LCOG LANE COUNCIL OF GOVERNMENTS

Lane Council of Governments

2024 Employee Benefits Guide

What's in this Guide?

Sources of Assistance

Carrier / Contact	Group/Policy Number	Website	Phone Number
Regence BlueCross BlueShield of Oregon Customer Service	HDHP-4 w/HRA	www.regence.com	888-370-6159
Kaiser Permanente Customer Service	Traditional HMO Plan	www.healthy.kaiserpermanente.org	800-813-2000
MetLife Dental / Life / Voluntary Life / Disability Customer Service	KMO05996633-G	www.metlife.com	800-275-4638
Willamette Dental Group Dental Customer Service	OR73	www.willamettedental.com	855-433-6825
Cascade Health Employee Assistance Program	N/A	www.cascadehealth.com	541-345-2800
Canopy Employee Assistance Program	Enter company name when you register as: CIS	www.my.canopywell.com	800-433-2320 Text: 503-850-7721 info@canopywell.com
PacificSource Administrators FSA / HRA Administration	N/A	www.psa.pacificsource.com	800-422-7038

Important Notice: The material in this benefits brochure is for informational purposes only and is neither an offer of coverage, medical advice or legal advice. It contains only a partial description of plan or program benefits and does not constitute a contract. Consult the Summary Plan Descriptions to determine governing contractual provisions, including procedures, exclusion and limitations relating to your plans. In case of a conflict between your plan documents and this information, the plan documents will govern.

Eligibility & Enrollment

Eligibility Rules

Full-time equivalent employees regularly scheduled to work at least 20 hours per week are eligible to participate in the Lane Council of Governments Employee Benefits Program. For most of our benefit plans, your coverage will become effective on the 1st of the month following your date of hire. You must be actively at work for your coverage to be effective on your eligibility date.

You may also enroll your eligible dependents. Eligible dependents include your legal spouse or registered domestic partner, as well as your eligible dependent, whether natural, adopted, step, foster or those for whom you have legal custody by court decree. When enrolling in medical, dental or vision coverage, you may enroll any eligible dependent child up to age 26.

Enrollment Is Simple

Open Enrollment is a once-a-year opportunity to make changes to your current benefits and to review which dependents you will be covering in the new plan year. All changes you request during open enrollment will take effect on January 1 of the new plan year.

If no changes are made at open enrollment, your current medical, vision and dental elections will remain the same.

If you choose to participate in the Health Flexible Spending or Dependent Care Assistance Plans, you will need to re-enroll at the beginning of each new plan year.

When Can You Enroll?

You can apply for benefits at any of the following times:

- After completing your initial eligibility period
- During the annual open enrollment period
- Within 30 days of a qualified event or family status change

Making Changes

Generally, you can only change your benefit elections during the annual benefits open enrollment period. However, you may be able to change some of your benefit elections upon the occurrence of certain change in status events, provided you properly notify your Benefits administrator within thirty (30) days of the event.

Examples of change in status events may include:

- Your marriage, divorce or legal separation
- Birth or adoption of a child or death of a spouse or child
- Change in a spouse's work status that affects his or her benefits eligibility
- Change in your work status that affects benefit eligibility Change in residence or worksite that affects eligibility for coverage
- Change in a child's eligibility for benefits
- Receiving a Qualified Medical Child Support Order (QMCSO)

If you have a family status change, you must timely notify your Benefits Administrator and complete the necessary forms. Employees may have up to 30 days to report any status changes that might affect their benefits and enrollment.

Benefits at a Glance

Medical and Vision Insurance

Lane Council of Governments offers two medical options through CIS, a High Deductible Health Plan option with Regence and a traditional HMO option with Kaiser. Both plans offer alternative care and pharmacy benefits.
Vision benefits are included with both medical plan options. If you elect medical coverage with Regence, your vision coverage will be administered through VSP. If you elect Kaiser, your vision coverage will be provided through their network.

Dental Insurance

For dental coverage, you have the option to choose between two separate plans with different networks: the MetLife plan, where you can choose any provider, or the Willamette Dental plan, which offers in-network benefits only but is copayment-based rather than requiring you to pay deductible/coinsurance amounts.

Life and AD&D Insurance

Employer-paid Basic Life and AD&D

Lane Council of Governments provides eligible full-time employees with Basic Life and AD&D insurance in the amount of 100% of your annual salary (rounded to the next $1,000), to a maximum of $100,000 for both Life and AD&D insurance (a total maximum of $200,000).

Voluntary Life and AD&D

Lane Council of Governments also allows you to purchase additional Life and AD&D insurance for you and your dependents. Employees can purchase additional insurance in $10,000 increments, up to a maximum of 5x annual earnings or $300,000 for employees and $300,000 for spouses, and in $2,000 increments up to $10,000 for children, as long as the employee or spouse is enrolled.

Long Term Disability (LTD)

The LTD plan is designed to provide you with a reasonable level of income replacement in case you can no longer work due to a disability. The disability benefit begins after 90 days of disability or the end of accumulated sick leave, whichever later, and pays up to 66.67% of your monthly wages, to a maximum benefit of $5,000 per month.

Voluntary Short-Term Disability

Lane Council of Governments offers an employee-paid Short-Term Disability (STD) benefit for non-work-related injury or illness. The Voluntary STD plan offers a benefit replacement percentage of 60% of your weekly base pay, after a waiting period of 7 consecutive days of disability, for injury or sickness. Benefits may continue for a maximum of 13 weeks. Certain limitations apply, including exclusions on pre-existing conditions.

Voluntary Accident-Only Insurance

The employee-paid Accident Only plan is designed to provide you with a one- time benefit for covered accidental injuries so you or your dependents can focus on healing. The plan pays a benefit for covered accidents only.

Additional Voluntary Products

Critical Illness – pays in addition to your medical plan and helps provide financial support if you or a family member becomes seriously ill.
Hospital Indemnity – helps pay for the cost of care if you or a family member are admitted to the hospital.
Trauma Coverage – offers support to individuals and families after a traumatic incident.
Allstate - Identity Protection

Health Reimbursement Arrangement

If you enroll in the employer-sponsored Regence medical plan, Lane Council of Governments will contribute money into a Health Reimbursement Arrangement to help reimburse you and your dependent(s) eligible medical expenditures throughout the plan year.

Flexible Spending Account

Lane Council of Governments also offers a Flexible Spending Account which allows employees to set aside pre-tax dollars for qualifying medical and dependent care expenses for yourself and your tax dependents. These funds are deducted from paychecks in equal installments, depending on the amount elected by the employee at the beginning of each plan year.

Benefits at a Glance - continued

Employee Assistance Program (EAP)
Lane Council of Governments offers two Employee Assistance Programs, Cascade Health and Canopy to all employees and members of their households. Up to five sessions of counseling, per distinct problem, per year will be provided at no cost. To access the EAP plan, please contact Cascade Health at 541-345-2800 or visit their website at www.cascadehealth.org.

Paid Leave
LCOG offers employees a generous paid leave program, including paid sick leave, vacation leave, and 11 paid holidays per year. Additionally, if your immediate past employer provided sick leave which was not paid out to you at the time of your termination, you are eligible for a credit of up to 56 hours, upon written verification from your previous employer. LCOG also has an employee leave donation/transfer program in place.

Public Employees Retirement System (PERS), OPSRP, and IAP Plans
LCOG currently pays both the employer's and the employee's contributions to PERS, OPSRP, and the IAP plans. Employees are eligible for PERS/OPSRP/IAP participation after six months and 600 hours of consecutive employment. (If you are an active member of PERS through a former employer, you may be eligible immediately.)

Normally, after five calendar years of employment you are vested in PERS and are eligible for a retirement pension. For more information, go to PERS website: www.oregon.gov/PERS

Deferred Compensation
A deferred compensation plan allows you to defer pre-tax salary into a retirement savings account. You are not taxed on your contributions or earnings (or losses) until you withdraw the money. If you elect to defer $25 or more a month, LCOG will contribute an additional $62.50 per month to employees covered by SEIU and $125 to employees covered by the EA and some non-represented employees.

