	\$19.14	\$42.61	\$66.69	\$56.81	\$33.35	\$28.41
Employee and Child(ren)	\$34.47	\$76.71	\$17.23	\$38.36	\$60.04	\$51.14	\$30.02	\$25.57
Family	\$57.44	\$127.84	\$28.72	\$63.92	\$100.05	\$85.23	\$50.03	\$42.61
Vision Service Plan	Employee	Metro	Employee	Metro	Employee	Metro	Employee	Metro
Employee Only	\$1.81	\$4.03	\$0.91	\$2.01	\$3.15	\$2.69	\$1.58	\$1.34
Employee and Spouse/Domestic Partner	\$2.90	\$6.44	\$1.45	\$3.22	\$5.04	\$4.30	\$2.52	\$2.15
Employee and Child(ren)	\$2.95	\$6.57	\$1.48	\$3.28	\$5.14	\$4.38	\$2.57	\$2.19
Family	\$4.76	\$10.60	\$2.38	\$5.30	\$8.29	\$7.07	\$4.15	\$3.53

NOTE: The Employer will contribute \$1,000 for employee only and \$2,000 for employee and dependent(s) per year into a Health Savings Account (H.S.A.) for those who select either of the two High Deductible plans.

**Part-time Represented Employee Health Insurance Contribution Rates
(Effective 01/01/2015)**

	AFSCME 3580, LIUNA 483, -0.75 FTE				AFSCME 3580, LIUNA 483, -0.5 FTE			
	Per Month		Per Pay Period		Per Month		Per Pay Period	
Kaiser Added Choice POS	Employee	Metro	Employee	Metro	Employee	Metro	Employee	Metro
Employee Only	\$227.74	\$544.26	\$113.87	\$272.13	\$409.16	\$362.84	\$204.58	\$181.42
Employee and Spouse/Domestic Partner	\$455.48	\$1,088.52	\$227.74	\$544.26	\$818.32	\$725.68	\$409.16	\$362.84
Employee and Child(ren)	\$409.93	\$979.67	\$204.97	\$489.83	\$736.49	\$653.11	\$368.24	\$326.56
Family	\$592.12	\$1,415.08	\$296.06	\$707.54	\$1,063.82	\$943.38	\$531.91	\$471.69
Kaiser Added Choice HDHP*	Employee	Metro	Employee	Metro	Employee	Metro	Employee	Metro
Employee Only	\$153.11	\$365.90	\$76.55	\$182.95	\$275.07	\$243.93	\$137.54	\$121.97
Employee and Spouse/Domestic Partner	\$306.20	\$731.78	\$153.10	\$365.89	\$550.13	\$487.85	\$275.06	\$243.93
Employee and Child(ren)	\$275.58	\$658.60	\$137.79	\$329.30	\$495.12	\$439.06	\$247.56	\$219.53
Family	\$398.06	\$951.30	\$199.03	\$475.65	\$715.16	\$634.20	\$357.58	\$317.10
Kaiser \$10 HMO	Employee	Metro	Employee	Metro	Employee	Metro	Employee	Metro
Employee Only	\$166.29	\$397.41	\$83.15	\$198.70	\$298.76	\$264.94	\$149.38	\$132.47
Employee and Spouse/Domestic Partner	\$332.58	\$794.80	\$166.29	\$397.40	\$597.51	\$529.87	\$298.76	\$264.93
Employee and Child(ren)	\$299.32	\$715.32	\$149.66	\$357.66	\$537.76	\$476.88	\$268.88	\$238.44
Family	\$432.35	\$1,033.25	\$216.18	\$516.62	\$776.77	\$688.83	\$388.38	\$344.42
Kaiser HDHP \$1500*	Employee	Metro	Employee	Metro	Employee	Metro	Employee	Metro
Employee Only	\$108.48	\$259.26	\$54.24	\$129.63	\$194.90	\$172.84	\$97.45	\$86.42
Employee and Spouse/Domestic Partner	\$216.95	\$518.49	\$108.48	\$259.24	\$389.78	\$345.66	\$194.89	\$172.83
Employee and Child(ren)	\$195.26	\$466.64	\$97.63	\$233.32	\$350.81	\$311.09	\$175.40	\$155.55
Family	\$282.04	\$674.04	\$141.02	\$337.02	\$506.72	\$449.36	\$253.36	\$224.68
MODA Dental	Employee	Metro	Employee	Metro	Employee	Metro	Employee	Metro
Employee Only	\$18.10	\$43.26	\$9.05	\$21.63	\$32.52	\$28.84	\$16.26	\$14.42
Employee and Spouse/Domestic Partner	\$35.85	\$85.69	\$17.93	\$42.84	\$64.42	\$57.12	\$32.21	\$28.56
Employee and Child(ren)	\$36.39	\$86.97	\$18.20	\$43.48	\$65.38	\$57.98	\$32.69	\$28.99
Family	\$55.59	\$132.85	\$27.79	\$66.43	\$99.87	\$88.57	\$49.94	\$44.28
Kaiser Dental	Employee	Metro	Employee	Metro	Employee	Metro	Employee	Metro
Employee Only	\$18.23	\$43.55	\$9.11	\$21.78	\$32.74	\$29.04	\$16.37	\$14.52
Employee and Spouse/Domestic Partner	\$36.43	\$87.07	\$18.22	\$43.53	\$65.46	\$58.05	\$32.73	\$29.02
Employee and Child(ren)	\$32.80	\$78.38	\$16.40	\$39.19	\$58.93	\$52.25	\$29.46	\$26.13
Family	\$54.66	\$130.62	\$27.33	\$65.31	\$98.20	\$87.08	\$49.10	\$43.54
Vision Service Plan	Employee	Metro	Employee	Metro	Employee	Metro	Employee	Metro
Employee Only	\$1.72	\$4.12	\$0.86	\$2.06	\$3.10	\$2.74	\$1.55	\$1.37
Employee and Spouse/Domestic Partner	\$2.76	\$6.58	\$1.38	\$3.29	\$4.95	\$4.39	\$2.48	\$2.19
Employee and Child(ren)	\$2.81	\$6.71	\$1.40	\$3.36	\$5.05	\$4.47	\$2.52	\$2.24
Family	\$4.53	\$10.83	\$2.27	\$5.41	\$8.14	\$7.22	\$4.07	\$3.61

NOTE: The Employer will contribute \$1,000 for employee only and \$2,000 for employee and dependent(s) per year into a Health Savings Account (H.S.A.) for those who select either of the two High Deductible plans.

KAISER HMO PLAN SUMMARY

Out-of-Pocket Maximum (All Copayment and Coinsurance amounts count toward the maximum, unless otherwise noted.)

For one Member	\$600 per Calendar Year
For an entire Family	\$1,200 per Calendar Year

Preventive Care Services	You pay
Routine preventive physical exam (includes adult, well baby, and well child)	\$0
Scheduled prenatal care and first postpartum visit	\$0
Immunizations	\$0
Preventive tests	\$0
Outpatient Services	
Primary care visit	\$10
Specialty care visit	\$10
Urgent care visit	\$30
Emergency department visit	\$75 (Waived if admitted)
Outpatient surgery visit	\$20
Chemotherapy/radiation therapy visit	\$10
Laboratory, X-ray, imaging, and special diagnostic procedures	\$10 per department visit
CT, MRI, PET scans	\$10
Routine eye exam	\$10
Nurse treatment room visits to receive injections	\$10
Administered medications, including injections (all outpatient settings)	20% Coinsurance
Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance
Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	\$10
Inpatient Hospital Services	\$50 per day up to \$250 per admission
Ambulance Services (per transport)	\$75
Hearing Aids for Children (limited to one hearing aid per ear every four years per Member age 18 years and younger, or enrollees age 19 to 25 and enrolled in an accredited educational institution)	20% Coinsurance
Skilled Nursing Facility Services (up to 100 days per Calendar Year)	\$0
Chemical Dependency Services	
Outpatient Services	\$10
Inpatient hospital & residential Services	\$50 per day up to \$250 per admission
Mental Health Services	
Outpatient Services	\$10
Inpatient hospital & residential Services	\$50 per day up to \$250 per admission

KAISER HMO PLAN SUMMARY (CONTINUED)

Student Out-of-Area Coverage Routine, continuing, and follow-up Services (up to \$1,200 per Calendar Year; amounts do not count toward the maximum)	20% of the actual fee the provider, facility, or vendor charged for the Service
Optional Benefits (Amounts do not count toward the maximum.)	
Alternative care (self-referred)	\$10 per visit for acupuncture, chiropractic, and naturopathic visits. \$25 per massage therapy visit (up to 12 visits per Calendar Year). \$1,500 benefit maximum for all Services combined.
Hearing aids (ages 19 years and older)	Not covered
Outpatient prescription drugs	\$15 generic/\$30 brand. \$0 for formulary contraceptives. You get up to a 30-day supply. When you use mail delivery, you get up to a 90-day supply of maintenance drugs for two Copayments.
Vision hardware and optical Services (ages 18 years and younger)	Not covered
Vision hardware and optical Services (ages 19 years and older)	Not covered

KAISER HMO HIGH DEDUCTIBLE PLAN SUMMARY

Deductible (All Services except preventive care are subject to the Deductible. You must pay Charges for the Services when you receive them, until you meet your Deductible. If you are the only Member in your Family, then you must meet the \$1,500 Deductible. If you are a Member in a Family of two or more Members, you meet the Deductible when your entire Family meets the \$3,000 Deductible amount. Every Member in your Family must pay Charges during the Calendar Year until the entire Family meets the \$3,000 Deductible. After you meet the Deductible, you pay the applicable Copayments or Coinsurance for covered Services the remainder of the Calendar Year until you meet your Out-of-Pocket Maximum. Note: The Deductible and Out-of-Pocket Maximum amounts are subject to increase if the U.S. Department of Treasury changes the minimum Deductible and Out-of-Pocket Maximum amounts required in High Deductible Health Plans.)

