July 1, 2016 – December 31, 2017

MAKING A GREAT PLACE

Metro

METRO EMPLOYEE BENEFITS HANDBOOK

TABLE OF CONTENTS

Forms

IMPORTANT NOTE

This handbook provides a summary of benefits. To learn about your specific benefits, refer to your collective bargaining agreement. You can find your complete contract on the Metro MetroNet or get a copy by contacting the benefits department at 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 will be on a calendar year schedule effective January 1, 2018 and renew each January 1. You can enroll or make changes to your medical, dental and vision benefits each year during open enrollment with an effective date of January 1. Open enrollment for health benefits is during November-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
benefitshelp@metro-region.org

Ning Fisher, Total Compensation Manager
Ph: 503-797-1723
ning.fisher@oregonmetro.gov

Jason Meyers, Benefits and Class/Comp Analyst
Ph: 503-797-1638
jason.meyers@oregonmetro.gov

Jackson Zug, Benefits Assistant
Ph: 503-797-1639
jackson.zug@oregonmetro.gov

Rolanda Thompson, Benefits Assistant
Ph: 503-797-1588
rolanda.thompson @oregonmetro.gov

Peri Tharp, Worker's Compensation Specialist
Ph: 503-797-1895
peri.tharp@oregonmetro.gov

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 for benefits eligibility and coverage. Generally, only employees in full-time, budgeted positions and who meet the eligibility under the Affordable Care Act are eligible for health and welfare benefits.

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.

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 enrollment 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.

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 and sign the waiver of group coverage form. Proof of other insurance coverage is required.

Full-time Employee Health Insurance Contribution Rates (Effective 07/01/2016)

	AFSCME 3580, 3580-1, IUOE 701, IUOE 701-1, ILWU 28, IATSE 28, LIUNA 483, Non-rep -- 92/8			
	Per Month		Per Pay Period	
Kaiser Added Choice POS	**Employee**	**Metro**	**Employee**	**Metro**
Employee Only	$61.30	$704.89	$30.65	$352.45
Employee and Spouse/Domestic Partner	$122.59	$1,409.78	$61.29	$704.89
Employee and Child(ren)	$110.33	$1,268.80	$55.17	$634.40
Family	$159.37	$1,832.71	$79.68	$916.36
Kaiser Added Choice HDHP*	**Employee**	**Metro**	**Employee**	**Metro**
Employee Only	$41.21	$473.89	$20.60	$236.95
Employee and Spouse/Domestic Partner	$82.42	$947.78	$41.21	$473.89
Employee and Child(ren)	$74.17	$853.01	$37.09	$426.50
Family	$107.14	$1,232.07	$53.57	$616.04
Kaiser $10 HMO	**Employee**	**Metro**	**Employee**	**Metro**
Employee Only	$44.76	$514.69	$22.38	$257.35
Employee and Spouse/Domestic Partner	$89.51	$1,029.39	$44.76	$514.69
Employee and Child(ren)	$80.56	$926.45	$40.28	$463.22
Family	$116.36	$1,338.20	$58.18	$669.10
Kaiser HDHP $1500*	**Employee**	**Metro**	**Employee**	**Metro**
Employee Only	$29.20	$335.80	$14.60	$167.90
Employee and Spouse/Domestic Partner	$58.40	$671.59	$29.20	$335.80
Employee and Child(ren)	$52.56	$604.43	$26.28	$302.22
Family	$75.92	$873.08	$37.96	$436.54
MODA Dental	**Employee**	**Metro**	**Employee**	**Metro**
Employee Only	$4.78	$54.97	$2.39	$27.49
Employee and Spouse/Domestic Partner	$9.47	$108.88	$4.73	$54.44
Employee and Child(ren)	$9.61	$110.51	$4.80	$55.26
Family	$14.68	$168.82	$7.34	$84.41
Kaiser Dental	**Employee**	**Metro**	**Employee**	**Metro**
Employee Only	$5.06	$58.14	$2.53	$29.07
Employee and Spouse/Domestic Partner	$10.11	$116.23	$5.05	$58.12
Employee and Child(ren)	$9.10	$104.64	$4.55	$52.32
Family	$15.16	$174.39	$7.58	$87.19
Vision Service Plan	**Employee**	**Metro**	**Employee**	**Metro**
Employee Only	$0.47	$5.37	$0.23	$2.69
Employee and Spouse/Domestic Partner	$0.75	$8.59	$0.37	$4.30
Employee and Child(ren)	$0.76	$8.76	$0.38	$4.38
Family	$1.23	$14.13	$0.61	$7.07

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

Part-time Employee Health Insurance Contribution Rates (Effective 07/01/2016)