You may invest with either of the two deferred compensation providers available. Fund options offered by these carriers represent a wide range of investment choices from high risk to guaranteed return. The providers are:

- MissionSquare: DeLana Hansen 541-933-2090
- Oregon Savings Growth Plan (OSGP): Wes Hadley 541-539-5508

Initial enrollment or changes to your contribution amount may be made on a monthly basis, within each provider's deadlines.

Alternative Medical Insurance
This coverage is for care provided by licensed chiropractors, naturopaths, and acupuncturists for the diagnosis and treatment of illness or injury.

LTD Bus Pass & Emergency Ride Home (ERH) Programs
LCOG offers an annual bus pass to employees who are eligible for benefits. LTD bus passes are available by downloading the free Umo Mobility app or purchasing an electronic tap card ($3.00 one-time fee).

If you commute to work by carpool, vanpool, bus, bicycle, or walking, you can get an emergency ride home, to the doctor's office, or hospital, if such an event occurs. LCOG participates in the Commuter Solutions Regional Emergency Ride Home (ERH) Program that will provide you with a free taxi ride, if you have an emergency. You have to enroll yourself to be eligible in the future, should the need arise. To enroll in this free program, go to: https://getthereoregon.org/

FitCity
LCOG employees are eligible to use the City of Eugene's Fitness Center, FitCity, at a reduced cost. The facility is located on the SW corner of 10th & Oak Streets in Eugene (1010 Oak Street). To be eligible to exercise there, employees are required complete the City of Eugene Fitness Center Waiver Form. This benefit is available to active LCOG employees but does not include their family members or LCOG retirees.

Cost of Coverage: *How You Pay for Health Care Costs*

You share the cost of health care services with Lane Council of Governments and the medical plans offered. A few key definitions to keep in mind when reviewing your medical plan options are:

Premium: A premium is the total cost for your medical insurance. Lane Council of Governments pays the premium for your medical and dental coverage and you pay the cost of your vision benefits if you choose to enroll. You pay your portion through pre-tax payroll deductions.

Deductible: A deductible is the amount you must pay before the medical plan begins sharing the cost of services. You pay this full amount, if required by your plan, before the plan pays benefits.

Coinsurance: When you are paying coinsurance, you are sharing a percentage of the cost of services with the medical plan. For example, in the medical plan, after you satisfy your deductible, you will pay the coinsurance amount for most medical care that you receive from preferred providers. Coinsurance may vary depending on the provider's participation in the network.

Out-of-Pocket Maximum: The annual out-of-pocket maximum protects you from major medical expenses. This is the most you would pay and includes your medical deductible and coinsurance, for eligible expenses during a plan year unless otherwise stated. Once you reach the out-of-pocket maximum, the plan pays 100% of covered services for in network providers and up to the usual, customary and reasonable (UCR) charges for eligible services to out of network providers for the balance of the calendar year.

Copayments: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

High Deductible Health Plan with HRA

Benefit Plan Summary and Regence BCBS Resources

CIS High Deductible Health Plan 4 w/ HRA - Alternative Care

Benefits Summary
Effective January 1, 2024

cis benefits
www.cisbenefits.org

These medical plans are insured by CIS, but administered by Regence BlueCross BlueShield (BCBS) of Oregon. This means that CIS, not Regence BCBS, pays for your covered medical services and supplies.

HDHP- 4 w/ HRA	
Deductible Per Calendar Year	$1,700 Individual $3,400 Family
Out-of-Pocket Maximum Per Calendar Year **Category 1, 2, & 3 –** Preferred, Participating, Non-Preferred Providers (includes deductible, medical copays and prescription copays*)	$3,400 Individual $6,800 Family

*__Important Note:__ The family out-of-pocket maximum for a calendar year is satisfied when two or more family members' deductible and coinsurance for covered services for that calendar year total and meet the family's out-of-pocket maximum amount.

Medical Services	**Member Pays** **Category 1 - Preferred** **Category 2 - Participating**	**Member Pays** **Category 3 - Non-Preferred**
Preventive Care Services		
Routine well-baby care, physical examinations, health screenings, and immunizations *(for a list of covered services, visit our website regence.com, hover over "Member dashboard" at the top, select Preventive Care from the drop down)*	0% for Category 1 & 2 (*deductible waived*) 40% for Category 3 (*after deductible*)	
Professional Services	**After Deductible – Member Pays**	
Office visits for illness or injury, mental/behavioral health or substance use disorder *(primary care, specialist, naturopath, urgent/immediate care center or virtual care)*	0% for first 3 visits; then 20%	40%
Outpatient laboratory, radiology, and diagnostic procedures	20%	40%
Maternity care	20%	40%
Therapeutic injections including allergy shots	20%	40%
Hospital/Facility Services	**After Deductible – Member Pays**	
Ambulatory Surgical Center	10% *(20% for all other facilities)*	40%
Emergency room care *(including professional charges)*	20%	
Inpatient/outpatient surgery and surgeon fees	20%	40%
Inpatient mental/behavioral health & substance use disorder	20%	40%
Skilled Nursing Facility – *120 inpatient days per year*	20%	40%
Other Services	**After Deductible – Member Pays**	
Ambulance	20%	
Rehabilitation Services*: Inpatient: Unlimited / Outpatient: 77 visits per year (visit limit shared with Neurodevelopmental therapy)*	20%	40%
Hearing Aids- *applies to children 18 years or younger or children 19 to 25 enrolled in an accredited education institution*	20%	40%
Home health care - *180 visits per year*	20%	40%
Hospice – *14 respite days per lifetime*	20%	40%
Durable Medical Equipment	20%	40%
Weight Management/Nutritional Counseling and Bariatric Surgery: - Weight management and nutritional counseling visits *Four visits per year*	0%	40%
- Bariatric surgery may be covered to treat morbid obesity (participant must meet participation requirements) *Limited to one surgery per claimant lifetime*	$1,000 copay then 20%	$1,000 copay then 40%

Prescription Medication Benefit *If you need drugs to treat your illness or condition, your prescription drug coverage is administered through Express Scripts (ES). Please visit Express Scripts' web site at www.express-scripts.com or contact their customer service at 1 (800) 496-4182.* *Regence BlueCross BlueShield of Oregon assumes no liability for the accuracy of your prescription drug benefits information.*	**At the Pharmacy (30-day supply) Member Pays**	**Mail Order thru the Express Scripts Pharmacy Program (90-day supply) Member Pays**
Individual deductible per calendar year	Shared with Medical Services	
Out-of-pocket maximum each calendar year	Shared with Medical Services	
Generic drugs	20% Retail/Mail Order Prescription	
Preferred brand drugs		
Non-Preferred brand drugs		
Specialty Drugs	Refer to generic, preferred brand and non-preferred brand drugs above, for specialty drugs or self-administrable cancer chemotherapy drug coverage.	
Limitations and Exceptions	*Coverage is limited to 30-day supply retail or 90-day supply mail order. Long-term medication fills at participating retail pharmacies may be filled for up to a 90-day supply. Visit Express Scripts' website for details. Specialty drug coverage is limited to a 30-day supply and must be filled through Accredo Specialty Pharmacy.* *Specialty medications filled at a retail pharmacy are subject to 100% copay/coinsurance, and this amount does not accumulate towards the out-of-pocket maximum.* *Certain preventive items and services as defined by the Affordable Care Act are covered at zero-dollar cost share.* ***Deductible*** *waived and $0 patient responsibility for generic and preferred brand drugs designated as preventive for treatment of chronic diseases that are on the Preventive Medications List.* *Product Selection Cost -If you request and obtain a brand name drug when a generic equivalent is available, you are responsible for the applicable coinsurance plus the cost difference between the brand name drug and the generic drug.*	

Additional Medical Services

Alternative Care Services – Member Pays	
Acupuncture and Chiropractic Spinal Manipulations	20% Category 1 & 2, 40% Category 3 - Maximum allowance of 12 visits per calendar year for Acupuncture and 20 visits per calendar year for Chiropractic Spinal Manipulations.