For a Family of one Member	\$1,500 per Calendar Year
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For a Family of two or more Members	\$3,000 per Calendar Year
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Out-Of-Pocket Maximum (All Deductible, Copayment, and Coinsurance amounts count toward the Out-of-Pocket Maximum unless otherwise noted.)

For a Family of one Member	\$3,500 per Calendar Year
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For a Family of two or more Members	\$7,000 per Calendar Year
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Preventive Care Services	You pay
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Routine preventive physical exam (includes adult, well baby, and well child)	\$0
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Scheduled prenatal care and first postpartum visit	\$0
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Immunizations	\$0
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Preventive tests	\$0
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Outpatient Services

Primary care visit	20% Coinsurance after Deductible
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Specialty care visit	20% Coinsurance after Deductible
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Urgent care visit	20% Coinsurance after Deductible
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Emergency department visit	20% Coinsurance after Deductible
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Outpatient surgery visit	20% Coinsurance after Deductible
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Chemotherapy/radiation therapy visit	20% Coinsurance after Deductible
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Laboratory, X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
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CT, MRI, PET scans	20% Coinsurance after Deductible
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Routine eye exam	20% Coinsurance after Deductible
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Nurse treatment room visits to receive injections	\$10 after Deductible
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Administered medications, including injections (all outpatient settings)	20% Coinsurance after Deductible
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Outpatient durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance after Deductible
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Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	20% Coinsurance after Deductible
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KAISER HMO HIGH DEDUCTIBLE PLAN SUMMARY (CONTINUED)

Inpatient Hospital Services	20% Coinsurance after Deductible
Ambulance Services (per transport)	20% Coinsurance after Deductible
Hearing Aids for Children (limited to one hearing aid per ear every four years per Member age 18 years and younger, or enrollees age 19 to 25 and enrolled in an accredited educational institution)	20% Coinsurance after Deductible
Skilled Nursing Facility Services (up to 100 days per Calendar Year)	20% Coinsurance after Deductible
Chemical Dependency Services	
Outpatient Services	20% Coinsurance after Deductible
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Mental Health Services	
Outpatient Services	20% Coinsurance after Deductible
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Student Out-of-Area Coverage Routine, continuing, and follow-up Services (up to \$1,200 per Calendar Year; amounts count toward the maximum)	20% after deductible of the actual fee the provider, facility, or vendor charged for the Service
Optional Benefits	
Alternative care (self-referred)	\$10 per visit after Deductible for acupuncture, chiropractic and naturopathic visits. \$25 after Deductible per massage therapy visit (up to 12 visits per Calendar Year). \$1,500 benefit maximum for all Services combined.
Hearing aids (ages 19 years and older)	Not covered
Outpatient prescription drugs	\$15 generic/\$30 brand after Deductible. You get up to a 30-day supply. When you use mail delivery, you get up to a 90-day supply of maintenance drugs for two Copayments.
Vision hardware and optical Services (ages 18 years and younger)	Not covered
Vision hardware and optical Services (ages 19 years and older)	Not covered

KAISER ADDED CHOICE PLAN SUMMARY

	Tier 1 Select Providers	Tier 2 PPO Providers	Tier 3 Non-Participating Providers
Deductible (The amounts you pay for covered Services subject to the Deductible in Tier 2 and Tier 3 do not cross accumulate. This means that the amounts you pay for covered Services in Tier 2 only count toward the Deductible in Tier 2, and the amounts you pay for covered Services subject to the Deductible in Tier 3 only count toward the Deductible in Tier 3.)			
For one Member per Calendar Year	\$0	\$500	\$1,000
For an entire Family per Calendar Year	\$0	\$1,500	\$3,000
Out-of-Pocket Maximum (All Deductible, Copayment, and Coinsurance amounts count toward the Out-of-Pocket Maximum unless otherwise noted. The amounts you pay for covered Services that count toward the Out-of-Pocket Maximum in Tier 1 and Tier 2 cross accumulate. This means that the amounts you pay for covered Services in Tier 1 also count toward the Out-of-Pocket Maximum in Tier 2, and do not count toward the Out-of-Pocket Maximum in Tier 3. The amounts you pay for covered Services that count toward the Out-of-Pocket Maximum in Tier 3 only count toward the Out-of-Pocket Maximum in Tier 3.)			
For one Member per Calendar Year	\$2,000	\$3,500	\$6,500
For an entire Family per Calendar Year	\$4,000	\$10,500	\$19,500
Preventive Care Services	You Pay*		
Routine preventive physical exam (includes adult, well baby, and well child)	\$0	\$0	40% Coinsurance after Deductible
Scheduled prenatal care and first postpartum visit	\$0	\$0	40% Coinsurance after Deductible
Immunizations	\$0	\$0	\$0
Preventive tests	\$0	\$0	40% Coinsurance after Deductible
Outpatient Services			
Primary care visit	\$20	\$30	40% Coinsurance after Deductible
Specialty care visit	\$30	\$40	40% Coinsurance after Deductible
Urgent care visit	\$40	\$50	40% Coinsurance after Deductible
Emergency department visit	\$100 (Waived if admitted)		
Outpatient surgery visit	\$100	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	\$30	\$40	40% Coinsurance after Deductible
Laboratory, X-rays, imaging, and special diagnostic procedures	\$20 per department visit	\$25 per department visit	40% Coinsurance after Deductible
CT, MRI, PET scans	\$50	20% Coinsurance after Deductible	40% Coinsurance after Deductible

KAISER ADDED CHOICE PLAN SUMMARY (CONTINUED)

Routine eye exam	\$20	\$30	40% Coinsurance after Deductible
Nurse treatment room visits to receive injections	\$10	\$30	40% Coinsurance after Deductible
Administered medications, including injections (all outpatient settings)	20% Coinsurance	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Physical, speech, and occupational therapies (all tiers combined) (up to 20 visits per therapy per Calendar Year)	\$30	\$40	40% Coinsurance after Deductible
Inpatient Hospital Services	\$200 per day up to \$1,000 per admission	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Ambulance Services (per emergency transport)	\$100		
Hearing Aids for Children (limited to one hearing aid per ear every four years per Member age 18 years and younger, or enrollees age 19 to 25 and enrolled in an accredited educational institution)	20% Coinsurance	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Skilled Nursing Facility Services (up to 100 days per Calendar Year) (All tiers combined)	\$0	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Chemical Dependency Services			
Outpatient Services	\$20	\$30	40% Coinsurance after Deductible
Inpatient hospital & residential Services	\$200 per day up to \$1,000 per admission	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental Health Services			
Outpatient Services	\$20	\$30	40% Coinsurance after Deductible
Inpatient hospital & residential Services	\$200 per day up to \$1,000 per admission	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Optional Benefits (Amounts do not count toward the maximum.)			
Alternative care (self-referred)	\$25 per visit for acupuncture, chiropractic, and naturopathic visits. \$25 per massage therapy visit (up to 12 visits per Calendar Year). \$1,500 benefit maximum for all Services combined.	\$25 per visit for chiropractic, naturopathic and acupuncture visits. \$25 per massage therapy visit (up to 12 visits per Calendar Year). \$1,500 benefit maximum for all Services combined.	
Hearing aids (ages 19 years and older)	Not covered		

KAISER ADDED CHOICE PLAN SUMMARY (CONTINUED)

Outpatient prescription drugs	\$15 generic/\$30 brand. \$0 for formulary contraceptives. You get up to a 30-day supply. When you use mail delivery, you get up to a 90-day supply of maintenance drugs for two Copayments.	\$20 generic/\$40 preferred brand/\$60 non-preferred brand/\$0 for formulary contraceptives at participating pharmacies for up to 30-day supply.
Vision hardware and optical Services (ages 18 years and younger)	Not covered	
Vision hardware and optical Services (ages 19 years and older)	Not covered	

***Note:** In Tier 1 and Tier 2, Coinsurance is a percentage of Charges. In Tier 3, Coinsurance is a percentage of the Allowed Amount; you will also be responsible for paying any provider or facility fees in excess of the Allowed Amount.

