Metro Employee
BENEFITS HANDBOOK

2018

TABLE OF CONTENTS

Forms Available by request

New Hire and Benefits Change form (required for newly eligible employees or for current employees changing plans)

Waiver of Group Coverage Form (required if opting out of medical insurance)

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

Cigna Enrollment and Beneficiary Designation Form (Required)

Flexible Spending Account Enrollment Form (Optional)

Domestic Partner Affidavit (required if enrolling domestic partner)

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 MetroNet or get a copy by contacting the benefits department at benefitshelp@oregonmetro.gov.

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.

Medical, Dental, and Vision benefits are on a calendar year and renew each January 1. You can enroll during your initial eligibility date 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 each year.

Enrollment and changes to your 401(k) and/or 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. You can also email them at benefitshelp@oregonmetro.gov.

Angie Bond, Total Compensation Manager
Ph: 503-797-1723
angie.bond@oregonmetro.gov

Jason Meyers, Classification/Compensation Analyst
Ph: 503-797-1638
jason.meyers@oregonmetro.gov

Jennie Spencer, HR Analyst – Class/Comp and Recruitment
Ph: 503-797-1575
jennie.spencer@oregonmetro.gov

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

Jennalee Bernard, HR Assistant – Benefits
Ph: 503-797-1639
jennalee.bernard@oregonmetro.gov

Peri Tharp, Worker's Compensation and FMLA Analyst
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 those 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 qualifying event. Qualifying event 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 a qualifying event within 30 days. 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 GT $150
- Kaiser HMO High Deductible Health Plan (HDHP) with Health Savings Account (HSA)
- Added Choice POS $250 Plan 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. An 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 an 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 a 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 (FSA) 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 $1,500 for individuals and $3,000 for those enrolling as employees plus dependent(s) per enrollment period. Metro contributes the full amount of the H. S.A. deductible, per employee or family enrollment, upon initial enrollment and the first subsequent re-enrollment into the HDHP. Renewing/continuing enrollees beginning the 3rd consecutive enrollment will receive monthly H.S.A. contributions by the 5th of each month, totaling the full deductible by the December deposit 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 on the Enrollment or Benefits Change form and sign the waiver of group coverage form. **Proof of other insurance coverage is required.**

This page was left blank intentionally.

Per Pay Period Rates	Full-Time(.8- 1.0 FTE)			.8 Variable Hour (Based on ACA Eligibility)		
	AFSCME 3580, IUOE 701/701-1, ILWU 28, IATSE 28, LIUNA 483, NON-REP					
Kaiser HMO	**Metro**	**Employee**	**Total**	**Metro**	**Employee**	**Total**
Employee Only	285.74	24.85	310.59	228.59	81.99	310.59
Employee & Spouse	571.48	49.69	621.17	457.18	163.99	621.17
Employee & Child(ren)	514.33	44.72	559.06	411.46	147.59	559.06
Employee & Family	742.92	64.60	807.53	594.34	213.19	807.53

Kaiser Added Choice	Metro	Employee	Total	Metro	Employee	Total
Employee Only	382.60	33.27	415.87	306.08	109.79	415.87
Employee & Spouse	765.20	66.54	831.74	612.16	219.58	831.74
Employee & Child(ren)	688.68	59.88	748.56	550.94	197.62	748.56
Employee & Family	994.75	86.50	1,081.26	795.80	285.45	1081.26

Kaiser HMO High Deductible	Metro	Employee	Total	Metro	Employee	Total
Employee Only	190.96	16.61	207.57	152.77	54.80	207.57
Employee & Spouse	381.93	33.21	415.15	305.55	109.60	415.15
Employee & Child(ren)	343.74	29.89	373.63	274.99	98.64	373.63
Employee & Family	496.51	43.17	539.69	397.21	142.48	539.69

Kaiser Added Choice High Deductible	Metro	Employee	Total	Metro	Employee	Total
Employee Only	269.50	23.43	292.93	215.60	77.33	292.93
Employee & Spouse	539.00	46.87	585.87	431.20	154.67	585.87
Employee & Child(ren)	485.09	42.18	527.28	388.07	139.20	527.28
Employee & Family	700.67	60.93	761.60	560.53	201.06	761.60