AFSCME 3580, 3580-1, LIUNA 483, Non-rep

	AFSCME 3580, 3580-1, LIUNA 483, Non-rep: 0.75FTE				AFSCME 3580, 3580-1, LIUNA 483 Non-rep: 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	$237.52	$528.67	$118.76	$264.34	$413.74	$352.45	$206.87	$176.22
Employee and Spouse/Domestic Partner	$475.03	$1,057.34	$237.52	$528.67	$827.48	$704.89	$413.74	$352.45
Employee and Child(ren)	$427.53	$951.60	$213.77	$475.80	$744.73	$634.40	$372.37	$317.20
Family	$617.54	$1,374.54	$308.77	$687.27	$1,075.72	$916.36	$537.86	$458.18
Kaiser Added Choice HDHP*	**Employee**	**Metro**	**Employee**	**Metro**	**Employee**	**Metro**	**Employee**	**Metro**
Employee Only	$159.68	$355.42	$79.84	$177.71	$278.15	$236.95	$139.08	$118.47
Employee and Spouse/Domestic Partner	$319.36	$710.84	$159.68	$355.42	$556.31	$473.89	$278.15	$236.95
Employee and Child(ren)	$287.43	$639.75	$143.71	$319.88	$500.68	$426.50	$250.34	$213.25
Family	$415.16	$924.05	$207.58	$462.03	$723.17	$616.04	$361.59	$308.02
Kaiser $10 HMO	**Employee**	**Metro**	**Employee**	**Metro**	**Employee**	**Metro**	**Employee**	**Metro**
Employee Only	$173.43	$386.02	$86.71	$193.01	$302.10	$257.35	$151.05	$128.67
Employee and Spouse/Domestic Partner	$346.86	$772.04	$173.43	$386.02	$604.21	$514.69	$302.10	$257.35
Employee and Child(ren)	$312.17	$694.84	$156.09	$347.42	$543.79	$463.22	$271.89	$231.61
Family	$450.91	$1,003.65	$225.46	$501.82	$785.46	$669.10	$392.73	$334.55
Kaiser HDHP $1500*	**Employee**	**Metro**	**Employee**	**Metro**	**Employee**	**Metro**	**Employee**	**Metro**
Employee Only	$113.15	$251.85	$56.58	$125.93	$197.10	$167.90	$98.55	$83.95
Employee and Spouse/Domestic Partner	$226.30	$503.69	$113.15	$251.85	$394.19	$335.80	$197.10	$167.90
Employee and Child(ren)	$203.67	$453.32	$101.83	$226.66	$354.77	$302.22	$177.39	$151.11
Family	$294.19	$654.81	$147.10	$327.41	$512.46	$436.54	$256.23	$218.27
MODA Dental	**Employee**	**Metro**	**Employee**	**Metro**	**Employee**	**Metro**	**Employee**	**Metro**
Employee Only	$18.52	$41.23	$9.26	$20.61	$32.27	$27.49	$16.13	$13.74
Employee and Spouse/Domestic Partner	$36.69	$81.66	$18.34	$40.83	$63.91	$54.44	$31.95	$27.22
Employee and Child(ren)	$37.24	$82.88	$18.62	$41.44	$64.86	$55.26	$32.43	$27.63
Family	$56.89	$126.62	$28.44	$63.31	$99.09	$84.41	$49.55	$42.21
Kaiser Dental	**Employee**	**Metro**	**Employee**	**Metro**	**Employee**	**Metro**	**Employee**	**Metro**
Employee Only	$19.59	$43.61	$9.80	$21.80	$34.13	$29.07	$17.06	$14.54
Employee and Spouse/Domestic Partner	$39.17	$87.17	$19.58	$43.59	$68.22	$58.12	$34.11	$29.06
Employee and Child(ren)	$35.26	$78.48	$17.63	$39.24	$61.42	$52.32	$30.71	$26.16
Family	$58.76	$130.79	$29.38	$65.39	$102.36	$87.19	$51.18	$43.60
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: Metro will contribute $1,000 for employee only and $2,000 for employee and dependent(s) per enrollment period into a Health Savings Account (H.S.A.) for those who select either of the two High Deductible plans.

Variable Hours Employee Health Insurance Contribution Rates (Effective 07/01/2016)