KAISER ADDED CHOICE HIGH DEDUCTIBLE PLAN SUMMARY

	Tier 1 Select Providers	Tier 2 PPO Providers	Tier 3 Non-Participating Providers
Deductible (The amounts you pay for covered Services subject to the Deductible in Tier 1 and Tier 2 cross accumulate. This means that the amounts you pay for covered Services in Tier 1 also count toward the Deductible in Tier 2, and do not count toward the Deductible in Tier 3. The amounts you pay for covered Services subject to the Deductible in Tier 3 only count toward the Deductible in Tier 3.)			
For one Member per Calendar Year	\$1,500	\$1,500	\$3,000
For an entire Family per Calendar Year	\$3,000	\$3,000	\$6,000
Out-of-Pocket Maximum (All Deductible, Copayment, and Coinsurance amounts count toward the Out-of-Pocket Maximum unless otherwise noted. The amounts you pay for covered Services that count toward the Out-of-Pocket Maximum in Tier 1 and Tier 2 cross accumulate. This means that the amounts you pay for covered Services in Tier 1 also count toward the Out-of-Pocket Maximum in Tier 2, and do not count toward the Out-of-Pocket Maximum in Tier 3. The amounts you pay for covered Services that count toward the Out-of-Pocket Maximum in Tier 3 only count toward the Out-of-Pocket Maximum in Tier 3.)			
For one Member per Calendar Year	\$3,000	\$3,000	\$9,000
For an entire Family per Calendar Year	\$6,000	\$6,000	\$18,000
Preventive Care Services	You Pay*		
Routine preventive physical exam (includes adult, well baby, and well child)	\$0	\$0	50% Coinsurance after Deductible
Scheduled prenatal care and first postpartum visit	\$0	\$0	50% Coinsurance after Deductible
Immunizations	\$0	\$0	\$0
Preventive tests	\$0	\$0	50% Coinsurance after Deductible
Outpatient Services			
Primary care visit	\$20 after Deductible	\$30 after Deductible	50% Coinsurance after Deductible
Specialty care visit	\$20 after Deductible	\$30 after Deductible	50% Coinsurance after Deductible
Urgent care visit	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Emergency department visit	10% Coinsurance after Deductible		
Outpatient surgery visit	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	\$20 after Deductible	\$30 after Deductible	50% Coinsurance after Deductible
Laboratory, X-rays, imaging, and special diagnostic procedures	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible
CT, MRI, PET scans	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Administered medications (all outpatient settings)	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible

KAISER ADDED CHOICE HIGH DEDUCTIBLE PLAN SUMMARY (CONTINUED)

Routine eye exam (ages 18 years and younger)	\$20 after Deductible	\$30 after Deductible	50% Coinsurance after Deductible
Routine eye exam (ages 19 years and older)	\$20 after Deductible	\$30 after Deductible	50% Coinsurance after Deductible
Injection visit provided in nurse treatment area	\$10 after Deductible	\$15 after Deductible	50% Coinsurance after Deductible
Durable medical equipment	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible
External prosthetic devices and orthotic devices	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Physical, speech, and occupational therapies (all tiers combined) (up to 20 visits per therapy per Calendar Year)	\$20 after Deductible	\$30 after Deductible	50% Coinsurance after Deductible
Physician-referred acupuncture (limited to 12 visits per Calendar Year)	\$20 after Deductible	Not Covered	
Inpatient Hospital Services	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Ambulance Services (per emergency transport)	10% Coinsurance after Deductible		Not Covered
Hearing Aids for Children (limited to one hearing aid per ear every four years per Member age 18 years and younger, or enrollees age 19 to 25 and enrolled in an accredited educational institution)	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Skilled Nursing Facility Services (up to 100 days per Calendar Year) (All tiers combined)	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Optional Benefits (Amounts do not count toward the maximum.)			
Alternative care (self-referred)	\$25 per visit for chiropractic, naturopathic and acupuncture after deductible, \$25 co-pay per message visit limit of 12 per year, after deductible. All services subject to \$1500 benefit maximum per calendar year.	\$25 per visit for chiropractic, naturopathic and acupuncture after deductible, \$25 co-pay per message visit limit of 12 per year, after deductible. All services subject to \$1500 benefit maximum per calendar year.	\$25 per visit for chiropractic, naturopathic and acupuncture after deductible, \$25 co-pay per message visit limit of 12 per year, after deductible. All services subject to \$1500 benefit maximum per calendar year.
Hearing aids (ages 19 years and older)	Not covered		
Outpatient prescription drugs	\$15 generic/\$30 brand after Deductible	\$20 generic/\$40 brand/\$60 non-formulary	
Vision hardware and optical Services (ages 18 years and younger)	Not covered		
Vision hardware and optical Services (ages 19 years and older)	Not covered		
Travel Services	Not covered	Not covered	
Chemical Dependency Services			

KAISER ADDED CHOICE HIGH DEDUCTIBLE PLAN SUMMARY (CONTINUED)

Outpatient Services	\$20 after Deductible	\$30 after Deductible	50% Coinsurance after Deductible
Inpatient hospital & residential Services	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Mental Health Services			
Outpatient Services	\$20 after Deductible	\$30 after Deductible	50% Coinsurance after Deductible
Inpatient hospital & residential Services	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible

**Note: In Tier 1 and Tier 2, Coinsurance is a percentage of Charges. In Tier 3, Coinsurance is a percentage of the Allowed Amount; you will also be responsible for paying any provider or facility fees in excess of the Allowed Amount.*

DENTAL PLANS	Kaiser Permanente	MODA HEALTH
Co-pays	\$10 co-pay Office visit; \$10 co-pay for emergency services	no charge
Deductible	no annual deductible	\$50 annual deductible (\$150 family) twice-yearly exams and cleanings not subject to deductible
Maximum benefit allowance	no annual benefit maximum allowance	\$1,500 individual annual benefit maximum allowance
Preventative treatment	\$10 co-pay	no charge (preventive service not subject to the maximum benefit allowance)
Restorative treatment	20% of charges for crowns and inlays	20% of charges for major restorative treatment, including most crowns and cast restorations
Bridges and dentures	20% of charges	80% / 50% coverage for partial and complete dentures and implants
Orthodontia	Children to age 17; 50% to \$1,000 lifetime maximum per person.	Children to age 17; 50% to \$1,000 lifetime maximum per person.
VISION PLANS	Vision Service Plan (VSP) VSP provider	Vision Service Plan (VSP) non-VSP provider
Examination covered every 12 months	\$15 co-pay for exams and glasses	\$50 reimbursement (\$15 copay applies to exam and glasses)
Lenses covered every 24 months	single vision lenses: paid in full lined bifocal: paid in full lined trifocal: paid in full	single vision lenses: \$50 lined bifocal: \$75 lined trifocal: \$100
Frames covered every 24 months	\$130 allowance plus 20% discount for amount over allowance or \$70 equivalent frame at Costco	up to \$70 reimbursement for frame choose between lenses and frame or contact lenses
Contact lenses covered every 24 months (in lieu of lenses and frame)	No more than \$60 copay for contact lens exam; up to \$150 allowance for contacts	up to \$105 reimbursement for contact lens exam and contacts in lieu of eyeglasses
Computer Vision Exam Covered every 12 months	\$10 co-pay for exam and/or eyewear	Not covered

LIFE AND AD&D INSURANCE

Life insurance is an important part of your financial wellbeing, especially if others depend on you for support. That is why Metro offers a life insurance program through Lincoln Financial Group that includes basic employee life and accidental death and dismemberment (AD&D) insurance for you, as well as the opportunity to purchase supplemental coverage. Under this policy, insurance coverage is reduced to 65 percent at age 70, to 50 percent at age 75, and to 35 percent at age 80.

Metro provides basic life and AD&D insurance equal to 1.5 times your annual base salary up to a maximum of \$50,000. Metro also provides dependent coverage of \$1,000 for your spouse, domestic partner and dependent children up to age 21 or age 25 if a full-time student.

Supplemental life insurance

You may purchase supplemental life insurance for yourself, your spouse, domestic partner and/or your eligible children. Supplemental AD&D insurance is available for you or your family in increments of \$10,000 up to a maximum of \$500,000. You can purchase up to a maximum of \$100,000 in supplemental life insurance during new hire enrollment without answering any medical questions. You may add supplemental life insurance, or if you are already enrolled in supplemental life insurance, you may increase your amount each year during open enrollment with evidence of insurability. The monthly cost of your supplemental coverage is based upon your age and the amount of coverage selected.

Supplemental life insurance rates

Age	Cost per \$10,000	Age	Cost per \$10,000
<30	\$0.75	55-59	\$7.82
30-34	\$1.04	60-64	\$9.51
35-39	\$1.22	65-69	\$14.69
40-44	\$1.70	70-74	\$22.60
45-49	\$2.64	75-79	\$34.85
50-54	\$4.61	80+	\$54.10

Spouse/Domestic Partner Supplemental Life Insurance

You can purchase life insurance for your spouse/domestic partner in increments of \$5,000 to a maximum of \$250,000, but this cannot exceed the total amount of your (the employee's) supplemental life coverage. If you elect more than \$25,000 of coverage for your spouse/domestic partner or are a late applicant, you will be asked to complete a medical questionnaire. The above rate table represents the monthly cost for spouse/domestic partner supplemental life insurance based upon your (the employee's) age and the amount of coverage selected.