Kaiser Permanente Dental	Metro	Employee	Total	Metro	Employee	Total
Employee Only	28.20	2.45	30.65	22.56	8.09	30.65
Employee & Spouse	56.37	4.90	61.27	45.09	16.18	61.27
Employee & Child(ren)	50.75	4.41	55.16	40.60	14.56	55.16
Employee & Family	84.57	7.35	91.93	67.66	24.27	91.93

MODA Dental	Metro	Employee	Total	Metro	Employee	Total
Employee Only	28.31	2.46	30.77	22.65	8.12	30.77
Employee & Spouse	56.07	4.88	60.95	44.86	16.09	60.95
Employee & Child(ren)	56.91	4.95	61.86	45.53	16.33	61.86
Employee & Family	86.94	7.56	94.5	69.55	24.95	94.50

Vision Service Plan	Metro	Employee	Total	Metro	Employee	Total
Employee Only	2.76	0.24	3.01	2.21	0.79	3.01
Employee & Spouse	4.42	0.38	4.81	3.54	1.27	4.81
Employee & Child(ren)	4.50	0.39	4.90	3.60	1.29	4.90
Employee & Family	7.27	0.63	7.90	5.81	2.09	7.90

Per Pay Period Rates	Budgeted Employee - AFSCME 3580, LIUNA 483, NON REP					
	.75 Part Time			.5 Part Time		
Kaiser HMO	**Metro**	**Employee**	**Total**	**Metro**	**Employee**	**Total**
Employee Only	214.30	96.28	310.59	142.87	167.72	310.59
Employee & Spouse	428.61	192.56	621.17	285.74	335.43	621.17
Employee & Child(ren)	385.75	173.31	559.06	257.17	301.89	559.06
Employee & Family	557.19	250.33	807.53	371.46	436.06	807.53

Kaiser Added Choice	**Metro**	**Employee**	**Total**	**Metro**	**Employee**	**Total**
Employee Only	286.95	128.92	415.87	191.30	224.57	415.87
Employee & Spouse	573.90	257.84	831.74	382.60	449.14	831.74
Employee & Child(ren)	516.51	232.05	748.56	344.34	404.22	748.56
Employee & Family	746.07	335.19	1081.26	497.38	583.88	1,081.26

Kaiser HMO High Deductible	**Metro**	**Employee**	**Total**	**Metro**	**Employee**	**Total**
Employee Only	143.22	64.35	207.57	95.49	112.09	207.57
Employee & Spouse	286.45	128.69	415.15	190.97	224.18	415.15
Employee & Child(ren)	257.80	115.83	373.63	171.87	201.76	373.63
Employee & Family	372.38	167.30	539.69	248.26	291.43	539.69

Kaiser Added Choice High Deductible	**Metro**	**Employee**	**Total**	**Metro**	**Employee**	**Total**
Employee Only	202.12	90.81	292.93	134.75	158.18	292.93
Employee & Spouse	404.25	181.62	585.87	269.50	316.37	585.87
Employee & Child(ren)	363.82	163.46	527.28	242.55	284.73	527.28
Employee & Family	525.50	236.09	761.60	350.33	411.26	761.60

Kaiser Permanente Dental	**Metro**	**Employee**	**Total**	**Metro**	**Employee**	**Total**
Employee Only	21.15	9.50	30.65	14.10	16.55	30.65
Employee & Spouse	42.28	18.99	61.27	28.18	33.09	61.27
Employee & Child(ren)	38.06	17.10	55.16	25.37	29.79	55.16
Employee & Family	63.43	28.50	91.93	42.29	49.64	91.93

MODA Dental	**Metro**	**Employee**	**Total**	**Metro**	**Employee**	**Total**
Employee Only	21.23	9.54	30.77	14.15	16.62	30.77
Employee & Spouse	42.06	18.89	60.95	28.04	32.91	60.95
Employee & Child(ren)	42.68	19.18	61.86	28.46	33.40	61.86
Employee & Family	65.21	29.30	94.50	43.47	51.03	94.50