Other services included in your CIS medical plan	Contact Information
Hinge Health - Hinge Health provides all the tools you need to get moving again from the comfort of your home. You'll get exercise therapy tailored to your condition and a personal care team of experts. Best of all, there's no additional cost to you.	To learn more, please call 1 (855) 902-2777 or sign on to the CIS Health Manager at www.regence.com. Scroll down to Resources and click on Hinge Health.
SurgeryPlus – A comprehensive surgical program that provides a personalized concierge experience from dedicated Care Advocates and access to quality-centric health care through a network of credentialed surgeons. By using the SurgeryPlus benefit, you may also save money through reduced financial responsibility.	To learn more, please call (833) 633-0511, go to cisbenefit.surgeryplus.com, or email cisbenefits@surgeryplus.com
MDLIVE (Telehealth) - With MDLIVE's telehealth service, you can see a doctor or therapist from home, work or on the go, 24/7/365. Board-certified doctors visit with you by phone or secure video to treat non-emergency medical conditions. They can diagnose symptoms, prescribe medication, and send prescriptions to your pharmacy.	To learn more, please call 1 (888) 725-3097 or sign on to the CIS Health Manager at www.regence.com and hover on "Programs & Resources", then click on Telehealth. Scroll down to Resources and click on MDLIVE.
Chronic Condition Coaching supports and educates members with chronic conditions including hypertension, diabetes, COPD, CAD, CHF, asthma and obesity.	To learn more, please call 1 (866) 865-6725.
BeyondWell - A comprehensive well-being solution for members that integrates wellness activities, goals, rewards and challenges into a single location for a holistic wellness offering.	To learn more, please call 1 (866) 865-6725 or sign on to the CIS Health Manager at www.regence.com. Scroll down to Resources and click on BeyondWell.
Case Management - Supports and educates members with serious illnesses or injuries.	To learn more, please call 1 (866) 543-5765 or sign on to the CIS Health Manager at www.regence.com. Scroll down to Resources and click on Care Management
Pregnancy Program (*Childbirth to Newborn resources*).	To learn more, please call 1 (888) 569-2229 or sign on to the CIS Health Manager at www.regence.com. Scroll down to Resources and click on Pregnancy Program
BlueCard Program (Out of Area Services) – access hospital and physicians when outside the four-state area Regence services (Oregon, Idaho, Utah and Washington) as well as receive care in 200 countries around the world.	Find a provider near you at www.regence.com or call 1 (800) 810-BLUE (2583).

Your VSP Vision Benefits Summary

CIS TRUST Vision Plan A and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Choice
EFFECTIVE DATE:
01/01/2024

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$10	Every calendar year
ESSENTIAL MEDICAL EYE CARE	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES		**$25**	
FRAME†	• $190 featured frame brands allowance • $170 frame allowance • 20% savings on the amount over your allowance • $95 Walmart®/Sam's Club®/Costco® frame allowance	Included in Prescription Glasses	Every other calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Anti-glare coating • Tints/Light-reactive lenses • Impact-resistant lenses • Scratch-resistant coating • UV protection • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $0 $0 $0 $0 $50 $50 $50	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $166 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation)	$0	Every calendar year
SAFETY GLASSES (EMPLOYEE-ONLY COVERAGE)			
FRAME†	• $65 allowance for a safety frame • 20% savings on the amount over your allowance • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	$0	Every other calendar year
LENSES	• Prescription single vision, lined bifocal, and lined trifocal • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	$0	Every calendar year
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider. Your plan provides the following out-of-network reimbursements:

Exam ..... up to $50	Lined Bifocal Lenses ..... up to $55	Contacts ..... up to $110
Frame ..... up to $70	Lined Trifocal Lenses ..... up to $70	Tints ..... up to $5
Single Vision Lenses ..... up to $35	Progressive Lenses ..... up to $105	

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington.

Regence

MDLIVE

Easy, convenient quality healthcare

With MDLIVE you and your covered family members have 24/7 access to board-certified doctors who are specially trained in virtual care.

Our doctors have more than 15 years' experience and are ready to help you with a variety of minor medical conditions, when and where it is convenient for you.

Talk to a doctor or schedule a visit today.

OUR DOCTORS TREAT OVER 50 MINOR MEDICAL CONDITIONS DAILY

- Allergies
- Common Cold
- Constipation
- Cough
- Diarrhea
- Ear Pain
- Fever
- Flu
- Headaches
- Insect Bites
- Nausea
- Pink Eye
- Rash
- Respiratory Issues
- Sore Throat
- Sinus Infections
- Urinary Tract Infection (Female, 18+)
- Vomiting
- And more

STEP 1

FIND A VIRTUAL DOCTOR

You can see a doctor right away or schedule your appointment for a time that works best for you.

Search through our network of board-certified doctors and choose the one that's right for you. You can see doctor photos, bios, and specialty.

STEP 2

START YOUR VISIT

Speak to a doctor on the phone or via video.

You'll be asked for photos, if appropriate, of your condition and to fill out a short questionnaire before your visit. Then your doctor will talk to you about your symptoms and recommend a treatment.

They will even send a prescription to your pharmacy, if appropriate.

STEP 3

FEEL BETTER

Our goal is to get you back on your feet faster.

You can have a virtual doctor visit at a time that's convenient for you, get your prescription filled quickly, and start on your path to being symptom-free.

Download the app.
Join for free. Visit a doctor.

MDLIVE.com/regence-or
888-725-3097

CIS | Hinge Health

Ready, set, enroll!

Open enrollment is here!

Join Hinge Health for exercise therapy without leaving home. No copays. No office visits. Reduce your back and joint pain in just 15 minutes a day. Best of all, there's no cost to you — your Hinge Health benefit is 100% covered by CIS Oregon.

Join Hinge Health to:

- Overcome pain or limited movement
- Recover from a recent or past injury
- Keep your joints healthy and pain free

Scan the QR code to enroll now!
hinge.health/cisoregon-oe
Questions? Call (855) 902-2777

Participants must be 18+ and enrolled in a CIS Oregon medical plan administered by Regence BlueCross BlueShield of Oregon. Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association. Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association. Hinge Health® is a separate and independent company that provides services for CIS members enrolled in a CIS Benefits medical plan administered by Regence.

Guided Access to Excellent Surgical Care

What is SurgeryPlus?

SurgeryPlus provides you with access to excellent and affordable care for many planned surgical procedures. It's already included in your CIS Benefits medical plan administered by Regence at no additional cost to you.

Did you know...

- PPO Plans: There will be no cost for your surgery.
- HDHP Plans: The cost of your surgery will be significantly reduced.

The SurgeryPlus Difference

Excellent Care

Access to our network of thousands of highly qualified surgeons

Impactful Savings

Your surgery will be at little or no cost to you when you use your SurgeryPlus benefit

Guided Support

Your personal Care Advocate will support you every step of the way through your care

Here's what's covered

In partnership with CIS Benefits, we cover the most expensive costs associated with surgery, so you'll pay less for your procedure when you use your SurgeryPlus benefit. Your coverage includes:

- Consults and appointments with your SurgeryPlus surgeon
- Anesthesia
- Procedure and facility (hospital) fees
- Dedicated support and guidance

Commonly Covered Procedures

- Spine
- Orthopedic
- Ear, Nose & Throat
- Cardiac
- Gynecology
- General Surgery
- Gastrointestinal
- Spine and Ortho Injections
- Bariatrics

Your medical coverage may require you to use your SurgeryPlus benefit for specific procedures. Call to learn more.

You deserve excellent and affordable surgical care.

Call us to learn more at 833.603.0511

Email: CISBenefits@SurgeryPlus.com
Website: CISBenefits.SurgeryPlus.com

cis benefits
cisbenefits.org

Surgery Plus

Elevate Your Health, One Step at a Time with BeyondWell

BeyondWell is a comprehensive lifestyle program that integrates wellness activities, goals, rewards and more into a single place. The result is a truly personalized well-being experience that is tailored to your unique needs.

Earn up to $150 per year in rewards - act now!

> Gift cards earned must be self-claimed by December 31 each year.
> Unclaimed rewards will be forfeited.

Our BeyondWell program is available now and continues into 2024–and Regence members and eligible spouses can **earn up to $150** in electronic gift cards. Engage throughout each year to maximize your rewards!

Get started today!

Regence members

1. **Log into** your CIS Health Manager at **regence.com**
2. Scroll down to the programs listed and **select** BeyondWell.
3. If this is your first year participating, you'll need to **register** and accept the Terms of Use.

If you are asked for a code during registration | **CODE: CIS**

$5 BeyondWell™ Take your well-being journey with you anywhere, anytime! Download the BeyondWell app now.