Child (ren) Supplemental Life Insurance

Supplemental life insurance for your child(ren) is available for a benefit amount of \$10,000. Child(ren) are eligible for coverage until the age of 21. Child(ren) who are full-time students are eligible for coverage until the age of 25. The monthly cost for your child(ren)'s coverage is \$1.50 for the \$10,000 regardless of the number of eligible children covered. You may elect this option provided that you have also elected supplemental life insurance for yourself.

Evidence of insurability

When applying for supplemental life insurance coverage, you may be asked to provide information about your general health to the insurance company. In some cases you will be required to submit to a basic physical exam. This is called evidence of insurability. If it is needed, you will receive the appropriate form after making your election. This form must be returned and approved by our life insurance provider before your new election becomes effective.

Supplemental Accidental Death and Dismemberment (AD&D) insurance

You can purchase additional AD&D insurance in increments of \$10,000 up to \$500,000 through Lincoln Financial Group.

- The monthly cost of the supplemental AD&D is .28 per \$10,000 for employee only.
- The monthly cost of the supplemental AD&D is .57 per \$10,000 for the family plan.

By selecting this plan, family members will automatically be insured at the following levels:

Family Protection Plus coverage levels

AD&D coverage for:	Amount of coverage provided	Examples
Employee and spouse/ domestic partner	50% of employee amount	If your coverage amount is \$100,000, your spouse/domestic partner will automatically receive \$50,000 in coverage
Employee and child(ren)	15% of employee amount for each child	If your coverage amount is \$100,000, each child will automatically be covered for \$15,000
Employee, spouse/domestic partner and child(ren)	40% of employee amount for spouse/domestic partner and 5% for each child	If your coverage amount is \$100,000, your spouse/domestic partner will automatically receive \$40,000 and each child will automatically receive \$5,000 in coverage

Life insurance beneficiary designation

Your life insurance beneficiary is the person you choose to receive life and AD&D benefits in the event of your death. A beneficiary form must be completed and returned to the benefits department in order to ensure that the insurance company follows your wishes and bequeath the appropriate beneficiaries.

LONG TERM DISABILITY

Metro provides long term disability insurance through Lincoln Financial Group, at no cost to the employee. If you become disabled due to a non-work injury and you meet the plan's definition of disability, you are eligible to apply and receive a monthly amount equal to 66-2/3 percent of your monthly salary, up to a maximum of \$3,000 per month (subject to reduction from other sources of income). This benefit lasts as long as you are disabled or until you qualify for Social Security. You must show a loss of income of 20 percent or more for at least 90 days in order to qualify for this benefit.

VOLUNTARY SHORT TERM DISABILITY

Metro provides eligible employees with employee-paid short term disability (STD) benefits insured by Lincoln Financial Group. If you become disabled due to an off-the-job illness or injury and you meet the plan's definition of disability, you are eligible to apply for a weekly STD benefit equal to 60% of you monthly salary (pre-disability earnings) to a maximum benefit of \$1,000 per week (subject to reduction from other sources of income). This benefit begins after 14 days of disability and continues as long as you are disabled according to the plan's definition of disability or until you reach the maximum benefit period, whichever occurs first. You may not be eligible for benefits if you have received treatment for a condition within the past 3 months until you have been covered under the plan for 6 months.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Metro sponsors a flexible spending account (FSA) program, administered by Eflexgroup, which allows you to defer salary into an account to pay for eligible medical and dependent care expenses with pre-tax dollars.

During open enrollment (from mid-November to mid-December each year), you can elect to defer up to \$2,550 for medical expenses and \$5,000 per married couple for dependent care expenses in to a FSA to be spent throughout the following calendar year. This IRS-regulated program is "use it or lose it," so plan wisely. Beginning in 2014, the IRS amended the FSA program allowing you to carryover up to \$500 of unused funds from the previous plan year for medical expenses; the carryover does not apply to dependent care expenses. Certain qualified dependent and employment status changes may allow you to change an election within 30 days of the status change.

The program offers an eflex debit card, which can be used everywhere MasterCard is accepted. You can use the eFlex debit card to pay at the time of service for your qualified purchases and submit a copy of the receipt to Metro's FSA provider.

Eligible health care expenses

To be eligible for reimbursement, health care expenses must be for medical care and primarily for a medical purpose. Over-the-counter medications must be accompanied by a doctor's prescription and a reimbursement request to be covered under the FSA. For a complete list of eligible expenses please see your eflex enrollment packet.

Alcoholism and drug addiction treatment	Hearing aids
Alternative care office visits (chiropractic, naturopath, and acupuncture)	Herbal supplements (if prescribed by a physician)
Ambulance	Hospital services
Artificial limbs and teeth	Laboratory fees
Blood pressure monitoring devices	Laser/LASIK eye surgery and radial keratotomy
Co-insurances, co-pays and deductibles	Massage therapy (if prescribed by a physician)
Contact lenses and solution	Operations/surgeries
Individual counseling (for a medical condition)	Orthodontia
Crutches	Osteopath
Dental and denture expenses	Physical therapy
Diabetic supplies and insulin	Pregnancy test
Diagnostic services and x-rays	Prescription drugs
Dietary supplements (if prescribed by a physician to treat a medical condition)	Psychiatric and psychology expenses
Exercise programs (if prescribed by a physician to treat a medical condition)	Smoking cessation program and products
Eye glasses and reading glasses	Sterilization procedures
Glucose monitoring equipment	Test strips
	Transplants
	Weight-loss programs (if prescribed by a physician)

Ineligible healthcare expenses

The following expenses are considered cosmetic or primarily used for general health purposes. These expenses are not eligible for reimbursement, even with a physician's recommendation.

- Annual fees for medical services (i.e. LifeFlight, MedicAlert)
- Cosmetic surgery
- Food supplements for weight loss
- Long-term care expenses
- Physician retainer fees
- Vitamins/herbal supplements for general health

Eligible dependent care expenses

To be eligible for reimbursement, the dependent care expense must be custodial in nature and allow you and your spouse, if married, to be gainfully employed. Gainfully employed means that you and your spouse, if married, are working and earning an income (i.e. not doing volunteer work). Since you are an employee, you are gainfully employed. Your spouse would also need to be gainfully employed for your expenses to be eligible.

- Before and after school care for children under the age of 13
- Care provided in your home (provider cannot be an IRS tax dependent or a dependent under the age of 19)
- Home or day care for eligible disabled IRS tax dependents (must spend at least eight hours per day in your home)
- Licensed day care providers
- Registration fees
- Summer day camps for children under the age of 13

Ineligible dependent care expenses

The following expenses are not considered custodial in nature and are not eligible for reimbursement.

- Enrichment programs (dance, sports or music lessons)
- Educational fees/tuition
- Overnight camps
- Food, clothing or transportation
- Housekeeping expenses
- Care not related to work

EMPLOYEE ASSISTANCE PROGRAM

The EmployeeConnect Employee Assistance Program (EAP) offers support, guidance and resources that can help you resolve personal issues and meet life's challenges. This service is provided at no additional cost to you and your immediate household family member(s) by Metro, in connection with your group long term disability coverage from Lincoln Financial Group. All calls and inquires made to the EAP are confidential.

The EmployeeConnect EAP can help you with a number of issues such as:

- Child care and elder care
- Alcohol and drug abuse
- Life improvement
- Difficulties in relationships
- Stress and anxiety with work or family
- Depression
- Personal achievement
- Emotional well-being
- Financial and legal concerns
- Grief and loss
- Identity theft and fraud resolution

The program is available 24 hours a day, every day, to you and members of your household. You'll receive up to four face-to-face counseling sessions per issue, per year.

You may also access WorkLife services. WorkLife services provide research and referrals for child care, elder care, education, and adoption.

How to contact EmployeeConnect EAP

EmployeeConnect EAP is ready to assist you 24 hours a day, 365 days a year.

Phone: 888-628-4824

Online: www.GuidanceResources.com or www.Lincoln4Benefits.com

Enter: username = LFGsupport; password = LFGsupport1

Group Name: Metro Regional Government

TRAVEL CONNECT

(TRAVEL ASSISTANCE SERVICES)

TravelConnect focuses on travel, medical and safety related services you may need while traveling. The TravelConnect benefit is provided at no additional cost to you and your family members and includes a wealth of services when traveling 100 miles or more from home. Services are provided for both business and leisure travel.

Medical evacuation and transportation - In a medical emergency, TravelConnect will arrange and pay for transportation of the patient to the nearest medical facility able to treat the illness or injury. Once the patient is able to travel home, Travel Connect will arrange and pay for the trip home.

Dependent child transportation- If a medical emergency leaves no parent available, TravelConnect will either arrange and pay for the child's trip home or arrange and pay for a family member to travel to and care for the child.

Medical Treatment monitoring- TravelConnect acts as the care manager when the traveler has a medical emergency. TravelConnect can request medical records and have them reviewed by their medical director to ensure the treatment is appropriate; they could act as an intermediary; they could provide medical translation services for the patient and/or family; or they could act as the communication conduit between the patient and their family back home.