AFSCME 3580, AFSCME 3580-1, IUOE 701, IUOE 701-1, ILWU 28, IATSE 28, LIUNA 483, Non-rep

	0.8 FTE					0.75 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	$202.27	$563.92	$101.14	$281.96		$237.52	$528.67	$118.76	$264.34
Employee and Spouse/Domestic Partner	$404.55	$1,127.82	$202.27	$563.91		$475.03	$1,057.34	$237.52	$528.67
Employee and Child(ren)	$364.09	$1,015.04	$182.05	$507.52		$427.53	$951.60	$213.77	$475.80
Family	$525.91	$1,466.17	$262.95	$733.09		$617.54	$1,374.54	$308.77	$687.27
Kaiser Added Choice HDHP*	**Employee**	**Metro**	**Employee**	**Metro**		**Employee**	**Metro**	**Employee**	**Metro**
Employee Only	$135.99	$379.11	$67.99	$189.56		$159.68	$355.42	$79.84	$177.71
Employee and Spouse/Domestic Partner	$271.97	$758.23	$135.99	$379.11		$319.36	$710.84	$159.68	$355.42
Employee and Child(ren)	$244.78	$682.40	$122.39	$341.20		$287.43	$639.75	$143.71	$319.88
Family	$353.55	$985.66	$176.78	$492.83		$415.16	$924.05	$207.58	$462.03
Kaiser $10 HMO	**Employee**	**Metro**	**Employee**	**Metro**		**Employee**	**Metro**	**Employee**	**Metro**
Employee Only	$147.69	$411.76	$73.85	$205.88		$173.43	$386.02	$86.71	$193.01
Employee and Spouse/Domestic Partner	$295.39	$823.51	$147.69	$411.76		$346.86	$772.04	$173.43	$386.02
Employee and Child(ren)	$265.85	$741.16	$132.93	$370.58		$312.17	$694.84	$156.09	$347.42
Family	$384.00	$1,070.56	$192.00	$535.28		$450.91	$1,003.65	$225.46	$501.82
Kaiser HDHP $1500*	**Employee**	**Metro**	**Employee**	**Metro**		**Employee**	**Metro**	**Employee**	**Metro**
Employee Only	$96.36	$268.64	$48.18	$134.32		$113.15	$251.85	$56.58	$125.93
Employee and Spouse/Domestic Partner	$192.72	$537.27	$96.36	$268.64		$226.30	$503.69	$113.15	$251.85
Employee and Child(ren)	$173.45	$483.54	$86.72	$241.77		$203.67	$453.32	$101.83	$226.66
Family	$250.54	$698.46	$125.27	$349.23		$294.19	$654.81	$147.10	$327.41
MODA Dental	**Employee**	**Metro**	**Employee**	**Metro**		**Employee**	**Metro**	**Employee**	**Metro**
Employee Only	$15.77	$43.98	$7.89	$21.99		$18.52	$41.23	$9.26	$20.61
Employee and Spouse/Domestic Partner	$31.24	$87.11	$15.62	$43.55		$36.69	$81.66	$18.34	$40.83
Employee and Child(ren)	$31.71	$88.41	$15.86	$44.20		$37.24	$82.88	$18.62	$41.44
Family	$48.44	$135.06	$24.22	$67.53		$56.89	$126.62	$28.44	$63.31
Kaiser Dental	**Employee**	**Metro**	**Employee**	**Metro**		**Employee**	**Metro**	**Employee**	**Metro**
Employee Only	$16.68	$46.52	$8.34	$23.26		$19.59	$43.61	$9.80	$21.80
Employee and Spouse/Domestic Partner	$33.35	$92.99	$16.68	$46.49		$39.17	$87.17	$19.58	$43.59
Employee and Child(ren)	$30.03	$83.71	$15.01	$41.86		$35.26	$78.48	$17.63	$39.24
Family	$50.04	$139.51	$25.02	$69.75		$58.76	$130.79	$29.38	$65.39
Vision Service Plan	**Employee**	**Metro**	**Employee**	**Metro**		**Employee**	**Metro**	**Employee**	**Metro**
Employee Only	$1.54	$4.30	$0.77	$2.15		$1.81	$4.03	$0.91	$2.01
Employee and Spouse/Domestic Partner	$2.47	$6.87	$1.23	$3.44		$2.90	$6.44	$1.45	$3.22
Employee and Child(ren)	$2.51	$7.01	$1.26	$3.50		$2.95	$6.57	$1.48	$3.28
Family	$4.06	$11.30	$2.03	$5.65		$4.76	$10.60	$2.38	$5.30

NOTE: Metro will contribute $1,000 for employee only and $2,000 for employee and dependent(s) per enrollment period 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 (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
Office visits	**You pay**
Routine preventive physical exam	$0
Primary Care	$10
Specialty Care	$10
Urgent Care	$30
Tests (outpatient)	
Preventive tests	$0
Laboratory	$10 per department visit
X-ray, imaging, and special diagnostic procedures	$10 per department visit
CT, MRI, PET scans	$10 per department visit
Medications	
Prescription drugs (outpatient)	$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.
Administered medications, including injections (all outpatient settings)	20% Coinsurance
Nurse treatment room visits to receive injections	$10
Maternity Care	
Scheduled prenatal care and first postpartum visit	$0
Laboratory	$10 per department visit
X-ray, imaging, and special diagnostic procedures	$10 per department visit
Inpatient Hospital Services	$50 per day up to $250 per admission
Hospital Services	
Ambulance Services (per transport)	$75
Emergency department visit	$75 (Waived if admitted)
Inpatient Hospital Services	$50 per day up to $250 per admission
Outpatient Services (other)	
Outpatient surgery visit	$20
Chemotherapy/radiation therapy visit	$10
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
Alternative Care	
Alternative care (physician-referred) (Acupuncture is limited to 12 visits per calendar year.)	$10
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.

KAISER HMO PLAN SUMMARY (CONTINUED)

Vision Services	
Routine eye exam	$10
Vision hardware and optical Services (ages 18 years and younger)	Not covered
Vision hardware and optical Services (ages 19 years and older)*	Not covered
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
Hearing Aids	
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
Hearing aids (ages 19 years and older) *	Not covered
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