Earn up to $150 in rewards for healthy activities:

- Download BeyondWell app
- Connect a device or app
- Verified steps through device
- Personal challenges
- Self-guided programs
- Dental exams
- Vision exams
- Flu shot, COVID-19 vaccinations
- Health assessment
- Preventive screenings
- Regence BabyWise℠ program

Flip to learn more about our 2024 program

2024

Below you'll see all the ways you and your qualified spouse on the Regence health plan can earn up to **$150** each in Amazon.com* electronic gift cards in 2024.

$5 Sync a device or app

Our platform syncs with over 100 different devices. Earn this credit once per year.

$1 Verified steps through device

When steps are logged from your synced device, you earn credit. $1 per 10,000 steps.[1]

$5 Download the BeyondWell app

Download and log in to the BeyondWell app after creating your account online and earn $5.

$5 Register on Regence.com

Register your account on regence.com and earn $5.

$15 Personal challenge

Challenge yourself to improve lifestyle habits and earn $15 per challenge (up to $45 annually).

$20 Flu or COVID-19 Vaccination

Get your flu shot, COVID-19 vaccination or booster and earn $20 once per year.[2]

$25 Health assessment

The health assessment will help personalize your experience. Earn this incentive once per year.

$30 Interactive self-guided program

Complete any interactive self-guided program and earn $30 (up to $60 annually).

$30 Vision exam

Complete a preventive vision exam and earn $30.[2]

$30 Preventive exam

Get a qualifying preventive exam and earn this incentive once per year.[2,3]

$30 Dental exam

Complete a preventive dental exam and earn $30.[2]

$50 Regence Pregnancy Program

Enroll and participate in the Regence Pregnancy program and earn this incentive once per year.[2]

$50 Chronic condition coaching

Enroll and engage in Chronic Condition Coaching in 2024 and earn a $50 incentive! If you are eligible for the program you will be outreached to directly.

$15 Attend a webinar

Attend a webinar hosted by your EAP or BeyondWell and earn $15 each (up to $60 annually).

EAP Webinars

Intro to Emotional Intelligence	*Jan16 @ 10am*
Eating for Mind & Body Health	*Apr 4 @ 1pm*
Work/Life Balance	*Aug 27 @ 9am*
Stress Management	*Nov14 @ 2pm*

BeyondWell Webinars

Make Your Heart Beet	*Feb 8 @ 11:30am*
Movement for Improvement	*Jun13 @ 11:30am*
Health Myths & Facts	*Aug22 @ 11:30am*
Holiday Treats & Sweets	*Oct24 @ 11:30am*

1. $1 per 10,000 steps; max $2 daily. Steps will not carry over from day to day. Max $25 per quarter for this activity.
2. This activity is tracked through claims. There will be processing time for these items, so it may take up to 8 weeks to see the credit in your account.
3. Qualifying preventive exams include: annual well-visit, pelvic exam, colorectal cancer screening, PSA and routine mammogram.

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BeyondWell™

Welcome to Express Scripts

CIS and Express Scripts want you to know that Express Scripts manages your prescription plan. We care about your health and work to make medications safer and more affordable. We encourage you to take advantage of the services and resources available to help you and your dependents manage your pharmacy benefit. We look forward to serving you soon!

Why pay more? Make the move to a 3-month supply.

Under your prescription plan, you have the option to order 3-month supplies of long-term medications from certain participating retail pharmacies or through home delivery from Express Scripts® Pharmacy. [1]

To start ordering a 3-month supply from Express Scripts® Pharmacy, register or log in at **express-scripts.com**. (Standard shipping is free with home delivery.[2])

To find a retail pharmacy that participates in 3-month supplies, log in at **express-scripts.com** and choose Find a Pharmacy from the menu under Prescriptions. The pharmacy can tell you how to transfer your prescription or start a new one. Search results will indicate whether a pharmacy is eligible to dispense up to a 3-month supply.

According to your plan, you can keep filling one month at a time but you could miss out on convenience and savings.

[1]Long-term medications are taken for an ongoing condition, such as high blood pressure, high cholesterol and asthma.
[2]Cost of standard shipping is included as part of your prescription plan.

Accredo, Your Specialty Pharmacy

Accredo is the Express Scripts specialty pharmacy. A specialty pharmacy provides medication and therapy for patients with serious, chronic conditions like cancer and hepatitis C. Accredo offers teams of pharmacists, nurses and clinicians who are specialty trained on your condition. This level of individualized, focused care gives you the most comprehensive, compassionate and customized care available.

Accredo offers many patient support services, including:

- Personal care and health advocacy assistance from patient care coordinators
- Coordination of financial assistance (availability varies by plan)
- Guidance for patients and caregivers for taking specialty medications most effectively
- All necessary ancillary supplies such as syringes and sharps containers

Specialty medications must be filled through Accredo to receive coverage. To learn more about Accredo, please visit **accredo.com.**

CIS has partnered with SaveonSP to provide a specialty pharmacy copayment assistance program. If you attempt to fill a specialty prescription that falls under this program, an Accredo representative will assist you with enrollment in the program by transferring you to SaveonSP. More information about this program can be found in your Plan Booklet.

EXPRESS SCRIPTS®

Network Retail Pharmacies

Network pharmacies are retail pharmacies that are preferred by your prescription plan. Use them for prescriptions you need on a short-term basis, like an antibiotic to treat an infection. When you go to an in-network pharmacy for up to a 30-day supply of medication, you'll typically pay less than at a retail pharmacy that's out of your network.

To find an in-network pharmacy near you, go to **express-scripts.com/CIS10** and select Locate a Pharmacy. Search results will indicate whether a pharmacy is eligible to dispense up to a 3-month supply. You may also log in at **express-scripts.com** and choose **Find a Pharmacy** from the menu under **Prescriptions** or call Express Scripts at 800.496.4182.

If you're new to Regence BCBS coverage, be sure to show your new Express Scripts ID card at the pharmacy. You can also access your ID card by downloading the Express Scripts® mobile app. If you don't show your ID card and instead choose to pay the entire cost of the medication, you must submit a claim form to Express Scripts for reimbursement. You'll be reimbursed based on the covered medication's contracted rate minus the appropriate copayment. This amount will be lower than the amount you paid out of pocket at the retail pharmacy.

If you need to transfer your prescription from an out-of-network pharmacy to an in-network pharmacy, just choose one of the following:

- Bring your prescription vial or container to an in-network pharmacy, and the pharmacist will transfer it.
- Call a pharmacy in your network, and ask the pharmacist to transfer your medication.
- Ask your doctor to send your prescription in to an in-network pharmacy using e-prescribing.

Manage Your Prescription

One of the great things about being an Express Scripts member is that you can manage your medication easily on your laptop, tablet, desktop or phone. Whether you want to check your order status, look for savings opportunities, look up information about your benefit, get a refill or even find a pharmacy, the Express Scripts website and mobile app can help!

Just register at express-scripts.com or download the mobile app to your mobile device for free by searching your app store for Express Scripts. (Availability and features may vary.)

Formulary

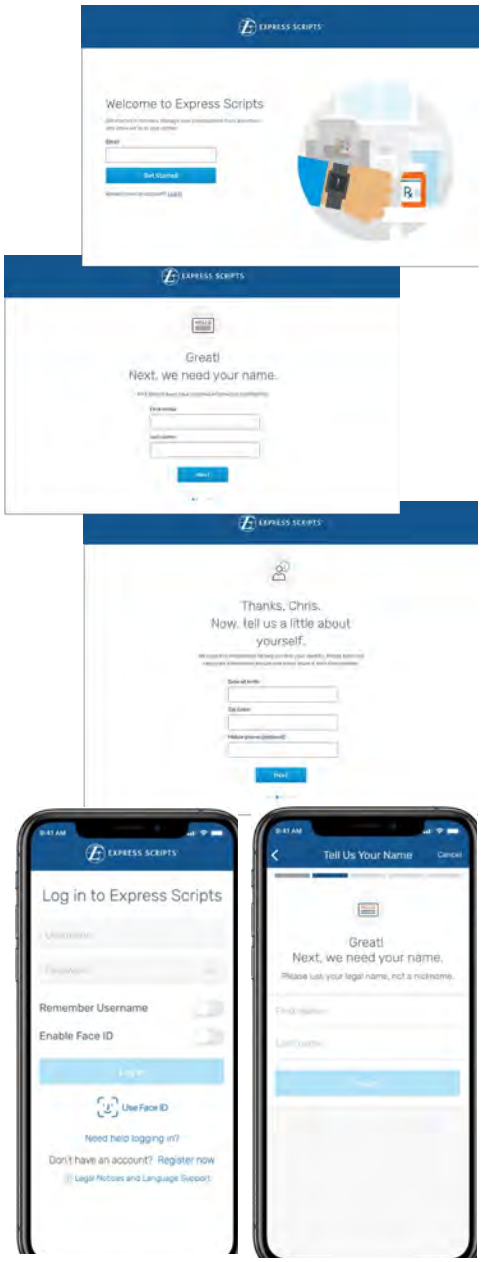
A preferred medication list, also called a formulary, helps keep healthcare costs down for everybody. It's a list of medications that have been reviewed and approved for safety and effectiveness by a panel of doctors and pharmacists. This list is continually reviewed and updated as new medications become available.