TravelConnect can also help you with a number of additional issues such as:

- Destination info — weather, currency and more
- Emergency travel arrangements and funds transfer
- Lost or stolen travel documents assistance
- Language translation services
- Medical and dental referrals
- Assistance with lost or broken corrective lenses or medical devices
- Arrangement for the delivery of medications, vaccines or other medical treatments
- Updates to family, employer and/or home physician in the event of medical emergency
- Repatriation of a deceased traveler
- Security and political evacuation help

How to contact TravelConnect

Phone: 800-527-0218

ID number 322541

PUBLIC EMPLOYEES RETIREMENT SYSTEM (PERS)

Metro participates in the Oregon Public Employees Retirement System (PERS). Employees become eligible after working six full months. A position is PERS qualified if it has 600 hours or more total service within a calendar year.

- If you were hired prior to Dec. 31, 1995, you are a PERS Tier 1 member.
- If you were hired after Jan. 1, 1996 but before Aug. 29, 2003, you are a PERS Tier 2 member.
- If you were hired on or after August 29, 2003, you are a part of the Oregon Public Service Retirement Plan (OPSRP).

The PERS system is a hybrid pension plan with two components – the Pension Program and the Individual Account Program (IAP). The employer portion is 6 percent towards the employee’s PERS. All new hires pay the employee portion of PERS. For current PERS employees, the employee portion may be paid by either the employee or the employer depending upon collective bargaining agreement or employment policy. The IAP portion is immediately 100 percent vested. The employer-paid portion is vested over a 5-year schedule. Eligibility and contributions are tracked and administered automatically by the payroll department. You do not need to fill out a form to participate in the PERS retirement program but you do need to fill out a beneficiary form that can be found on the PERS web site at www.oregon.gov/PERS. You are not able to use other beneficiary forms you have completed for PERS.

PERS comparison chart

	Tier one	Tier two	OPSRP pension	IAP
Retirement age	58 (or 30 years of service)	60 (or 30 years of service)	65 (58 with 30 years of service)	55
Early retirement	55	55	55	55
Earnings	Guaranteed assumed rate; currently 8% annually	No guarantee; market returns	N/A; no member account	No guarantee; market returns

For more information about PERS, contact PERS at 503-598-7377 or visit www.oregon.gov/PERS.

VOLUNTARY EMPLOYEE PAID RETIREMENT

Metro offers both a 401(k) and a 457 retirement plan option. Participation in these plans is voluntary. You may contribute into one or both plans.

ICMA-RC 401(k) plan

401(k) plans are typically offered to private sector employees. Metro offered this plan prior to becoming a governmental agency and was able to “grandfather” in this benefit. Metro’s 401(k) plan is administered through ICMA-RC. This plan offers both the traditional pre-tax contribution election and the Roth 401(k) plan after-tax election option. As of the 2015 calendar year employees under age 50 may defer up to \$18,000 into the 401(k) plan; employees age 50 and older may defer up to \$24,000 per calendar year. You can self-direct your contributions into a number of ICMA-RC funds.

ICMA-RC 457 plan

457 plans are the voluntary retirement savings plans that are typically offered to governmental employees. Metro’s 457 plan is administered through ICMA-RC. This plan offers both the traditional pre-tax contributions and the Roth 457 plan after-tax election option. As of the 2015 calendar year employees under age 50 may defer up to \$18,000 into the 457 plan; employees age 50 and older may defer \$24,000 per calendar year. Employees who meet the pre-retirement catch-up limit may defer \$36,000 per calendar year. You can self-direct your contributions into a number of ICMA-RC funds.

You may enroll or change your 401(k) and 457 plan elections at any time by completing an enrollment/change form obtained from Metro’s intranet or by visiting the benefits department.

OTHER BENEFITS

Membership eligibility and discounts

- Advantis Credit Union membership eligibility
- Point West Credit Union membership eligibility
- LA Fitness corporate membership discounts with no enrollment fee
- Lloyd Athletic Club corporate membership discount with no enrollment fee

Home Ownership Program

Metro, in partnership with HomeStreet Bank, offers an Employee Assisted Housing Program. This program has a comprehensive amount of resources to assist you in the home purchasing process. Benefits of the program include:

- Free home buying seminars
- Budget and credit resources
- Special loan programs
- Access to down payment assistance
- Significant savings on closing costs

For more information about the home ownership program, contact HomeStreet Bank at 503-227-3956 or toll free at 888-408-0066 or visit www.homestreet.com/Metro

Commute Options Metro offers a number of programs to encourage employees to develop sustainable commuting habits. Most Metro sites offer a Tri-Met Universal Pass, pre-tax parking expense, discounted parking expense for carpooling, and rewards for biking and walking to work.

Payroll services Direct deposit and annual paycheck deduction for charitable contributions.

Online Access to benefit and payroll information Metro's e-Portal provides employees with an up-to-date view of their personal, employment and benefit information. All employee accessible data from the Human Resources and payroll systems are available online. Visit e-Portal to access and manage your information.

- View and print paycheck information.
- Discontinue printed direct deposit statements.

- Update federal tax withholding and direct deposit information.
- View your current benefits elections and deductions.
- Maintain current emergency contact, e-mail or phone numbers.
- Update your address.
- Submit a name change. (This requires a copy of your new Social Security card, marriage certificate or divorce decree to be sent to Human Resources before the change will be approved.)

How to get started

Type **e-Portal** in your internet browser address bar.

Your e-Portal User ID is the same as your employee ID number with the leading zeros (for example, 000441). Your initial password will be the first two letters of your last name (upper case) and the last four digits of your social security number. (For example, the password for employee John Morse, SSN 555-55-1234 would be MO1234.)

For assistance with e-Portal, call the help desk at 503-797-1722 or ext. 2222.

Important benefit notices

Please read the following notices providing important information about your benefits. In some cases, the government requires Metro to provide these notices to you to help you make better choices in regard to your health insurance and to help you understand your rights under these plans. Please read the complete benefit booklet(s) for your health plans for more details or contact Metro's Benefits Department at 503-797-1723 for assistance.

Privacy Notice (HIPAA)

The Health Portability and Accountability Act of 1996 (HIPAA) privacy rules went into effect April 14, 2003, for certain agencies and health care providers. Part of this federal law protects your personally identifiable health information (called Protected Health Information or *PHI* under HIPAA) and gives you rights in relation to accessing this information. For those Metro health plans that are insured by insurance carriers, Metro does not receive PHI from these carriers and has only a minimal level of compliance responsibilities under HIPAA. For example, if you or a family member requests a member of Metro's Benefits Division to assist you in resolving a health claim issue, you may need to sign an authorization form allowing Metro staff to view and/or use your PHI for this purpose. You may contact our health insurance carriers at any time for a notice of their HIPAA privacy practices and/or to request information about how your PHI is used by these carriers.

In regard to Metro's self-funded health flexible spending account, Metro does not access plan PHI for any reason other than to administer this plan and then, only as allowed by HIPAA privacy and security laws. In addition, Metro has policies and procedures in place to safeguard and protect the PHI of plan participants. Contact the Benefits Division at any time for a copy of Metro's Notice of Privacy Practices for this plan.

Medicare Part D – Notice of Group Health Plan Creditability

This notice applies to those retirees who are age 65 or older, or who have a covered spouse that is age 65 or older. It also applies if you or your eligible dependent are under age 65 and qualify for Medicare due to disability or end stage renal disease (ESRD).

Medicare's prescription drug coverage "Medicare Part D" went into effect January 1, 2006 for qualified Medicare beneficiaries who enroll for this benefit. Group health plans coordinate with the Medicare Part D Prescription Drug benefits. Metro is required to notify you that the prescription drug benefits provided by Metro's PacificSource and Kaiser medical plans **are considered "creditable" with Medicare Part D drug benefits.** This

means they are equal to or better than the Medicare Part D prescription drug benefits. Please contact Metro’s Benefits Department for our complete Creditable Coverage Notice and keep it in the event you need to provide documentation of creditable coverage in the future. It is important that an individual be able to provide evidence that he/she had creditable prescription drug coverage during any period they were eligible for, but did not enroll in, Medicare Part D benefits or the individual must pay significantly higher Medicare Part D premiums for late enrollment. You can learn more about Medicare Part D and creditable coverage on the CMS website: <http://www.cms.gov/CreditableCoverage/>.

Medicaid and the Children’s Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families (CHIPRA)

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.HealthCare.gov.

Oregon – Medicaid and CHIP	Washington - Medicaid
Medicaid Website: http://www.oregon.gov/DHS/healthplan/index.shtml Medicaid Phone: 1-800-359-9517 CHIP Website: http://www.oregon.gov/DHS/healthplan/app_benefits/ohp4u.shtml CHIP Phone: 1-800-359-9517	Website: http://hrsa.dshs.wa.gov/premiumpymt/apply.shtm Phone: 1-877-543-7669

To see if any more States have added a premium assistance program or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
 Employee Benefits Security Administration
www.dol.gov/ebsa
 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
 Centers for Medicare & Medicaid Services
www.cms.hhs.gov
 1-877-267-2323, Ext. 61565

WHCRA Annual Notice – Benefits for Mastectomy-Related Treatment

The medical plans provided to you by Metro, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provide benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas.