***AMOUNTS DO NOT COUNT TOWARD OUT OF POCKET MAXIMUM.**

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 one Member	$1,500 per Calendar Year
For an entire Family	$3,000 per Calendar Year
Out-of-Pocket Maximum (All Deductible, Copayment, and Coinsurance amounts count toward the maximum, unless otherwise noted.)	
For one Member	$3,500 per Calendar Year
For an entire Family	$7,000 per Calendar Year
Office visits	**You pay**
Routine preventive physical exam	$0
Primary Care	20% Coinsurance after Deductible
Specialty Care	20% Coinsurance after Deductible
Urgent Care	20% Coinsurance after Deductible
Tests (outpatient)	
Preventive tests	$0
Laboratory	20% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
CT, MRI, PET scans	20% Coinsurance after Deductible
Medications	
Prescription drugs (outpatient)	Not covered, except you pay $0 for formulary contraceptives, not subject to Deductible and 20% of charges after Deductible for certain diabetic supplies when purchased at Kaiser Permanente pharmacies.
Administered medications, including injections (all outpatient settings)	20% Coinsurance after Deductible
Nurse treatment room visits to receive injections	$10 after Deductible
Maternity Care	
Scheduled prenatal care and first postpartum visit	$0
Laboratory	20% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible
Hospital Services	
Ambulance Services (per transport)	20% Coinsurance after Deductible
Emergency department visit	20% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible
Outpatient Services (other)	
Outpatient surgery visit	20% Coinsurance after Deductible

KAISER HMO HIGH DEDUCTIBLE PLAN SUMMARY (CONTINUED)

Chemotherapy/radiation therapy visit	20% Coinsurance after Deductible
Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance after Deductible
Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	20% Coinsurance after Deductible
Alternative Care	
Alternative care (physician-referred) (Acupuncture is limited to 12 visits per calendar year.)	20% Coinsurance after Deductible
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.
Vision Services	
Routine eye exam	20% Coinsurance after Deductible
Vision hardware and optical Services (ages 18 years and younger)	Not covered
Vision hardware and optical Services (ages 19 years and older)*	Not covered
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
Hearing Aids	
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
Hearing aids (ages 19 years and older)*	Not covered
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

***AMOUNTS DO NOT COUNT TOWARD OUT OF POCKET MAXIMUM.**

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	$,1000
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
Office visits		**You Pay**	
Routine preventive physical exam	$0	$0	40% Coinsurance after Deductible
Primary Care	$20	$30	40% Coinsurance after Deductible
Specialty Care	$30	$40	40% Coinsurance after Deductible
Urgent Care	$40	$50	40% Coinsurance after Deductible
Tests (outpatient)			
Preventive tests	$0	$0	40% Coinsurance after Deductible
Laboratory	$20 per department visit	$25 per department visit	40% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	$20 per department visit	$25 per department visit	40% Coinsurance after Deductible
CT, MRI, PET scans	$50 per department visit	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Medications			
Prescription drugs (outpatient)	$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.	

KAISER ADDED CHOICE PLAN SUMMARY (CONTINUED)

Administered medications, including injections (all outpatient settings)	20% Coinsurance	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Nurse treatment room visits to receive injections	$10	$30	40% Coinsurance after Deductible
Maternity Care			
Scheduled prenatal care and first postpartum visit	$0	$0	40% Coinsurance
Laboratory	$20 per department visit	$25 per department visit	40% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	$20 per department visit	$25 per department visit	40% Coinsurance after Deductible
Inpatient Hospital Services	$200 per day up to $1,000 per admission	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Hospital Services			
Ambulance Services (per transport)		$100	
Emergency department visit		$100 (Waived if admitted)	
Inpatient Hospital Services	$200 per day up to $1,000 per admission	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Services (other)			
Outpatient surgery visit	$100	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	$30	$40	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 (up to 20 visits per therapy per Calendar Year)	$30	$40	40% Coinsurance after Deductible
Alternative Care			
Alternative care (physician-referred)	$30	Not Covered	Not Covered
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.		
Vision Services			
Routine eye exam	$20	$30	40% Coinsurance after Deductible
Vision hardware and optical Services (ages 18 years and younger)	Not covered		Not covered
Vision hardware and optical Services (ages 19 years and older)*		Not covered	
Skilled Nursing Facility Services (up to 100 days per Calendar Year)	$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

KAISER ADDED CHOICE PLAN SUMMARY (CONTINUED)

Inpatient hospital & residential Services	$200 per day up to $1,000 per admission	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Hearing Aids			
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
Hearing aids (ages 19 years and older)*		Not covered	

*Amounts do not count toward Out of Pocket Maximum.
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
Office visits	**You Pay**		
Routine preventive physical exam	$0		$0
Primary Care	$20 after Deductible	$30 after Deductible	50% Coinsurance after Deductible
Specialty Care	$20 after Deductible	$30 after Deductible	50% Coinsurance after Deductible
Urgent Care	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Tests (outpatient)			
Preventive tests	$0	$0	50% Coinsurance after Deductible
Laboratory	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible
X-ray, 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
Medications			
Prescription drugs (outpatient)	$15 generic/$30 brand after Deductible. $0 for formulary contraceptives, not subject to 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.	$20 generic/$40 preferred brand/$60 non-preferred brand/$0 for formulary contraceptives at participating pharmacies for up to 30-day supply.	