Note that certain medications are excluded from your formulary, which means they're not covered. An equally effective and safe alternative may be available. To check pricing and coverage for a medication, visit express-scripts.com/CIS10. Drug classes with excluded medications include Autonomic and Central Nervous System, Cardiovascular and Dermatological.

Registering with Express Scripts

Online access to savings and convenience

Manage your medications anywhere, any time with express-scripts.com and the Express Scripts® mobile app



Register now so you can experience:

- **More savings.**
  Compare prices of medications at multiple pharmacies. Get free standard shipping[1] from Express Scripts® Pharmacy.
- **More convenience.**
  Get up to 90-day supplies of your long-term medication sent to your home. Order refills, check order status, and track shipments. Print forms and Digital ID cards, if needed.
- **More flexibility.**
  Download the Express Scripts mobile app to manage your medications, find nearby pharmacies and get directions, and use your Digital ID card while on the go.

Get Started Today!

Registering is safe and simple. Your information is secure and confidential. Please have your member ID number or SSN available.

- Go to express-scripts.com and select **Register**, or download the **Express Scripts mobile app** for free from your mobile device's app store and select **Register.**
- Complete the information requested, including email address and personal information, and create a password. We have several options for how to identify you in order to link to your prescription benefit, including the last four digits of your Social Security number (SSN), your member ID, a prescription number and more. Create your username and password, along with security information in case you ever forget your password.
- Once you're registered, click Get Started to set your communication preferences.[2] If you ever need to update them, select **Communication Preferences** from the menu under **Account**.

Members who have **touch or facial ID authentication** on their mobile devices can enable it to log in to their Express Scripts account on the mobile app, if desired.

[1] Standard shipping costs are included as part of your prescription plan.
[2] Preferences include the option to share your prescription information with other adult members of your household (aged 18+) covered under your prescription plan.

- All covered adults (aged 18+) in the household need to register separately.
- When you grant permission to share your prescription information with other registered household members, they can view your information, place orders on your behalf and more.

The Express Scripts mobile app is available for iPhone®, iPad®, and Android™ mobile devices.

Know your behavioral health options

If you or your loved one is facing a behavioral health challenge, we want to make it as easy as possible to get care. You can find in-network providers at regence.com. (Some services aren't available on narrow network plans.)

Help is available. No referral is needed.

Thoughts of suicide? Call 988—National Suicide and Crisis Lifeline—available 24/7.

Go to regence.com to find a doctor and look for these in-network options:

- Private practitioners with a variety of expertise, such as psychiatrists, psychologists, social workers, licensed counselors and more
- Inpatient care
- Outpatient programs

Also available are:

- AbleTo Therapy+ for a unique, 8-week series of one-on-one therapy sessions by phone or video, with digital tools for support between sessions: **AbleTo.com** or 1-866-287-1802
- Charlie Health telehealth for treating teens and young adults with behavioral health needs: **charliehealth.com**
- Equip telehealth for treatment of all eating disorders as well as co-existing conditions like anxiety and depression for ages 6 to 24: **equip.health**
- NOCD for app-based care specializing in treatment of obsessive-compulsive disorders: **treatmyocd.com**
- Talkspace for app-based care specializing in counseling for general behavioral health needs: **talkspace.com**

If your company offers an EAP program for urgent help, this may be a good place for you to start to get care. Talk to your Human Resources representative for further information.

You can also turn to these in-network providers for substance use disorder support:

- Boulder Care for inpatient and outpatient treatment: **boulder.care** or 1-866-901-4860
- Eleanor Health for outpatient treatment: **eleanorhealth.com** or 1-781-487-1070 (only available in Washington)
- Hazelden Betty Ford for inpatient and outpatient treatment: **hazeldenbettyford.org** or 1-877-859-2124

Only available in Washington:

- Quartet is a platform that can make it simpler to find the correct provider for your needs: **Quartethealth.com**
- Headway connects you to in-person and virtual providers within your network: **headway.co**

Commonly treated behavioral health issues:

Behavioral health issues often involve more than one concern that affect overall health and happiness. Experts can help sort through what can be the most effective treatment path for the following:

- Substance use and abuse
- Trauma and post-traumatic stress disorder (PTSD)
- Anxiety and depression
- Eating disorders
- Obsessive compulsive disorder (OCD)

Customer Service

You can call our award-winning team, Monday through Saturday, at the phone number listed on the back of your member ID card.

We're here to help you:

- Understand your benefits
- Check claim status or get an explanation of benefits
- Find an in-network provider

Regence

Resource information is current as of April 2023.

Boulder Care is a separate company that provides substance abuse and addiction treatment services. AbleTo and Talkspace are separate companies that provide mental health telehealth services.

Regence BlueCross BlueShield of Oregon
is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Oregon
100 SW Market Street | Portland, OR 97201

REG-OR-104078-23/04

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711).

KAISER PERMANENTE® thrive

Traditional HMO $250 Deductible

Benefit Plan Summary and Kaiser Permanente Resources

Deductible: Alternative Care & Vision **January 1, 2024 - December 31, 2024**	
Deductible	
For one Member per Calendar Year	$250
For an entire Family per Calendar Year	$750
Out-of-Pocket Maximum (Note: All Deductible, Copayment, and Coinsurance amounts count toward the Out of Pocket Maximum, unless otherwise noted.)	
For one Member	$2,000
For an entire Family	$6,000
Office visits	**You pay**
Routine preventative physical exam	$0
Telehealth (phone/video)	$0*
Primary Care	$5 for first 3 visits; then $15 for additional visits in the same Year *
Specialty Care	$25
Urgent Care	$35
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	$15 per department visit
X-ray, imaging, and special diagnostic procedures	$15 per department visit
CT, MRI, PET scans	$15 per department visit
Medications (outpatient)	**You pay**
Prescription drugs (up to a 30 day supply)	Generic $10, Preferred $20, Non-preferred $20, Specialty $20 (Per prescription)
Mail Order Prescription drugs (up to a 90 day supply)	2 x Copay
Administered medications, including injections (all outpatient settings)	$0
Nurse treatment room visits to receive injections	$10
Maternity Care	**You pay**
Scheduled prenatal care visits and postpartum visits	$0
Laboratory	$15 per department visit
X-ray, imaging, and special diagnostic procedures	$15 per department visit
Inpatient Hospital Services	20% Coinsurance after Deductible
Hospital Services	**You pay**
Ambulance Services (per transport)	20% Coinsurance after Deductible
Emergency services	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	$25 after Deductible
Durable medical equipment	20% Coinsurance after Deductible
Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	$25
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 100 days per Calendar Year)	20% Coinsurance after Deductible
Mental Health and Substance Use Disorder Services	**You pay**
Outpatient Services (Group visit ½ copay)	$5 for first 3 visits; then $15 for additional visits in the same Year *
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Alternative Care (self-referred)**	**You pay**

Acupuncture Services (up to 12 visits per year)	$20 per visit
Chiropractic Services (up to 20 visits per year)	$20 per visit
Massage Therapy (up to 12 visits per year)	$25 per visit
Naturopathic Medicine	$5 for first 3 visits; then $15 for additional visits in the same Year *
Vision Services	**You pay**
Routine eye exam (covered until the end of the month in which Member turns 19 years of age)	$0
Vision hardware and optical Services (covered until the end of the month in which the Member turns 19 years of age.)**	No charge for eyeglass lenses or frames or contact lenses every 12 months.
Routine eye exam (For members 19 years and older)	$15
Vision hardware and optical Services (For members 19 years and older)*	Balance after $150 allowance, once every calendar year

***** First 3 visits (or days) are any combination of in-person or telemedicine Services for primary care non-specialty medical Services, mental health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient Services.