Vision Service Plan	**Metro**	**Employee**	**Total**	**Metro**	**Employee**	**Total**
Employee Only	2.07	0.93	3.01	1.39	1.62	3.01
Employee & Spouse	3.32	1.49	4.81	2.21	2.59	4.81
Employee & Child(ren)	3.38	1.52	4.90	2.26	2.64	4.90
Employee & Family	5.45	2.45	7.90	3.63	4.27	7.90

Summary of Medical Benefits
HMO GT $150

Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of Pocket Maximums accumulate.	
Deductible	
For one Member per Year	$150
For an entire Family per Year	$450
Out-of-Pocket Maximum *	
For one Member per year	$1,150
For an entire Family per year	$3,450
Office visits	**You pay**
Routine preventive physical exam	$0
Primary Care	$10
Specialty Care	$20
Urgent Care	$30
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	$10 per department visit
X-ray, imaging, and special diagnostic procedures	$10 per department visit
CT, MRI, PET scans	$100 per department visit
Medications (outpatient)	**You pay**
Prescription drugs (up to a 30 day supply)	$15 generic / $30 preferred brand
Mail Order Prescription drugs (up to a 90 day supply)	$30 generic / $60 preferred brand
Administered medications, including injections (all outpatient settings)	10% Coinsurance after Deductible
Nurse treatment room visits to receive injections	$10
Maternity Care	**You pay**
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	10% Coinsurance after Deductible
Hospital Services	**You pay**
Ambulance Services (per transport)	10% Coinsurance after Deductible
Emergency department visit	10% Coinsurance after Deductible
Inpatient Hospital Services	10% Coinsurance after Deductible
Outpatient Services (other)	**You pay**
Outpatient surgery visit	10% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	$20 after Deductible
Durable medical equipment, external prosthetic devices, and orthotic devices	10% Coinsurance after Deductible
Physical, speech, and occupational therapies (up to 20 visits per therapy per Year)	$20
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 100 days per Year)	10% Coinsurance after Deductible
Chemical Dependency Services	**You pay**
Outpatient Services	$10
Inpatient hospital & residential Services	10% Coinsurance after Deductible

Summary of Medical Benefits
HMO GT $150 continued

Behavioral Health Services	**You pay**
Outpatient Services	$10
Inpatient hospital & residential Services	10% Coinsurance after Deductible
Alternative Care (self referred) **	**You pay**
Benefit Maximum per Year (all Covered Services combined)	$1,500
Acupuncture Services	$10
Chiropractic Services	$10
Massage Therapy	$25
Naturopathic Medicine	$10
Vision Services	**You pay**
Routine eye exam (through first month of age 19)	$10
Vision hardware and optical Services (through first month of age 19)	Not covered
Routine eye exam (age 19 and older)	$10
Vision hardware and optical Services (age 19 years and older)	Not covered

*Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.

** Refer to your Evidence of Coverage (EOC) for any applicable visits limits.

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample EOCs are available upon request or you may go to http://www.kp.org/plandocuments

Questions? Call Member Services (M-F, 8 am-6 pm) or visit **kp.org** Portland area: 503-813-2000
All other areas: 1-800-813-2000 TTY.711. Language Interpretation Services, all areas 1-800-324-8010

This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on benefit coverage, claims review, and adjudication procedures, please see your EOC or call Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.