COBRA Health Plan Continuation Benefits

The Consolidated Omnibus Budget Reconciliation Act (COBRA) passed by Congress in 1986 provides for continuation of group health insurance when that coverage might otherwise be terminated due to certain “qualifying events” under this law. If eligible for COBRA, group coverage can be extended to former employees, retirees, spouses, former spouses, and dependent children at group rates, however, COBRA participants must pay the entire cost of the continued health coverage and an additional 2% surcharge. The type of qualifying event will determine who the qualified beneficiaries are and the amount of time that Metro’s health plans must offer continued coverage to them. To be eligible for COBRA coverage, you must have been enrolled in a Metro health plan when the qualifying event occurred and the Metro health plan must continue to be in effect for active employees. Continuation of health FSA benefits is governed by federal cafeteria plan rules; contact our FSA administrator for continuation information if you lose your health FSA coverage and have un-used health FSA funds remaining in your account.

There may be other coverage options for you and your family. Instead of enrolling in COBRA continuation of coverage, there may be more affordable coverage options for you and your family through the Health Insurance Marketplace or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. You can access the Marketplace at www.HealthCare.gov.

Uniformed Services Employment & Reemployment Rights Act Notice (USERRA)

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. This notice is about your rights under USERRA.

REEMPLOYMENT RIGHTS. You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- you ensure that your employer receives advance written or verbal notice of your service;
- you have five years or less of cumulative service in the uniformed services while with that particular employer;
- you return to work or apply for reemployment in a timely manner after conclusion of service; and
- you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION. If you are a past or present member of the uniformed service; have applied for membership in the uniformed service; or are obligated to serve in the uniformed service; then an employer may not deny you:

- initial employment;
- reemployment;
- retention in employment;
- promotion; or
- any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION. If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT. The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at <http://www.dol.gov/vets>. An interactive online USERRA Advisor can be viewed at <http://www.dol.gov/elaws/userra.htm>. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. 1-800-336-4590

Contact information

<p>Kaiser Medical <i>Medical group number 1543</i> 503-813-2000 www.kp.org</p>	<p>ICMA-RC 800-669-7400 www.icmarc.org 401(k) Plan # 106953, 457 Plan # 307037</p>
<p>Kaiser Pharmacy Administration 503-261-7900 Kaiser Mail Order Pharmacy 800-548-9809, option 4</p>	<p>Eflexgroup (flexible spending accounts and health savings account) 877-933-3539 www.eflexgroup.com</p>
<p>Added Choice MedImpact Pharmacy 800-788-2949 Added Choice Prior Authorization 503-813-1031</p>	<p>Advantis Credit Union 503-785-2528 www.advantiscu.org</p>
<p>Kaiser Dental <i>Dental group number 1543-043</i> 503-813-2000 www.kaiserpermanentedentalnw.org</p>	<p>Point West Credit Union 503-546-5000 www.pointwestcu.com</p>
<p>MODA Dental (formerly ODS) <i>Group number 10001772</i> 503-265-5680 www.modahealth.com</p>	<p>EmployeeConnect Services Employee Assistance Program 888-628-4824 www.GuidanceResources.com username = LFGsupport password = LFGsupport1 Group: <i>Metro Regional Government</i></p>
<p>Vision Service Plan (VSP) <i>Group number 3107884</i> 800-877-7195 www.vsp.com</p>	
<p>PERS <i>Metro employer number 2594</i> 503-598-7377 www.oregon.gov/PERS</p>	<p>Home Street Bank Home Ownership Program 503-227-3956 www.homestreet.com/Metro</p>
<p>Lincoln Financial Life Insurance Policy # 000010165956 LTD Policy # 000010165957 (800) 423-2765 www.LincolnFinancial.com</p>	<p>LA Fitness <i>All locations</i> www.lafitness.com</p>
<p>Kaiser Alternative Care (CHP Group) 800-449-9479 www.chpgroup.com</p>	<p>Lloyd Athletic Club 503-287-4594 www.lloydac.com</p>

Medical, Dental, and Vision Enrollment/Change Form

01/01/2015 – 06/30/2015

Last Name, First Name, Middle Initial		Social Security Number:		Employee ID Number:		Birth Date:	
Street Address, Apt		City, State, Zip:		Home Phone:		Work Phone:	
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree		<input type="checkbox"/> Represented <input type="checkbox"/> Non-Represented Union (if Represented):			

Acknowledgement:

I understand that, by signing and submitting this form, I am making a legally binding election of my benefits and authorizing any corresponding payroll deductions. I cannot change my elections during the plan year unless I have a status change event. The coverage provided will be subject to the terms and conditions of the group insurance policies for which I have elected. I certify that the information on this form is true and correct to the best of my knowledge and I understand that my benefits may be affected by failure to provide complete, accurate and timely information. I understand that any person who knowingly and with intent to defraud any insurance company provides false or misleading information concerning any material fact commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties. I understand that after I enroll, the carriers selected on this form may need to obtain Confidential Information. I also understand that the carriers may need to provide this confidential information to others. Until revoked in writing, this authorization may be relied upon by the carriers, Metro, and other parties involved in insurance administration.



Employee Benefits
 Phone: 503-797-1723
 Fax: 503-797-1798

Coverage

Medical - Traditional Plan **Medical – HDHP w/ HSA³** **Dental Plan** **Vision**

Employee Only Kaiser HMO Kaiser HMO HDHP Kaiser Dental VSP
 Employee and Spouse¹ Added Choice Added Choice HDHP MODA Dental
 Employee and Domestic Partner¹ Opt Out² Opt Out

Employee and Children ¹ Requires a copy of marriage license or Domestic Partner Certification upon initial enrollment
 Employee and Family¹ ² Must have other coverage to opt out
 Employee, Domestic Partner¹, and Family ³ Complete a Health Savings Account (HSA) Enrollment Form if enrolling in a High-Deductible Health Plan (HDHP)

Enrollment Information

Last Name, First Name, Middle Initial	Gender (M/F)	Date of Birth (month/day/year)	Social Security Number	Your legal dependent?	Is dependent disabled?	Other Insurance? (Name of plan and policy number)
Spouse						
Child						
Child						
Child						
Child						

Child Custody Information if you are enrolling children of a previous relationship, you must complete this section for any court ordered coverage listed above.

Child's Name	Whose Child	Joint Custody	Custodial Parent Name	Custodial Parent Address	Custodial Parent Phone Number	If Court Order, Name Responsible for Insurance

Employee/Retiree Signature (read acknowledgement prior to signing)

I authorize and confirm my election as indicated. I understand that I cannot change my election until July 1, 2015 unless I have a qualified change in family status. My signature authorizes Metro to withhold my portion of the monthly premium from my paycheck.

Date



HSA ENROLLMENT FORM

Instructions

1. Complete this form in order to open an HSA. (* = Required Fields)
2. Submit to designated personnel.
3. If you have any questions regarding this form, please call **877-933-3539**.

Accountholder Profile Information

Employer/Company Name

*Name (Last, First, MI)

 - -

*Social Security Number

*Employee ID

*E-mail Address

*Address Line 1 (cannot be PO Box)

*Address Line 2 (cannot be PO Box)

*City

*State

*Zip

 - -

*Home Phone

 - -

*Daytime Phone Number

*Date of Birth

 Male Female

*Gender

 Married Single

*Marital Status

*Mother's Maiden Name

*Hire Date

*Hours Worked Per Week

*Payroll Frequency

Election

Please choose one of the following enrollment options.

I am enrolling in an HSA through my employer. I authorize my employer to deduct my HSA contributions from my pay and forward them to my HSA. (Please complete the section immediately below.)

Note: Your employer may also make a contribution to your HSA that will apply to your maximum contribution allowed. You are solely responsible for determining whether contributions to an HSA exceed the maximum annual contribution limitation. You are also responsible for notifying the custodian of any excess contribution and requesting a withdrawal of the excess contribution together with any net income attributable to the excess contribution.

*Indicate an annual employee election or a pay period election:

\$

Employee Annual Contribution

or

\$

Per Pay Period Contribution

*Indicate HDHP Coverage Level:

Self-only or Family/Other

*Indicate if you are enrolled in an HDHP through your employer: Yes or No

Your contributions will be withdrawn from your pay in each pay period. If your employer maintains a cafeteria plan that permits HSA contributions, your contributions will be made with pre-tax dollars. You may also make contributions outside of your employment. If you would like to make a contribution immediately, please complete an HSA Contribution Form and submit that form with your payment.

Direct Deposit Setup

This section is required if you have chosen Direct Deposit as your HSA Reimbursement Method above.

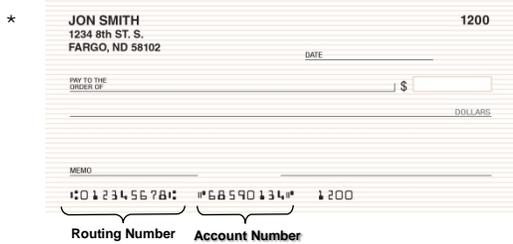
*Bank Name

*Address *City *State *Zip

Checking Savings
 *Account Type

*Routing Number

*Account Number



Beneficiary Designation and Information

I designate the following individual(s) or entity as my primary or contingent death beneficiary(ies) of this HSA. If I am married in common law or in a community or marital property state, I must designate my spouse as my Primary Beneficiary unless spouse's signature is obtained and notarized below. Share percentages must equal 100% for primary and 100% for contingent.