**** Any amount you pay for covered Services does not count toward the Out-of-Pocket Maximum.**

kp.org Resources:

Here are some ways to make managing your care easier:

Sign on to our convenient online services and stay on top of your treatment from the comfort of your home.

- Find or switch doctors
- View lab test results
- Health risk assessments
- Order prescription refills
- Schedule and cancel appointments
- Exchange secure emails with your doctor and health care team
- Find locations of our medical centers and offices

Appointment Alternatives:

-Advice Nurse Line - If you have a health concern but aren't sure where to go for care, call the Kaiser Permanente advice nurse line at (800) 813-2000. Available 24 hours a day, our advice nurses can give you guidance on getting the care you need, view your medical record, and help schedule an appointment if needed.

-Virtual Care - Virtual care options are available for many health concerns. You can skip a copay and schedule a visit to see a doctor using your computer or mobile device. Call (800) 813-2000 (toll free), (503) 813-2000, or 711 (TTY for the hearing/speech impaired). You can use online scheduling to make an appointment with our Urgent Care providers. We offer both same-day Urgent Care Telephone Appointments and Urgent Care Video Visits.

-Email Your Doctor - You can send a secure email to your doctor and care team for answers to non-urgent health and wellness questions at any time by logging on to kp.org on your computer or mobile device.

Disease Management:

Our integrated health care delivery system provides comprehensive and coordinated care for our members with chronic conditions. All members who are identified by specified criteria are automatically enrolled in one of our disease management programs. Your personal physician, specialists, pharmacists, nurses, nutritionists, class instructors, and others will care for the whole you, body and mind.

Healthy Lifestyle Programs: kp.org/healthylifestyles or **kphealthylifestyles.org**.:

Digital and telephonic health coaching programs are available at no cost to members. These personalized interactive programs can help a member's goals to lose weight, eat better, manage stress, quit smoking, and more.

The online healthy lifestyle programs include:

- **Balance®** - A weight management program
- **Breathe®** - A program to help you quit smoking (**kp.org/quit smoking)**
- **Care® for Your Back –** Delivers personalized strategies for preventing and managing back pain
- **Care® for Diabetes –** Tools for managing Diabetes
- **Care for Pain® -** For members living with chronic pain
- **Care® for Depression –** Help with managing depression
- **Care® for sleep –** Tools for sleeping better
- **Relax® -** Stress management

Member Discounts: kp.org/choosehealthy

Available to you at no cost through your health plan, ChooseHealthy™offers a directory of complementary care providers, an online store, fitness club discounts, savings on health products and services, and more. You'll find reduced rates on:

- Fitness facility memberships
- Massage therapy services
- Chiropractic care
- Acupuncture
- Health & fitness books & videos
- Herbs, vitamins, and supplements

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). EOCs are available upon request or you may go to **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.

BeyondWell™

cis benefits
cisbenefits.org

Kaiser Member

Elevate Your Health, One Step at a Time with BeyondWell

BeyondWell is a comprehensive lifestyle program that integrates wellness activities, goals, rewards and more into a single place. The result is a truly personalized well-being experience that is tailored to your unique needs.

Earn up to $150 per year in rewards - act now!

> Gift cards earned must be self-claimed by December 31 each year.
> Unclaimed rewards will be forfeited.

Our BeyondWell program is available now and continues into 2024–and Kaiser members and eligible spouses can **earn up to $150** in electronic gift cards. Engage throughout each year to maximize your rewards!

Get started today!

Kaiser members

1. Visit **www.beyondwellhealth.com**.
2. Select **Login/Register** in the top right-hand corner.
3. Log into your existing account or register for a new account and accept the Terms of Use.

BeyondWell Invitation Code*
CIS

$5 Beyond Well™

Take your well-being journey with you anywhere, anytime! Download the BeyondWell app now.

Earn up to $150 in rewards for healthy activities:

- Download BeyondWell app
- Connect a device or app
- Verified steps through device
- Personal challenges
- Self-guided programs
- Dental exams
- Flu shot
- Health assessment
- Select cancer screenings
- Register on KP.org

Flip to learn more about our 2024 program

2024

Below you'll see all the ways you and your qualified spouse on the Kaiser health plan can earn up to **$150** each in Amazon.com* electronic gift cards in 2024.

$5 Sync a device or app

Our platform syncs with over 100 different devices. Earn this credit once per year.

$1 Verified steps through device

When steps are logged from your synced device, you earn credit. $1 per 10,000 steps.[1]

$5 Download the BeyondWell app

Download and log in to the BeyondWell app after creating your account online and earn $5.

$30 Interactive self-guided program

Complete any interactive program and earn $30 (up to $60 annually)

$30 Dental exam

Complete a preventive dental exam and earn $30.[2]

$20 Flu or COVID-19 vaccine

Get your flu shot or COVID-19 vaccination and earn $20 once per year.[2]

$25 Health assessment

The health assessment will help personalize your experience. Earn this incentive once per year.

$15 Personal challenge

Challenge yourself to improve lifestyle habits and earn $15 per challenge (up to $30 annually).

$30 Cancer screenings

Earn an incentive when you get a qualified cancer screening with KP physician.[2,3]

$5 Register on KP.org

Register your account on KP.org and earn $5.[4]

$15 Attend a webinar

Attend a webinar hosted by your EAP or BeyondWell and earn $15 each (up to $60 annually).

EAP Webinars

Intro to Emotional Intelligence	*Jan16 @ 10am*
Eating for Mind & Body Health	*Apr 4 @ 1pm*
Work/Life Balance	*Aug 27 @ 9am*
Stress Management	*Nov14 @ 2pm*

BeyondWell Webinars

Make Your Heart Beet	*Feb 8 @ 11:30am*
Movement for Improvement	*Jun13 @ 11:30am*
Health Myths & Facts	*Aug22 @ 11:30am*
Holiday Treats & Sweets	*Oct24 @ 11:30am*

1. $1 per 10,000 steps; max $2 daily. Steps will not carry over from day to day. Max $25 per quarter for this activity.
2. This activity is tracked through claims and will require the completion of a Kaiser Permanente HIPAA authorization form. The form will be available to complete on the BeyondWell site beginning in January 2024.
3. Qualifying preventive exams include: mammogram, colonoscopy, and pelvic exam.
4. This activity requires the participant to log in to their KP.org account and complete the Kaiser Permanente HIPAA Authorization Form. Once complete, it may take up to eight weeks to see the activity credit in your account.

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BeyondWell™

Kaiser Permanente Office Hours

Kaiser Permanente is hosting monthly office hours by phone and it is a great opportunity to speak with a representative one-on-one. Appointments are 15 minutes long and we can help if you have questions related to:

- Benefits
- Coverage
- Self-care tools
- Telemedicine & kp.org
- Transition of care
- Healthy resources

Select dates and times are available. If you are needing more time, you may schedule more than one appointment. To schedule your 1:1 appointment, please visit: https://www.signupgenius.com/go/20F0F49ADA72DABFF2-kaiser5

KAISER PERMANENTE®

Learn about your out-of-area benefit for dependent children

FOR MEMBERS ON LARGE GROUP PLANS (51+ EMPLOYEES)[1]

Your dependent children have access to care beyond urgent and emergency care outside the Kaiser Permanente network. Your out-of-area benefit covers routine, continuing, and follow-up care for dependent children residing outside the service area.