Summary of Medical Benefits
HMO HDHP

Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of Pocket Maximums accumulate.	
Deductible	
For one Member per Year	$1,500
For an entire Family per Year	$3,000
Out-of-Pocket Maximum *	
For one Member per year	$3,500
For an entire Family per year	$6,850
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)	**You pay**
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 (outpatient)	**You pay**
Prescription drugs (up to a 30 day supply)	After Deductible: $15 generic / $30 preferred brand
Mail Order Prescription drugs (up to a 90 day supply)	After Deductible: $30 generic / $60 preferred brand
Administered medications, including injections (all outpatient settings)	20% Coinsurance after Deductible
Nurse treatment room visits to receive injections	$10 after Deductible
Maternity Care	**You pay**
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	**You pay**
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)	**You pay**
Outpatient surgery visit	20% Coinsurance after Deductible
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 Year)	20% Coinsurance after Deductible
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 100 days per Year)	20% Coinsurance after Deductible
Chemical Dependency Services	**You pay**
Outpatient Services	20% Coinsurance after Deductible
Inpatient hospital & residential Services	20% Coinsurance after Deductible

Summary of Medical Benefits
HMO HDHP continued

Mental Health Services	**You pay**
Outpatient Services	20% Coinsurance after Deductible
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Alternative Care (self referred) **	**You pay**
Benefit Maximum per Year (all Covered Services combined)	$1,500
Acupuncture Services	$10 after Deductible
Chiropractic Services	$10 after Deductible
Massage Therapy	$25 after Deductible
Naturopathic Medicine	$10 after Deductible
Vision Services	**You pay**
Routine eye exam (through first month of age 19)	20% Coinsurance after Deductible
Vision hardware and optical Services (through first month of age 19)	Not covered
Routine eye exam (age 19 and older)	20% Coinsurance after Deductible
Vision hardware and optical Services (age 19 years and older)	Not covered
*Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.	
** Refer to your Evidence of Coverage (EOC) for any applicable visits limits.	

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample EOCs are available upon request or you may go to http://www.kp.org/plandocuments

Questions? Call Member Services (M-F, 8 am-6 pm) or visit **kp.org** Portland area: 503-813-2000
All other areas: 1-800-813-2000 TTY.711. Language Interpretation Services, all areas 1-800-324-8010

This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on benefit coverage, claims review, and adjudication procedures, please see your EOC or call Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.

Summary of Medical Benefits
Added Choice POS $250

Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of Pocket Maximums accumulate.

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.

	Tier 1 **Select Providers**	**Tier 2** **PPO Providers**	**Tier 3** **Non-Participating Providers ***
For one Member per Year	$250	$500	$750
For an entire Family per Year	$750	$1,500	$2,250
Out-of-Pocket Maximum **			
For one Member per year	$1,250	$2,500	$3,500
For an entire Family per year	$3,750	$7,500	$10,500
Office visits	**You pay**		
Routine preventive physical exam	$0	$0	35% Coinsurance after Deductible
Primary Care	$20	$30	35% Coinsurance after Deductible
Specialty Care	$30	$40	35% Coinsurance after Deductible
Urgent Care	$40	$50	35% Coinsurance after Deductible
Tests (outpatient)	**You pay**		
Preventive Tests	$0	$0	35% Coinsurance after Deductible
Laboratory	$20 per department visit	$30 per department visit	35% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	$20 per department visit	$30 per department visit	35% Coinsurance after Deductible
CT, MRI, PET scans	$100 per department visit	20% Coinsurance after Deductible	35% Coinsurance after Deductible
Medications (outpatient)	**You pay**		
Prescription drugs (up to a 30 day supply)	$15 generic / $30 preferred brand	At MedImpact Pharmacy $20 generic/$40 preferred brand/$60 non-preferred brand	
Mail Order Prescription drugs (up to a 90 day supply)	$30 generic / $60 preferred brand	Refer to Mail-Delivery Pharmacy 1-800-548-9809 kp.org/addedchoice	
Administered medications, including injections (all outpatient settings)	10% Coinsurance after Deductible	20% Coinsurance after Deductible	35% Coinsurance after Deductible
Nurse treatment room visits to receive injections	$10	$30	35% Coinsurance after Deductible
Maternity Care	**You pay**		
Scheduled prenatal care and first postpartum visit	$0	$0	35% Coinsurance after Deductible
Laboratory	$20 per department visit	$30 per department visit	35% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	$20 per department visit	$30 per department visit	35% Coinsurance after Deductible
Inpatient Hospital Services	10% Coinsurance after Deductible	20% Coinsurance after Deductible	35% Coinsurance after Deductible