KAISER ADDED CHOICE HIGH DEDUCTIBLE PLAN SUMMARY (CONTINUED)

Administered medications, including injections (all outpatient settings)	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Nurse treatment room visits to receive injections	$10 after Deductible	$15 after Deductible	50% Coinsurance after Deductible
Maternity Care			
Scheduled prenatal care and first postpartum visit	$0	$0	50% Coinsurance after Deductible
Laboratory	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Inpatient Hospital Services	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Hospital Services			
Ambulance Services (per transport)	10% Coinsurance after Deductible		
Emergency department visit	10% Coinsurance after Deductible		
Inpatient Hospital Services	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Services (other)			
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
Durable medical equipment, external prosthetic devices, and orthotic devices	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	$20 after Deductible	$30 after Deductible	50% Coinsurance after Deductible
Alternative Care			
Alternative care (physician-referred) (Acupuncture is limited to 12 visits per calendar year.)	$20 after Deductible	Not covered	Not covered
Alternative care (self-referred)*	$25 per visit for chiropractic, naturopathic and acupuncture after deductible, $25 copay per message visit limit of 12 per year, after deductible. All services subject to $1500 benefit maximum per calendar year.		
Vision Services			
Routine eye exam	$20 after Deductible	$30 after Deductible	50% Coinsurance after Deductible
Vision hardware and optical Services (ages 18 years and younger)	Not covered		
Vision hardware and optical Services (ages 19 years and older)*	Not covered		
Skilled Nursing Facility Services (up to 100 days per Calendar Year)	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Chemical Dependency 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

KAISER ADDED CHOICE HIGH DEDUCTIBLE PLAN SUMMARY (CONTINUED)

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
Hearing Aids			
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
Hearing aids (ages 19 years and older)*		Not covered	

*Amounts do not count toward Out of Pocket Maximum.
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	20% of charges for bridges; 50% of charges 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	$170 allowance plus 20% discount for amount over allowance or $95 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 Unum 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 26.

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 $180,000 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
15-24	$0.70	50-54	$4.61
25-29	$0.70	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+	$34.85

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 26. The monthly cost for your child(ren)'s coverage is $1.50 for $10,000 of coverage, 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 Unum.

- The monthly cost of the supplemental AD&D is $0.28 per $10,000 for employee only.
- The monthly cost of the supplemental AD&D is $0.14 per $5,000 for spouse coverage.
- The monthly cost of the supplemental AD&D is $0.28 per $10,000 for child 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 Unum, 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 Unum. 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 TASC, 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 a debit card, which can be used everywhere MasterCard is accepted. You can use the 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 TASC enrollment packet.

- Alcoholism and drug addiction treatment
- Alternative care office visits (chiropractic, naturopath, and acupuncture)
- Ambulance
- Artificial limbs and teeth
- Blood pressure monitoring devices
- Co-insurances, co-pays and deductibles
- Contact lenses and solution
- Individual counseling (for a medical condition)
- Crutches
- Dental and denture expenses
- Diabetic supplies and insulin
- Diagnostic services and x-rays
- Dietary supplements (if prescribed by a physician to treat a medical condition)
- Exercise programs (if prescribed by a physician to treat a medical condition)
- Eye glasses and reading glasses
- Glucose monitoring equipment
- Hearing aids
- Herbal supplements (if prescribed by a physician)
- Hospital services

Laboratory fees
Laser/LASIK eye surgery and radial keratotomy
Massage therapy (if prescribed by a physician)
Operations/surgeries
Orthodontia
Osteopath
Physical therapy
Pregnancy test
Prescription drugs
Psychiatric and psychology expenses
Smoking cessation program and products
Sterilization procedures
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 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 Unum. All calls and inquires made to the EAP are confidential.

The LifeBalance 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 three face-to-face counseling sessions per issue, per year.

How to contact LifeBalance EAP

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

Phone: 1-800-854-1446 (English) or 1-877-858-2147 (Spanish)

Online: lifebalance.net

Enter: username = lifebalance; password = lifebalance

ASSIST AMERICA

(*TRAVEL ASSISTANCE SERVICES*)

Assist America focuses on travel, medical and safety related services you may need while traveling. The Assist America 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, Assist America 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, Assist America will arrange and pay for the trip home.

Dependent child transportation – If a medical emergency leaves no parent available, Assist America 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 – Assist America acts as the care manager when the traveler has a medical emergency. Assist America 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.

Assist America 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 Assist America

Within the U.S.: 1-800-872-1414

Outside the U.S.: (U.S. access code) +609-986-1234

Email: medservices@assistamerica.com

Reference Number: 01-AA-UN-762490

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. 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 503-598-7377or 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 2016 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 2016 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 MetroNet 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
- Great Wolf Lodge corporate membership discount

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 l4, 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 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