No.	Name and Address	Date of Birth	Social Security Number	Primary or Contingent	Relationship	Share %
1.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	<input type="text"/>
2.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	<input type="text"/>
3.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	<input type="text"/>

Please check one of the following:

- I am not married. If I become married at a future date, I must complete a new Beneficiary Designation form.
- I am married. I understand that if I choose to designate a primary death beneficiary other than my spouse, he or she must agree to the designation by signing below. My spouse's signature must be notarized.

 Signature of Spouse

 Date

Subscribed and sworn to before me this
 _____ day of _____, 20____

 Notary Public

Privacy Policy.

By executing this form, you acknowledge receipt of the Privacy Policy. You agree to receive future notices of any updates to the Privacy Policy at www.healthcarebank.com, and to review the Privacy Policy no less frequently than annually. See Privacy Policy below.

FACTS

Rev. Sept 2013

WHAT DOES HEALTHCARE BANK, A DIVISION OF BELL STATE BANK & TRUST, DO WITH YOUR PERSONAL INFORMATION

Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, shares, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: <ul style="list-style-type: none"> -Social Security number and account balances -payment history and transaction history -account transactions and checking account information <p>When you are <i>no longer</i> our customer, <i>we</i> continue to share your information as described in this notice.</p>
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Healthcare Bank, a division of Bell State Bank & Trust, chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Healthcare Bank, a division of Bell State Bank & Trust, share?	Can you limit this sharing?
For our everyday business purposes – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes – to offer our products and services to you	Yes	No
For joint marketing with other financial companies	No	We don't share
For our affiliates' everyday business purposes – information about your transactions and experiences	No	We don't share
For our affiliates' everyday business purposes – information about your creditworthiness	No	We don't share
For nonaffiliates to market to you	No	We don't share

Questions?Call toll free 1-866-442-2472 option 1 or go to www.healthcarebank.com

Who we are	
Who is providing this notice?	Healthcare Bank, a division of Bell State Bank & Trust
What we do	
How does Healthcare Bank, a division of Bell State Bank & Trust, protect my personal information?	<p>To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings.</p> <p>We also maintain other physical, electronic and procedural safeguards to protect this information and we limit access to information to those employees for whom access is appropriate.</p>
How does Healthcare Bank, a division of Bell State Bank & Trust, collect my personal information?	<p>We collect your personal information, for example, when you</p> <ul style="list-style-type: none"> -open an account or apply for a loan -make deposits or withdrawals from your account -use your credit or debit card -seek advice about your investments <p>We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.</p>
Why can't I limit all sharing?	<p>Federal law gives you the right to limit only</p> <ul style="list-style-type: none"> -sharing for affiliates' everyday business purposes – information about your creditworthiness -affiliates from using your information to market to you -sharing for nonaffiliates to market to you <p>State laws and individual companies may give you additional rights to limit sharing.</p>
Definitions	
Affiliates	<p>Companies related by common ownership or control. They can be financial and nonfinancial companies.</p> <p><i>-Our affiliates include financial companies such as State Bankshares, Inc. and nonfinancial companies, such as Discovery Benefits, Inc.</i></p>
Nonaffiliates	<p>Companies not related by common ownership or control. They can be financial and nonfinancial companies.</p> <p><i>-Healthcare Bank, a division of Bell State Bank & Trust, does not share with nonaffiliates so they can market to you.</i></p>
Joint marketing	<p>A formal agreement between nonaffiliated financial companies that together market financial products or services to you.</p> <p><i>-Healthcare Bank, a division of Bell State Bank & Trust, doesn't jointly market.</i></p>

Terms, Conditions and Signature

Important Information Regarding Patriot Act Requirements

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial organizations to obtain, verify, and record information that identifies each individual who opens an account. What this means for you, when you open an account, you are required to provide your name, residential address, date of birth, and identification number. As part of the ongoing maintenance of your account we may require other information or documentation that allows us to identify you. You understand that your HSA may be closed if additional verification is not possible. Upon such closure, funds deposited in your HSA will be returned to you, less any fees or expenses chargeable against your HSA, or penalties or surrender charges associated with the early withdrawal of any savings instrument or other investment in your HSA account. As custodian, Healthcare Bank, a division of Bell State Bank & Trust shall not be liable for any tax consequences or tax withholdings you may incur as a result of the transfer or distribution of your assets.

Important Information about Electronic Payments

I authorize electronic debit and credit entries, if applicable, to my designated checking or savings account. I also authorize adjustments to these accounts for error corrections. This authorization will remain in effect until the termination of your HSA.

Important Information about your Account

The maximum balance allowed in my Cash Account is based on the designated threshold established by my TPA or me.

Important Information Regarding Death Beneficiary Information

If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary death beneficiary. If any primary or contingent death beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining death beneficiary(ies) shall be increased on a pro rata basis. If more than one primary death beneficiary is designated and no distribution percentages are indicated, the death beneficiaries will be deemed to own equal share percentages in the HSA. Multiple contingent death beneficiaries with no share percentage indicated will also be deemed to share equally. If no primary death beneficiary(ies) survives me, the contingent death beneficiary(ies) shall acquire the designated share of my HSA.

I understand that if I designate my spouse as primary death beneficiary or contingent death beneficiary of the HSA, the dissolution, termination, annulment or other legal termination of my marriage will automatically revoke such designation.

Important Information Regarding My Account Summary

I understand that account summaries are made available electronically and may be viewed at any time by logging into my account at **[Enter TPA Website Address]**. The Healthcare Bank Privacy policy is available online at www.healthcarebank.com. For an additional fee, the HSA Administrator that I identify as my Designated Representative may send paper account summaries and paper copies of the Healthcare Bank Privacy Policy to my address by U.S. mail. I will check the box below if I also wish to receive paper account summaries and paper copies of the Healthcare Bank Privacy Policy by U.S. Mail.

- I wish to receive paper account summaries and paper copies of the Healthcare Bank Privacy Policy by U.S. Mail. By electing this option I acknowledge that an additional fee may apply. The amount of the fee and frequency of the paper account summaries and paper copies of the Healthcare Bank Privacy Policy are set forth on the attached fee schedule. Paper account summaries are limited to current balances, contributions and distributions.

Important Information Regarding My HSA Investment Account

I understand that once I have accumulated the designated threshold in cash in my HSA as set forth by my TPA or me in the Application, the balance of my account above the designated threshold will automatically be invested in an interest-bearing, FDIC-insured account. For purposes of this enrollment form, "Application" shall mean the 1Cloud by Evolution1® system available through a link provided by my TPA which provides me access to my HSA account information, Investment Account and is used to process my HSA transactions. I may also choose to change my allocation choices and select from the TPA's list of mutual funds for the investment of HSA assets in excess of the designated threshold. The HSA Investment Account is exclusively available online at **[Enter TPA Website Address]**. An email address must be included in enrollment or it will not be available. All investment transactions in the HSA Investment Account will be initiated and conducted electronically. All required disclosures of investment information and trade confirmations will be made electronically, and by opening an HSA Investment Account I consent to the electronic delivery/access of all documents of any issuer whose securities are made available to my HSA, including issuers and securities made available after the date my account is opened.

Important Information Regarding Substitute W-9 Certification

Under penalties of perjury, I certify that: (1) the Social Security Number shown on this form is my correct taxpayer identification number and, (2) I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and (3) I am a U.S. citizen (including a U.S. resident alien).

Important Information Regarding Fees

Any applicable fees shall be deducted from my account. Fees payable in connection with my HSA are set forth on the attached fee schedule.

Important Information Regarding Custodial and Investment Information

I have read and understand the HSA Custodial Agreement and Disclosure Statement and agree to be bound by those terms and conditions. I understand the eligibility requirements for this HSA and I state that I am responsible for determining whether I qualify to make deposits to this HSA. I am responsible for:

- a. determining that I am eligible to make contributions to an HSA for each year I make a contribution;
- b. ensuring that all contributions are within the maximum limitations set forth by the tax laws, taking into account my coverage under a high deductible health plan;
- c. the tax consequences of any contributions (including rollover contributions) or distributions; and
- d. seeking the assistance of a qualified tax or legal professional to address any questions or concerns I may have about eligibility, contribution limitations, or the taxation of contributions or distributions from my HSA.

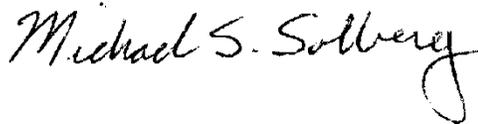
If I choose to select an investment allocation from the TPA's list of mutual funds, I will be solely responsible for direction of the investment of my HSA. I represent that I will carefully review investment information prior to making investment decisions and that I will seek assistance of a financial professional if I have questions about available investment options or how to select investments for my HSA.

I authorize Healthcare Bank, a division of Bell State Bank & Trust, and its agents to initiate permitted transfers, including contributions, to my HSA, as directed by me or my Designated Representative through the electronic account service features or as otherwise permitted under this HSA. Any such direction shall remain in effect until Healthcare Bank and its agents receive notice of a change to such directions via the electronic account service features or as otherwise permitted under this HSA.