SERVICES

With this benefit, you will pay 20% of the charges for the service received.[2] This benefit includes the following services:[3]

- 10 office visits per year, including preventive care, primary care, naturopathic care, specialty care, outpatient mental health and substance use disorder services, allergy injections, and outpatient physical therapy
- 10 diagnostic X-rays and lab tests per year (covers diagnostic X-rays but excludes CT, MRI, PET, and other specialty scans)
- 10 prescription drug fills per year

PAYMENT

You have 2 payment options for services you receive using the out-of-area benefit for dependent children:

- The health care provider can bill Kaiser Permanente directly, and no claim needs to be submitted.
- You can pay out of pocket and submit a Claim Reimbursement form for reimbursement. This form can be found at **kp.org/disclosures**.

Payments for these services count toward your plan's out-of-pocket maximum.

[1]The dependent out-of-area benefit does not apply to Added Choice® plans, PPO Plus® plans, Standard plans, Cascade plans, Senior Advantage plans, or WA Conversion plans.

[2]The cost share is subject to deductible on HSA-qualified high deductible health plans.

[3]Any other services not specifically listed as covered are excluded under this out-of-area benefit.

Customer Service contact information:

Oregon and Washington

1-800-813-2000

711 (TTY)

1-800-324-8010
(Interpreter-Assisted Appointing and Advice)

Monday through Friday,
8 a.m. to 6 p.m. PT

KAISER PERMANENTE®

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All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

ELIGIBILITY

The following requirements apply:

- Dependent children must meet eligibility requirements and be under the age limit specified in the *Evidence of Coverage*.
- Dependent children must be living outside the service area. Dependent children who reside in another Kaiser Foundation Health Plan service area may use their visiting member benefit.

PRESCRIPTION DRUG COVERAGE

Out-of-area dependent children may buy prescription drugs from:

- **Mail-order pharmacy.** Dependent children residing outside the service area but within Oregon and Washington may use our mail-order pharmacy. Members will pay their normal copay or coinsurance.
- **Nonparticipating pharmacies.** Dependent children residing outside the service area may also use a nonparticipating pharmacy. Members will pay 20% and Kaiser Permanente will pay 80% for up to 10 prescription fills per year. We will reimburse only when the drugs are medically necessary.

EXCLUSIONS AND LIMITATIONS

The following services are not covered under the dependent out-of-area benefit but may be covered under another benefit, with applicable copays or coinsurance:

- Emergency services, post-stabilization, and urgent care*
- Transplant services
- Visiting member services (care received when in another Kaiser Foundation Health Plan); go to **kp.org/travel** for more information on other service areas

WHAT SERVICES DOES THIS BENEFIT COVER?

We will cover limited services for dependent children outside our service area but within the United States (which for the purpose of this benefit means the 50 states, the District of Columbia, and the U.S. territories).

*Emergency and urgent care is separate from the dependent out-of-area benefit. If you reasonably believe you have an emergency medical condition, which is a medical or psychiatric condition that requires immediate medical attention to prevent serious jeopardy to your health, call 911 or go to the nearest emergency department. For the complete definition of an emergency medical condition, please refer to your *Evidence of Coverage*.

This form is available on **kp.org/disclosures**.

KAISER PERMANENTE®

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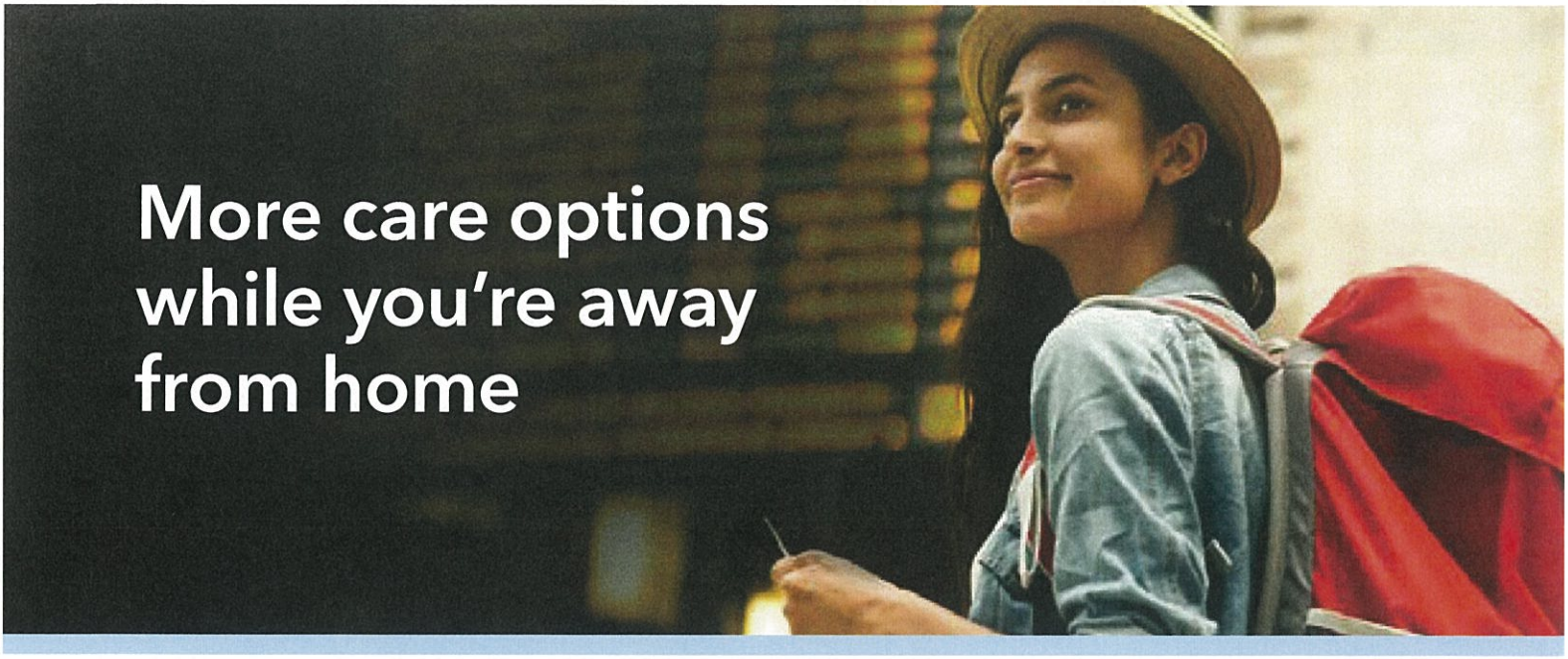


More care options while you're away from home

No matter where life takes you, Kaiser Permanente has you covered. If something unexpected happens while you're away from home, it's easier than ever to get care.

Nonurgent care

Use your **kp.org** account or the Kaiser Permanente app across the U.S. to:

- Get 24/7 care and advice from Kaiser Permanente clinicians by phone or online
- Access care by phone,[1] video,[1] or e-visit – usually at no cost[2]
- Email nonurgent questions to your doctor's office

Urgent care[3]

You can get urgent care anywhere in the world. At many locations outside Kaiser Permanente states, you'll only pay your copay or coinsurance for care or prescriptions[4] related to your urgent care visit – no need to file a claim later:

- Cigna PPO Network[5]
- MinuteClinic, including pharmacies[6]
- Concentra Urgent Care[6]
- The Little Clinic, including pharmacies[6]

At all other locations, you must pay the full cost of care upfront and file a claim for reimbursement later.

Emergency care[7]

No matter where you are, you can simply go to the nearest hospital emergency room. If it's a Kaiser Permanente location or Cigna PPO provider, you'll only pay your normal copay or coinsurance.

Support while you're away

Need help finding care or learning what's covered while you're away? Call the Away from Home Travel Line at **951-268-3900** (TTY **711**)[8] or visit **kp.org/travel**.