Kaiser Medical *Medical group number 1543* 503-813-2000 www.kp.org	**ICMA-RC** 800-669-7400 www.icmarc.org 401(k) Plan # 106953, 457 Plan # 307037
Kaiser Pharmacy Administration 503-261-7900 **Kaiser Mail Order Pharmacy** 800-548-9809, option 4	**TASC (flexible spending accounts and health savings account)** 877-933-3539 www.eflexgroup.com
Added Choice MedImpact Pharmacy 800-788-2949 **Added Choice Prior Authorization** 503-813-1031	**Advantis Credit Union** 503-785-2528 www.advantiscu.org
Kaiser Dental *Dental group number 1543-043* 503-813-2000 www.kaiserpermanentedentalnw.org	**Point West Credit Union** 503-546-5000 www.pointwestcu.com
MODA Dental *(formerly ODS)* *Group number 10001772* 503-265-5680 www.modahealth.com	**LifeBalance Services** Employee Assistance Program 1800-854-1446 www.lifebalance.net username = lifebalance password = lifebalance
Vision Service Plan (VSP) *Group number 3107884* 800-877-7195 www.vsp.com	
PERS *Metro employer number 2594* 503-598-7377 www.oregon.gov/PERS	**Travel Assistance Program** 1-800-872-1414 (U.S.) US access code+609-986-1234 (Overseas) Reference # 01-AA-UN-762490
Unum Group Life Insurance and LTD Policy # 608495 Voluntary Life Insurance Policy # 608497 Voluntary STD Policy # 608496 1-800-275-8686 www.unum.com	**Home Street Bank** Home Ownership Program 503-227-3956 www.homestreet.com/Metro
	LA Fitness *Nation-wide membership* *www.lafitness.com*
Kaiser Alternative Care (CHP Group) 800-449-9479 www.chpgroup.com	**Lloyd Athletic Club** 503-287-4594 www.lloydac.com

Medical, Dental and Vision - Enrollment / Change Form

07/01/2016 – 12/31/2017

Employee Benefits
BenefitsHelp@metro-region.org
Phone: 503-797-1638
Fax: 503-797-1798

Metro

Full Name		Social Security #	
Street Address, Apt. #		Date of Birth	
City, State, Zip		Home Phone #	
Gender		Work Phone #	
Employee Type	☐ Active ☐ COBRA ☐ Retiree	Employee ID #	
Union Affiliation	☐ Non-Represented ☐ Union-Represented by:	Date of Hire	

Coverage Type	**Kaiser Medical**	**Dental**	**Vision**
☐ Employee Only	☐ Health Maintenance Organization (HMO)	☐ Kaiser	☐ VSP
☐ Employee and Spouse [1]	☐ Health Maintenance Organization (HMO) High-Deductible + Health Savings Account (HSA) [2]	☐ MODA	
☐ Employee and Domestic Partner [1]	☐ Added Choice Point of Service (POS)	☐ Opt Out	
☐ Employee and Children	☐ Added Choice Point of Service (POS) High-Deductible + Health Savings Account (HSA) [2]		
☐ Employee, Spouse and Children [1]	☐ Opt Out [3]		
☐ Employee, Domestic Partner and Children [1]			

[1] *Requires proof of marriage license or domestic partner certification upon initial enrollment*

[2] *Requires Health Savings Account (HSA) enrollment form (Metro's contribution to HSA only applies to active employees)*

[3] *Requires other coverage to opt out*

Enrollment Information – *Spouse/Domestic Partner/Children*

Full Name	Gender	Date of Birth	Social Security #	Spouse, domestic partner or legal dependant?	Disabled? (Y/N)	Other insurance? (Plan and policy #)

Child Custody Information - *If you are enrolling children from a previous relationship, you must complete this section for any court ordered coverage listed above.*

Child's Name	Whose Child?	Joint Custody? (Y/N)	Custodial Parent Name	Custodial Parent Address	Custodial Parent Phone #	If Court Order, List Name Responsible for Insurance

Acknowledgment: 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 qualifying 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. I understand that my benefits may be affected by failure to provide complete, accurate and timely information. I understand that knowingly providing false and misleading information with intent to defraud insurance companies is a crime subject 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 selected on this form 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.

Signature		Date	

600 NE Grand Ave.
Portland, OR 97232-2736
www.oregonmetro.gov

Metro | *Making a great place*

Waiver of Group Coverage

I confirm by my signature below that I have been offered the opportunity to enroll in Metro's Group Medical plan and am waiving the coverage as of my eligibility date. I understand that the plan offered meets the criteria for a Qualified and Affordable Health Plan under the Affordable Care Act for the individual requirement.

Print Name: _____

Signature: _____

Date: _____

Please provide your contact information below:

Email: _____

Phone Number: _____

Please return this form to Metro Human Resources or
email a scanned copy to BenefitsHelp@metro-region.org.

BENEFICIARY DESIGNATION FORM
GROUP LIFE AND GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE
Unum Life Insurance Company of America
Provident Life and Accident Insurance Company
The Paul Revere Life Insurance Company

Instructions: Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). This form cancels all prior designations. If more than one beneficiary is named and no percentages are indicated, payment will be made to them in equal shares. If there are more than three (3) primary and/or contingent beneficiaries, please attach a separate sheet of paper. **Return the completed form to your employer.**

SECTION 1: Employee Information

Name (Last Name, Suffix, First Name, MI)	Social Security Number

Employer Name	Check the coverages listed below to which this beneficiary designation applies: ☐ Basic Life ☐ Supplemental Life ☐ AD&D ☐ All

SECTION 2: Primary Beneficiary (ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage
				Total Must Equal 100%

SECTION 3: Contingent Beneficiary (ies)

If **all** primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage
				Total Must Equal 100%

SECTION 4: Signature

X _____ _____

Employee Signature **Date**

Important Information About Designation of Beneficiaries

Beneficiary Information

- **Primary Beneficiary(ies)** means the person(s) you choose to receive your life insurance benefits. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any primary beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining primary beneficiary(ies).