Summary of Medical Benefits

Added Choice POS $250 continued

	Tier 1 Select Providers	Tier 2 PPO Providers	Tier 3 Non-Participating Providers *
Hospital Services	**You pay**		
Ambulance Services (per transport)	10% Coinsurance after Deductible		
Emergency department visit	$200 after Deductible (Waived if admitted)		
Inpatient Hospital Services	10% Coinsurance after Deductible	20% Coinsurance after Deductible	35% Coinsurance after Deductible
Outpatient Services (other)	**You pay**		
Outpatient surgery visit	10% Coinsurance after Deductible	20% Coinsurance after Deductible	35% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	$30 after Deductible	20% Coinsurance after Deductible	35% Coinsurance after Deductible
Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance after Deductible	30% Coinsurance after Deductible	35% Coinsurance after Deductible
Physical, speech, and occupational therapies (up to 20 visits per therapy per Year)	$30	20% Coinsurance after Deductible	35% Coinsurance after Deductible
Skilled Nursing Facility Services	**You pay**		
Inpatient skilled nursing Services (up to 100 days per Year)	$0 after Deductible	20% Coinsurance after Deductible	35% Coinsurance after Deductible
Chemical Dependency Services	**You pay**		
Outpatient Services	$20	$30	35% Coinsurance after Deductible
Inpatient hospital & residential Services	10% Coinsurance after Deductible	20% Coinsurance after Deductible	35% Coinsurance after Deductible
Behavioral Health Services	**You pay**		
Outpatient Services	$20	$30	35% Coinsurance after Deductible
Inpatient hospital & residential Services	10% Coinsurance after Deductible	20% Coinsurance after Deductible	35% Coinsurance after Deductible
Alternative Care (self-referred)	**You pay**		
Benefit Maximum per Year (all Covered Services combined)	$1,500		
Acupuncture Services	$25	$25	$25
Chiropractic Services	$25	$25	$25
Massage Therapy	$25	$25	$25
Naturopathic Medicine	$25	$25	$25

Summary of Medical Benefits

Added Choice POS $250 continued

	Tier 1 Select Providers	Tier 2 PPO Providers	Tier 3 Non-Participating Providers *
Vision Services	**You pay**		
Routine eye exam (through first month of age 19)	$20	$30	35% Coinsurance after Deductible
Vision hardware and optical Services (through first month of age 19)	Not covered		Not covered
Routine eye exam (age 19 and older)	$20	$30	35% Coinsurance after Deductible
Vision hardware and optical Services (age 19 years and older)	Not covered		

* Tier 3 may be subject to balance billing.

**Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.

***Refer to your Evidence of Coverage (EOC) for any applicable visits limits.

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample EOCs are available upon request or you may go to http://www.kp.org/plandocuments

Questions? Call Member Services (M-F, 8 am-6 pm) or visit **kp.org** Portland area: 503-813-2000
All other areas: 1-800-813-2000 TTY.711. Language Interpretation Services, all areas 1-800-324-8010

This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on benefit coverage, claims review, and adjudication procedures, please see your EOC or call Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.

This page was left blank intentionally.

Summary of Medical Benefits

Added Choice HDHP

	Tier 1 Select Providers	Tier 2 PPO Providers	Tier 3 Non-Participating Providers *
Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of Pocket Maximums accumulate.			
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 Year	$1,500	$1,500	$3,000
For an entire Family per Year	$3,000	$3,000	$6,000
Out-of-Pocket Maximum **			
For one Member per year	$3,000	$3,000	$9,000
For an entire Family per year	$6,000	$6,000	$18,000
Office visits	**You pay**		
Routine preventive physical exam	$0	$0	50% Coinsurance after Deductible
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)	**You pay**		
Preventive Tests	$0	$0	50% Coinsurance after Deductible
Laboratory	10% Coinsurance after Deductible	20% Coinsurance after Deductible	40% 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 (outpatient)	**You pay**		
Prescription drugs (up to a 30 day supply)	After Deductible: $15 generic / $30 preferred brand	At MedImpact Pharmacy After Deductible: $20 generic/$40 preferred brand/$60 non-preferred brand	
Mail Order Prescription drugs (up to a 90 day supply)	After Deductible: $30 generic / $60 preferred brand	Refer to Mail-Delivery Pharmacy 1-800-548-9809 kp.org/addedchoice	
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