I certify that the information provided by me on this Enrollment Form is accurate, and that I have received a copy of the HSA Custodial Agreement and Disclosure Statement and amendments thereto. I also acknowledge receipt of the Healthcare Bank Privacy Policy. I assume sole responsibility for all consequences found in the Enrollment Form and Custodial Agreement and Disclosure Statement. I understand that I may revoke the HSA on or before the seventh day after the date of establishment. I have not received any tax or legal advice from Healthcare Bank, and I will seek the advice of my own tax or legal professional to ensure my compliance with related laws. I release and agree to hold the Healthcare Bank harmless against any and all claims or losses arising from my actions.

I hereby further agree to designate the TPA to serve as my Designated Representative with respect to my HSA account. By signing below I agree to be bound by the terms and conditions of the separate agreement entitled Designation of Representative by HSA Client and by my signature each party respectively acknowledges his or her understanding and agreement with such terms and conditions.

Signature of HSA Accountholder



Date

Authorized Signature of Healthcare Bank as Custodian



Flexible Spending Account (FSA) Enrollment Form

Employee Information *(Please print clearly)*

Social Security No. _____ First Name, Middle Initial _____
 Last name _____ Date of Birth (mm/dd/yyyy) _____
 Date of Hire (mm/dd/yyyy) _____ Area Code _____ Phone number _____
 Home Address _____
 City _____ State _____ Zip Code _____
 email _____

Employer to complete this section

Employer Name _____ Dept/Division/Client _____
 Payroll Frequency _____ No. of Payroll Deductions _____ Hours per Week _____
 Employee Plan Effective Date (mm/dd/yyyy) _____ Date of 1st Payroll Deduction _____
 Deduction Code _____ Short Plan Year 12-Month Plan Year

Employee Elections *(Employee to complete the information below)*

Yes, I want to enroll. My elections are below. **No, I do not want to enroll.** If a change in status occurs, I may have the right to enroll in the plan at that time (if plan allows).

A. Group Medical Premiums. If you participate in your employer's insurance plan(s), your premiums will automatically be deducted on a tax free basis under this plan unless you notify your Human Resources or Personnel Department.

	Annual Election	Divided by (/) Number of Payrolls	Equals (=) Amount Per Pay Check	Employer Contribution <i>(if applicable)</i>	
				Per Month	Per Year
B. Health FSA	\$	/	\$	\$	\$
C. Dependent Care FSA	\$	/	\$	\$	\$
D. Premium Reimbursement Account (PRA)	\$	/	\$	\$	\$
E. Limited Purpose FSA	\$	/	\$	\$	\$
Totals	\$	/	\$	\$	\$

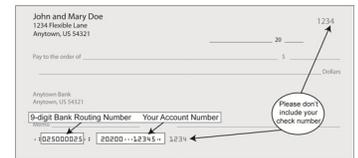
My employer offers the claims auto download through my medical carrier. I would like to take advantage of this service.

Direct Deposit Information *(Complete this section if you are a new eflex customer or if your bank account information has changed in the past year.*

You don't need to complete this section if you had direct deposit in the last plan year and your bank account information hasn't changed.) **IMPORTANT: Please provide a voided check (not a deposit slip) for each account listed below. We can't process without a voided check.**

Bank Name _____ Bank Address _____
 City _____ State _____ ZIP Code _____
 Name on the Account _____ Routing and Transit Number _____
 Account Number _____ Account Type _____

With my signature below, I authorize reimbursements from my eflex plan to be sent to the financial institution named above to be deposited in the designated account. In the event funds are deposited erroneously into my account, I authorize eflex to debit my account(s) not to exceed the original amount of the credit. I also understand that all direct deposits are made through the automated clearing house (ACH), and that funds availability is subject to the terms and limitations of the ACH as well as my financial institution.



In setting up my eflex plan, I understand and agree that the IRS regulations state four conditions: 1) Any expenses I/we incur must be within the plan year; 2) Any expenses I/we incur must not be covered by any other source, such as insurance; 3) I/we must provide proper documentation to receive payment; 4) I/we cannot change or revoke elections during the plan year unless there is a specific change in status and my employer allows such changes. Please see the Summary Plan Description for details.

Signature _____ Date _____

Fax, email, or mail this completed form with a voided check to your HR/Personnel Department.



Use or Disclosure Authorization

Complete this form to allow spouse, family members and/or agents to discuss your eflex account, claims, and other plan-related details with us.

By completing this Use or Disclosure Authorization, I hereby authorize eflex/eCOBRA the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary, that I may refuse to sign this authorization, and that I may revoke it at any time by submitting my revocation in writing to eflexgroup.com (eflex/eCOBRA).

I authorize the following person(s)/organization(s) to receive and/or discuss health information for me and my dependents.

Last name, First name	Relationship (e.g., spouse, agent, etc.)	Company (if applicable)	Disclose all health information? (Y/N) <i>If No, please provide specific description of information to be used or disclosed</i>

I understand the specific purpose of the disclosure may be made at the request of the authorized individual: Yes No

This authorization will expire upon termination of coverage. However, I may revoke authorization at any time by submitting written revocation to eflex/eCOBRA.

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying eflex/eCOBRA, in writing, but the revocation will not have any effect on any actions that may have occurred before receiving the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- Information used or disclosed pursuant to this authorization may be re-disclosed by persons/organizations I have authorized to receive information. I have the right to seek assurances from the above-named persons/organizations that they will not re-disclose information to any other party without my further authorization.

Your Full Name (print) _____ Your SSN _____

Your Date of Birth _____ Employer Name _____

Your Signature _____ Date _____

Please keep a copy for your records. Mail, email, or fax completed authorization to:
eflex Customer Care, 2740 Ski Lane, Madison, WI 53713
f: 877-231-1287 | e: customer care@eflexgroup.com





The Lincoln National Life Insurance Company
 P.O. Box 2616, Omaha, NE 68103-2616
 Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID: METROOR	GROUP POLICY #:	Billing Division or Location:
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A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) Metro		County	Employer ZIP	State
Employee Last Name	First Name	Middle Initial	Social Security Number	Date of Birth
Spouse Last Name	First Name	Middle Initial	Social Security Number	Date of Birth
Street Address		City	State	Zip
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single		Home Phone ()	Work Phone ()

Completed By Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Yearly \$ _____	Date of Full-Time Employment:	Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

Basic Coverage NOTE: Please mark the box or boxes for each coverage you are applying for.
 All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Class	Effective Date	Type of Coverage	Amount of Coverage	Total Premium
		Basic Group Life/AD&D <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No*	\$	Employer Paid
		Dependent Life <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$	Employer Paid
		Long Term Disability <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No*	\$	Employer Paid

*By selecting No, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense.

--Actual deductions may vary slightly from above illustrations due to rounding--

Voluntary Coverage NOTE: Please mark the box or boxes for each coverage you are applying for.
 All coverage amounts are subject to the limitations and exclusions as stated in the policy.

TYPE OF COVERAGE	AMOUNT OF COVERAGE	TOTAL PREMIUM
Voluntary Employee Life Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$	\$
Voluntary Spouse Life Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$	\$
Voluntary Dependent Child Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$	\$
Voluntary Accidental Death & Dismemberment (Standalone) <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee Only <input type="checkbox"/> Family	\$
Voluntary Short Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Weekly Benefit Amount \$ _____	\$

*By selecting No, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense.

--Actual deductions may vary slightly from above illustrations due to rounding--

C. Beneficiary Information (Complete ONLY for Life/AD&D)				
Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip
Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.				

D. Request for Coverages
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:
<input type="checkbox"/> REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company. I hereby enroll for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.
<input type="checkbox"/> NOT ENROLL myself in the Program. I understand that if I enroll for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.
<input type="checkbox"/> NOT ENROLL my dependents in the Program. I understand that if I enroll for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

NOTE: A PERSON MAY BE COMMITTING INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A MISSTATEMENT, MISREPRESENTATION, OMISSION OR CONCEALMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, or its insurance partners, and the initial premium is paid to The Lincoln National Life Insurance Company. A delayed effective date will apply if the employee is not Actively at Work or an Active Member, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Full Name: _____ Employee Signature: _____ Date: _____

Clean air and clean water do not stop at city limits or county lines. Neither does the need for jobs, a thriving economy, and sustainable transportation and living choices for people and businesses in the region. Voters have asked Metro to help with the challenges and opportunities that affect the 25 cities and three counties in the Portland metropolitan area.

A regional approach simply makes sense when it comes to providing services, operating venues and making decisions about how the region grows. Metro works with communities to support a resilient economy, keep nature close by and respond to a changing climate. Together, we're making a great place, now and for generations to come.

Stay in touch with news, stories and things to do.

www.oregonmetro.gov/connect

Metro Council President

Tom Hughes

Metro Council

- Shirley Craddick, District 1
- Carlotta Collette, District 2
- Craig Dirksen, District 3
- Kathryn Harrington, District 4
- Sam Chase, District 5
- Bob Stacey, District 6

Auditor

Brian Evans

**MAKING A
GREAT
PLACE**