- **Contingent Beneficiary(ies)** means the person(s) you choose to receive your life insurance benefits only if **all** primary beneficiaries are disqualified or die before you. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any contingent beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining contingent beneficiary(ies).

- **Minor Beneficiary(ies)** – When you designate minors as beneficiaries, it is important to understand that insurance benefits may not be released to a minor child. They may, however, be paid to a court appointed guardian of the child's estate. The regulations governing minor beneficiaries vary by state.

- **Trust** – You may designate a valid trust as a beneficiary.

Types of Coverage Information

- **Basic Life** is life insurance provided by your employer for which they pay the premiums.

- **Supplemental Life** is life insurance elected by you for which you pay the premiums.

- **AD&D** is Accidental Death & Dismemberment coverage.

- If you wish to designate different beneficiaries for any of the above coverages, please complete a separate form.

General Information

- **Updates to Your Beneficiary Designation** – You can change your beneficiary designation at any time. You may wish to review your designation periodically.

- **Consult an Attorney** – This information is not intended to be relied on as legal advice. You may wish to get the assistance of an attorney to help ensure your beneficiary designation correctly reflects your intentions.

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

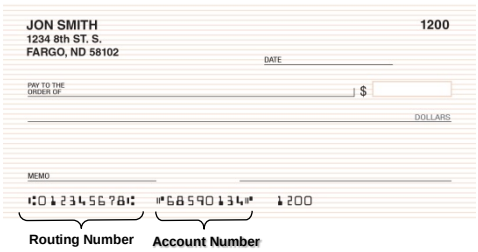
*Address | *City | *State | *Zip

☐ 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.				☐ Primary ☐ Contingent	☐ Spouse ☐ Dependent ☐ Other	
2.				☐ Primary ☐ Contingent	☐ Spouse ☐ Dependent ☐ Other	
3.				☐ Primary ☐ Contingent	☐ Spouse ☐ Dependent ☐ Other	

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

Subscribed and sworn to before me this

_____ day of _____, 20____

Date

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.

Rev. Sept 2013

FACTS

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: -Social Security number and account balances -payment history and transaction history -account transactions and checking account information When you are *no longer* our customer, *we* continue to share your information as described in this notice.
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?	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. 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.
How does Healthcare Bank, a division of Bell State Bank & Trust, collect my personal information?	We collect your personal information, for example, when you -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 We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only -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 State laws and individual companies may give you additional rights to limit sharing.

Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. -*Our affiliates include financial companies such as State Bankshares, Inc. and nonfinancial companies, such as Discovery Benefits, Inc.*
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. -*Healthcare Bank, a division of Bell State Bank & Trust, does not share with nonaffiliates so they can market to you.*
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. -*Healthcare Bank, a division of Bell State Bank & Trust, doesn't jointly market.*

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

Michael S. Solberg

Authorized Signature of Healthcare Bank as Custodian

Underwritten by:
Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122

Metro

Term Life and AD&D Insurance Enrollment Form

Policy #608497

Please print legibly and complete this form in its entirety. Blank fields will cause significant delays in processing.

Application Type:
☐ **Initial Enrollment:** To make initial elections; OR
☐ **Annual Enrollment:** To make changes to existing elections and/or information. The elections/information you indicate will replace your prior elections/information on file with Unum. **Note: If you do not wish to make any changes, do not complete this form. Please contact your plan administrator with any questions.**

Employee Social Security Number ___ - ___ - ____ **Gender** M ☐ F ☐ **Date of Birth (mm/dd/yyyy)** __ / __ / ____ **Hours Worked Per Week** __

Employee First Name _____ **M.I.** ☐ **Last Name** _____

Employee Street Address _____ **City** _____ **State** __ **Zip Code** _____

Original Date of Hire __ / __ / ____ **Annual Salary** ___ , ___ **Occupation** _____

☐ **Exempt** ☐ **Non-Exempt**

If date below unknown, consult with your Plan Administrator to complete:
☐ **Date entered into an eligible class (*ex: part time to full time*) or**
☐ **Rehire Date or**
☐ **Date of promotion to an eligible class** __ / __ / ____

Spouse First Name (if coverage is selected) _____ **Spouse Date of Birth (mm/dd/yyyy)** __ / __ / ____

COVERAGE ELECTIONS: Please indicate below the coverage amounts you would like to select for you and your spouse and/or child, if applicable. Dependent life and/or AD&D coverage amounts cannot exceed 100% of your life and/or AD&D coverage amounts. Any coverage amounts left blank will result in a coverage amount of $0.

Amount of coverage selected for:

Life You: $ ___ , ___ Your Spouse: $ ___ , ___ Your Child: $ __ , ___

AD&D You: $ ___ , ___ Your Spouse: $ ___ , ___ Your Child: $ __ , ___

Note: If you have chosen Life coverage over the Guarantee Issue amount of **$180,000 for you or $25,000 for your spouse**, you will also need to complete an Evidence of Insurability form. The amount of Life coverage over your Guarantee Issue amount will be subject to medical underwriting approval and will become effective in accordance with the terms of the policy. If you DO NOT APPLY FOR coverage for you or your dependent(s) during your or their initial enrollment period, you will need to complete an Evidence of Insurability form for all amounts of coverage. This applies to Life coverage only. You may complete and electronically submit an Evidence of Insurability form–please see your Plan Administrator.