Summary of Medical Benefits

Added Choice HDHP continued

	Tier 1 Select Providers	Tier 2 PPO Providers	Tier 3 Non-Participating Providers *
Maternity Care	**You Pay**		
Scheduled prenatal care and first postpartum visit	$0	$0	50% Coinsurance after Deductible
Laboratory	10% Coinsurance after Deductible	20% Coinsurance after Deductible	40% 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	**You pay**		
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)	**You pay**		
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 Year)	$20 after Deductible	$30 after Deductible	50% Coinsurance after Deductible
Skilled Nursing Facility Services	**You pay**		
Inpatient skilled nursing Services (up to 100 days per Year)	10% Coinsurance after Deductible	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Chemical Dependency Services	**You pay**		
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
Behavioral Health Services	**You pay**		
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

Summary of Medical Benefits

Added Choice HDHP continued

	Tier 1 Select Providers	Tier 2 PPO Providers	Tier 3 Non-Participating Providers *
Alternative Care (self-referred) ***	**You pay**		
Benefit Maximum per Year (all Covered Services combined)	$1,500		
Acupuncture Services	$25 after Deductible	$25 after Deductible	$25 after Deductible
Chiropractic Services	$25 after Deductible	$25 after Deductible	$25 after Deductible
Massage Therapy	$25 after Deductible	$25 after Deductible	$25 after Deductible
Naturopathic Medicine	$25 after Deductible	$25 after Deductible	$25 after Deductible
Vision Services	**You Pay**		
Routine eye exam (through first month of age 19)	$20 after Deductible	$30 after Deductible	50% Coinsurance after Deductible
Vision hardware and optical Services (through first month of age 19)	Not covered		
Routine eye exam (age 19 and older)	$20 after Deductible	$30 after Deductible	50% Coinsurance after Deductible
Vision hardware and optical Services (age 19 years and older)	Not covered		

* Tier 3 may be subject to balance billing.

** Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.

***Refer to your Evidence of Coverage (EOC) for any applicable visits limits.

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample EOCs are available upon request or you may go to http://www.kp.org/plandocuments

Questions? Call Member Services (M-F, 8 am-6 pm) or visit **kp.org** Portland area: 503-813-2000

All other areas: 1-800-813-2000 TTY.711. Language Interpretation Services, all areas 1-800-324-8010

This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on benefit coverage, claims review, and adjudication procedures, please see your EOC or call Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.

DENTAL PLANS	Kaiser Permanente	MODA DENTAL *(Premier Plan)*
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 Cigna 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. Evidence of insurability is required for amounts above the guarantee issue. 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, you will be asked to complete an evidence of insurability form. The above rate table also represents the monthly cost for spouse/domestic partner supplemental life insurance based upon your (spouse's/domestic partner'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 Cigna. **(Benefit amounts are subject to limits based on an employee's salary, as well as other limits. See plan documents for details)**

- The monthly cost of the supplemental AD&D is $0.028 per $1,000 for employee only.
- The monthly cost of the supplemental AD&D is $0.028 per $1,000 for spouse coverage.
- The monthly cost of the supplemental AD&D is $0.028 per $1,000 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 Cigna, 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% of your monthly salary, up to a maximum of $5,000 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 employees with employee-paid short term disability (STD) benefits insured by Cigna. 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 your weekly 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. This must be elected by employees and paid for through payroll deductions.**

FLEXIBLE SPENDING ACCOUNTS (FSA)

Metro sponsors a flexible spending account (FSA) program, administered by TASC/eflex, 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 (exact dates TBD), you can elect to defer up to $2,650 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 qualifying event.

The program offers a debit card, which can be used everywhere VISA 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

CIGNA SECURE TRAVEL
(*TRAVEL ASSISTANCE SERVICES*)

Cigna Secure Travel provides a special assistance for emergency medical, financial, legal and communication assistance when you travel. This program gives covered individuals access to a travel assistance customer service center from anywhere in the world when travelling at least 100 miles from home. For more information about Secure Travel, call (888)-226-4567.

LIFE ASSISTANCE PROGRAM

The Life Assistance Program (LAP), also known as 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 Cigna. All calls and inquires made to the LAP are confidential.

They 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/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 Life Assistance Program

Life Assistance Program is ready to assist you 24 hours a day, 365 days a year.

Phone: 1-800-538-3543 www.cignabehavioral.com/cgi

Cigna offers you numerous ways to maintain your health, well-being and sense of security through the following programs:

- Will Preparation – Cigna's Will Preparation Program helps you and your family to plan and protect your financial future by using a simple, online tool. Cigna's Will Center is secure, easy-to-use and available to you and your covered spouse seven days a week, 365 days a year. Visit CignaWillCenter.com to learn more about the Will Preparation Program.

- Identity Theft – Cigna's Identity Theft Program provides customers with access to personal case managers who give step-by-step assistance and guidance to individuals who have had their identity stolen. For more information on these and other services in the Identity Theft Program, call 1-888-226-4567.

PUBLIC EMPLOYEES RETIREMENT SYSTEM (PERS/OPSRP)

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). All new hires pay 6 percent towards their IAP. For current PERS employees, the 6 percent may be paid by either the employee or the employer depending upon collective bargaining agreements or when they began employment with Metro. 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.

DEFERRED COMPENSATION

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 2018 calendar year employees under age 50 may defer up to $18,500 into the 401(k) plan; employees age 50 and older may defer up to $24,500 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 2018 calendar year employees under age 50 may defer up to $18,500 into the 457 plan; employees age 50 and older may defer $24,500 per calendar year. Employees who meet the pre-retirement catch-up limit may defer $37,000 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 or Contribution Change form obtained from the 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
- Oregon Zoo free admission for active Metro employees and eligible family members

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.
- Change contribution amounts to 401k and/or 457.
- 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 NOTICES FROM METRO REGARDING THE METRO GROUP BENEFITS PLAN

The following notices provide important information about the group health plan provided by your employer. Please read the attached notices carefully and keep a copy for your records.

If you have any questions regarding any of these notices, please contact:

Plan Administrator: Angie Bond
Phone: 503-797-1723
Email: angie.bond@oregonmetro.gov
Mailing Address: 600 NE Grand Ave.
Portland, OR 97232

These notices are available, free of charge, upon request to the Plan Administrator.

Please note this is not a legal document and should not be construed as legal advice.

Important Notice About Your Prescription Drug Coverage and Medicare

If you or any of your eligible dependents are eligible for Medicare, or will soon become eligible for Medicare, please read this notice. If not, you can disregard this notice.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the health plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. We have determined that the prescription drug coverage offered by the health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

Your overall benefit will not be affected, however, whether Medicare or your group health plan pays first or primary will depend on technical legal rules. Contact your plan administrator for an explanation of the prescription drug coverage plan provisions/options under the plan available to Medicare-eligible individuals when you become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents generally will not be permitted to reenroll in your employer's health plan until the plan's next open enrollment period, unless you have a "special-enrollment" event (such as marriage or the birth or adoption of a child). See your summary plan description for more information about open enrollment and special enrollment.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current health plan coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage please contact the plan administrator indicated on the first page of this notice, or contact your pharmacy administrator on your member ID card.

NOTE: *You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through your current health plan changes. You also may request a copy of this notice at any time.*

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Newborns' and Mothers' Health Protection Act

Newborns' and Mothers' Health Protection Act requires that group health plans and health insurance issuers who offer childbirth coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

For additional information about NMHPA provisions, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not 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**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at **www.askebsa.dol.gov** or by calling toll-free **1-866-444-EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. You should contact your state for further information on eligibility.