Beneficiary Information: Please complete the beneficiary information on the reverse side of this form.

Request for Signature and Certification: *I have read and understand the "Limitations and Exclusions" on the reverse side of this enrollment form.* I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

_____ __ __/__ __/__ __ __ _____ _____

Employee Signature *Date* *Work Phone* *Home Phone*

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYER

Beneficiary Information

Name *(last name, first, middle initial)*:	**Relation to You:**	**Benefit %:**
If the beneficiary(ies) named above are not living, then pay:		

Please be aware that your coverage may be impacted by certain limitations and exclusions including, but not limited to, the following:

Limitations and Exclusions

Delayed Effective Date:

Employee: Insurance will be delayed for employees not in active employment until the first of the month, coincident with or next, following the date they return to work. Regularly scheduled vacation time is considered active employment.
Dependents: Coverage for totally disabled dependents will be delayed until the first of the month, coincident with or next, following the date the individual is no longer disabled. This delay does not apply to newborn children while dependent insurance is in effect. "Totally disabled" means that, as a result of injury, a sickness or a disorder, your dependent is confined in a hospital or similar institution; is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness; is cognitively impaired; is receiving or is entitled to receive any disability income from any source due to any sickness or injury; is receiving chemotherapy radiation therapy or dialysis treatment; or has a life threatening condition. Disabled children over the maximum child age may be eligible for benefits, please see your plan administer for more details.

Exclusion for Suicide:

Where the cause of death is suicide:

1. No benefits will be payable for a loss occurring within 24 months after the individual's initial effective date; and
2. No increased or additional insurance will be payable for a loss occurring within 24 months after the day such increased or additional insurance is effective.

This Suicide Exclusion does not apply to Washington residents.

AD&D Benefit Exclusions

AD&D Benefits would not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders;
- Suicide, self-destruction while sane, or self-inflicted injury;
- War, declared or undeclared, or any act of war;
- Active participation in a riot;
- Attempt to commit or commission of a crime;
- The voluntary use of any prescription or non-prescription drug, poison, fume or any other chemical substance unless used according to the prescription or direction of the individual's doctor. This exclusion does not apply to the individual if the chemical substance is ethanol; or
- Intoxication. ("Intoxicated" means that the individual's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.)

Please see your Plan Administrator [or your Policy] for a complete listing of applicable limitations and exclusions.

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYER

Underwritten by:
Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122

Metro
Short Term Disability Insurance
Enrollment Form
Policy #608496

Please complete this form in its entirety. Blank fields will cause significant delays in processing.

Employee Social Security Number ___ - ___ - ____ **Gender** M ☐ F ☐ **Date of Birth (mm/dd/yyyy)** __ / __ / ____ **Hours Worked Per Week** __

Employee First Name _____ **M.I.** ☐ **Last Name** _____

Employee Street Address _____ **City** _____ **State** __ **Zip Code** _____

Original Date of Hire __ / __ / ____ **Annual Salary** ___ , ___ **Occupation** _____

☐ **Exempt** ☐ **Non-Exempt**

☐ **Date entered into an eligible class (*ex: part time to full time*) *or***
☐ **Rehire Date *or***
☐ **Date of promotion to an eligible class**
__ / __ / ____ **(If unknown, consult with your Plan Administrator to complete.)**

STD Cost Calculation: To calculate your per-paycheck cost for this coverage, complete the calculations below. *Final Cost may vary slightly due to rounding.

NOTE: *If your weekly salary exceeds _____, use _____ as your weekly salary in the calculation.*

_____ (Annual Salary) ÷ 52 = _____ (Weekly Salary) X 60% (Benefit %) = _____ **Your Weekly Benefit**

_____ (Your Weekly Benefit) X .049 (Your Rate) = _____ **Your Monthly Cost**

_____ (Your Monthly Cost) X 12 = _____ (Annual Cost) ÷ _____ (# Paychecks per Year) = _____ **Cost per Paycheck***

☐ **Yes,** I would like to participate. I authorize my employer to deduct from my salary or wages the necessary premium for this coverage. My signature verifies the accuracy of information contained on this form.

I understand the effective date of my coverage will be delayed if I am not in active employment because of an injury, sickness, temporary lay-off or leave of absence on the date this insurance would otherwise become effective. **I have also read and understand the information in the Plan Highlights, including all statements regarding exclusions and benefit amounts and offsets.**

☐ **No,** I do not wish to participate. I understand that evidence of insurability will be required, at my own expense, if I decide to elect this coverage in the future.

Employee Signature: _____ Date: __ __/__ __/__ __ __ __

Return Forms To: _____ By: __ __/__ __/__ __ __ __

This section to be completed by your employer:
Coverage Effective Date: __ __/__ __/__ __ __ __

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 *(if applicable)*	
				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**.

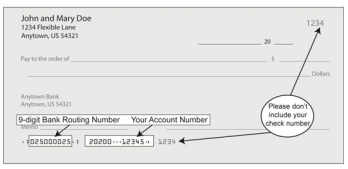
Bank Name _____ Bank Address_____

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) *If No, please provide specific description of information to be used or disclosed*

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: customercare@eflexgroup.com

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

MAKING A GREAT PLACE

Metro