WASHINGTON – Medicaid	OREGON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

To see if any more states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
http://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, Menu Option 4, Ext. 61565

Wellness Program – Notice of Reasonable Alternatives

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 503-797-1723 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.'

NOTICE REGARDING WELLNESS PROGRAM

The wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which will include a blood test for cholesterol and/or diabetes. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive an incentive.

Additional incentives may be available for employees who participate in certain health-related activities, or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Angie Bond at Angie.Bond@oregonmetro.gov.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Metro may use aggregate information it collects to design a program based on identified health risks in the workplace, the Metro wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Angie Bond at Angie.Bond@oregonmetro.gov.

Patient Protection Notice
Metro Group Benefits Plan may require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Angie Bond at Angie.Bond@oregonmetro.gov.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from the insurer or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology.

HIPAA Notice of Privacy Practices
The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of your protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

If not attached to this document, you may request a copy of the Plan's current Privacy Practices, explaining how medical information about you may be used and disclosed and how you can get access to this information, by contacting the plan administrator using the contact information on the first page of this booklet.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance.

To request special enrollment or obtain more information, contact the plan's general contact using the information on this first page of this booklet.

Qualified Medical Child Support Orders (QMCSOs)

In addition to your rights to enroll a child pursuant to the Plan's annual-enrollment and special-enrollment rules discussed in this booklet and the Plan's SPD, your child may be enrolled pursuant to a "qualified medical child support order," which is a court or administrative order that requires the Plan to enroll your child and meets certain requirements. The Plan has procedures for determining which medical child support orders are qualified and for administering orders determined to be qualified. You may obtain a copy of the Plan's procedures governing qualified medical child support orders, without charge, by making a written request to the Plan Administrator.

**** Continuation Coverage Rights Under COBRA ****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace.

By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Metro, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired

employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: The Plan Administrator, Angie Bond at Angie.Bond@oregonmetro.gov.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Angie Bond
Total Compensation Manager
600 NE Grand Ave.
Portland, OR 97232

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Angie Bond at Angie.Bond@oregonmetro.gov.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Metro		4. Employer Identification Number (EIN) 93-0636311
5. Employer address 600 NE Grand Ave.		6. Employer phone number 503-797-1723
7. City Portland	8. State OR	7. City Portland
10. Who can we contact about employee health coverage at this job? Angie Bond		
11. Phone number (if different from above) 503-797-1723	12. Email address Angie.Bond@oregonmetro.gov	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
-

[ ]	All employees. Eligible employees are:
[X]	Some employees. Eligible employees are: full-time, budgeted positions and who meet the eligibility under the Affordable Care Act

- With respect to dependents:
-

[X]	We do offer coverage. Eligible dependents are: Legal Spouse, Domestic Partners, and dependent children to age 26 regardless of student status.
[ ]	We do not offer coverage.
[X]	If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

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 *Group number 10001772* 503-265-5680 www.modahealth.com	**Life Assistance Program** *(also known as EAP)* 1-800-538-3543 **Cigna Secure Travel** *(Travel Assistance)* 1-888-226-4567
Vision Service Plan (VSP) *Group number 3107884* 800-877-7195 www.vsp.com	**Home Street Bank** Home Ownership Program 503-227-3956 www.homestreet.com/Metro
PERS *Metro employer number 2594* 503-598-7377 www.oregon.gov/PERS	**LA Fitness** *Nation-wide membership* *www.lafitness.com*
Cigna Group Life Insurance Policy #FLX 968162 Group AD&D Insurance Policy #OK 969639 Voluntary STD Policy #VDT 962459 Group LTD Policy #LK 965538 1-800-732-1603 www.cigna.com	**Lloyd Athletic Club** 503-287-4594 **Alternative Care - CHP Group** *(self-referred)* 800-449-9479 www.chpgroup.com

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

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

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

www.oregonmetro.gov/connect

Metro