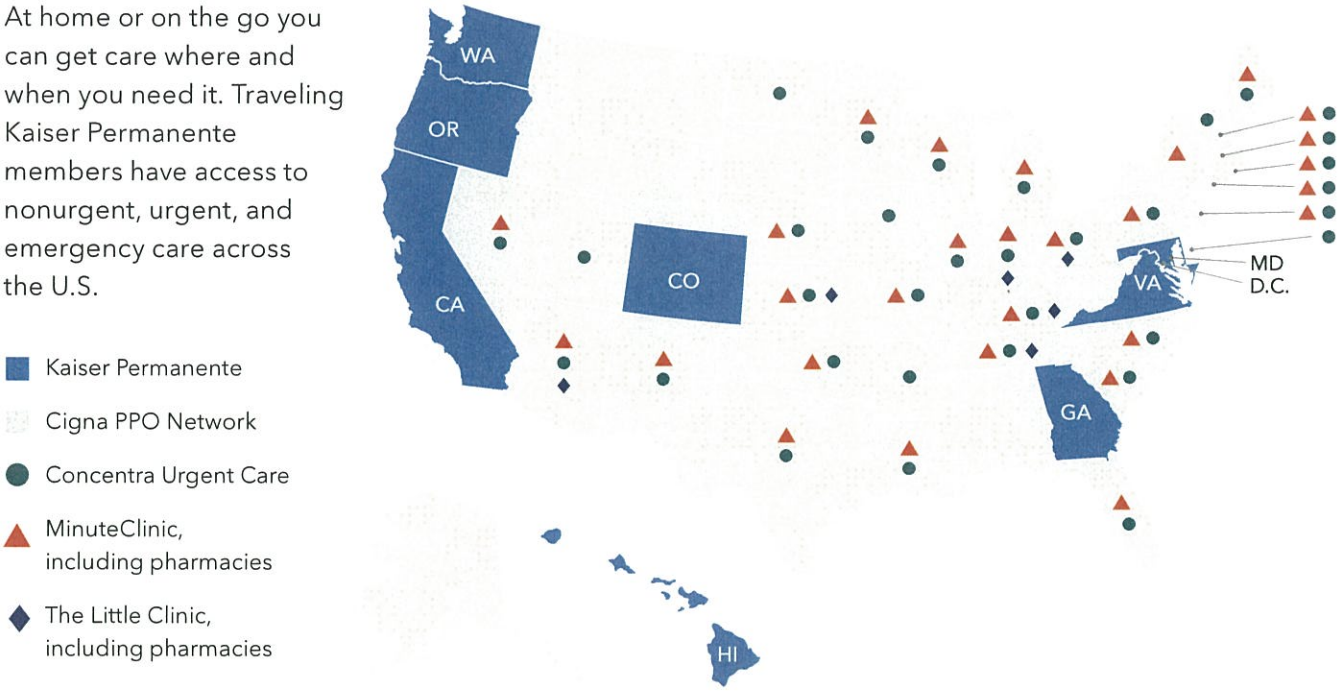
Learn more at **kp.org/travel**

KAISER PERMANENTE®

1020222594 January 2023

Find care near you

At home or on the go you can get care where and when you need it. Traveling Kaiser Permanente members have access to nonurgent, urgent, and emergency care across the U.S.



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1. When appropriate and available. If you travel out of state, phone appointments and video visits may not be available in select states due to licensing laws. Laws differ by state. **2.** If you have an HSA-qualified deductible plan, you may need to pay the full charges for scheduled phone appointments and video visits until you reach your deductible. Once you reach your deductible, you won't pay anything for scheduled phone appointments and video visits. **3.** An urgent care need is one that requires prompt medical attention, usually within 24 or 48 hours, but is not an emergency medical condition. This can include minor injuries, backaches, earaches, sore throats, coughs, upper-respiratory symptoms, and frequent urination or a burning sensation when urinating. **4.** GA commercial members are required to pay upfront and seek reimbursement for prescriptions. If employee is in a state that has Kaiser Permanente providers, but outside one of our service areas, the member pays upfront for services and prescriptions and will need to file a claim for reimbursement. Maintenance medications (e.g., blood pressure, cholesterol), high cost or specialty medications are not included in this benefit, and the member will need to file a claim for reimbursement. Reimbursement is subject to the pharmacy benefit as described in the member's *Evidence of Coverage* or other coverage documents. **5.** The Cigna PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna PPO for Shared Administration. **6.** MinuteClinic, Concentra Urgent Care, and The Little Clinic payment experiences vary by plan. **7.** If you believe you have an emergency medical condition, call 911 or go to the nearest hospital. For the complete definition of an emergency medical condition, please refer to your *Evidence of Coverage* or other coverage documents. **8.** This number can be dialed inside and outside the United States. Before the phone number, dial "001" for landlines and "+1" for mobile lines if you're outside the country. Long-distance charges may apply, and we can't accept collect calls. The phone line is closed on major holidays (New Year's Day, Easter, Memorial Day, July Fourth, Labor Day, Thanksgiving, and Christmas). It closes early the day before a holiday at 10 p.m. Pacific time (PT), and it reopens the day after a holiday at 4 a.m. PT.

The Cigna PPO Network is not available to HMO and EPO members enrolled in coverage issued by Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc.

Cigna is an independent company and not affiliated with Kaiser Foundation Health Plan, Inc., and its subsidiary health plans. Access to the Cigna PPO Network is available through Cigna's contractual relationship with the Kaiser Permanente health plans. The Cigna PPO Network is provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

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Kaiser Permanente Insurance Company (KPIC), One Kaiser Plaza, Oakland, CA 94612

Learn more at **kp.org/travel**

KAISER PERMANENTE®

1020222594 January 2023

Dental Insurance

Lane Council of Governments offers a Dual-Option dental benefit program for all eligible employees through Met Life and Willamette Dental Company. For information regarding plan benefits and member responsibilities, please refer to the benefit summaries on the following pages.

Please Note: *It is recommended that when a course of treatment is expected to cost $300 or more, and is of a non-emergency nature, your dentist should submit a treatment plan to the insurer before he or she begins treatment. This will enable you to see what your out-of-pocket expenses will be so you can budget accordingly. There is also a possibility that suggested procedures may be denied, and alternative procedures may be approved, based upon x-rays and other supporting documentation.*

The MetLife Plan

This plan provides dental coverage with a coinsurance-based design, meaning that for all services provided (with the exception of Preventive services) you will owe a percentage of the cost of the service as well as the deductible (until it is met for the plan year). For example, if you have a Basic service performed and have not already satisfied the deductible, you will owe a $50 deductible plus 20% of the cost of the service. One big difference in the MetLife plan is that you have the freedom to choose any dental provider you want. If your current dentist is not in the MetLife network, you can still receive coverage for services received from them.

The Willamette Dental Plan

This plan is a copayment-based plan, meaning that you will only be responsible for a copayment ($5 for most services) when receiving services from In-Network Willamette Dental providers. You can **only** use Willamette Dental providers if you enroll in the Willamette Dental Plan. If you receive services from a dentist who is not in the network, you will have no coverage for those services.

You can compare the MetLife and Willamette Dental plan benefit summaries on the following pages to determine which plan best fits you and your dependents' needs.

Dental Benefits

Metropolitan Life Insurance Company

Overview of Benefits for: LANE COUNCIL OF GOVERNMENTS
The Preferred Dentist Program was designed to help you get the dental care you need and help lower your costs. You get benefits for a wide range of covered services — both in and out of the network. The goal is to deliver affordable protection for a healthier smile and a healthier you.

Coverage Type	**In-Network:** % of Negotiated Fee	**Out-of-Network:** % of R&C Fee[1]
Type A	100%	100%
Type B	80%	80%
Type C	50%	50%
Orthodontia	50%	50%
Deductible: Individual/Family*	$50 (Type B & C)	$50 (Type B & C)
Annual Maximum Benefit: Per Individual	$1500	$1500
Orthodontia Lifetime Maximum: Per Individual	$1000	$1000
	Ortho applies to Adult and Child (Up to dependent age limit)	

Understanding Your Dental Benefits Plan

With the MetLife Preferred Dentist Program you can visit the dentist of your choice – an “in-network” dentist (a participating MetLife dentist) or an “out-of-network” dentist.

- Plan benefits for in-network services are based on the percentage of the Negotiated fee –the fee that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefit maximums. Negotiated fees are subject to change.
- Plan benefits for out-of-network services are based on a percentage of the Reasonable and Customary (R&C) charge. If you choose a dentist who does not participate in the network, your out-of-pocket expenses may be higher, since you will be responsible for paying any difference between the dentist's fee and your plan's payment for the approved service. Please refer to the Selected Covered Services and Frequency Limitations page of this document for details regarding how R&C charges are defined under this plan.

Take advantage of online self-service capabilities with MyBenefits.

- Check the status of your claims
- Locate a participating dentist
- Access MetLife’s Oral Health Library
- Elect to view your Explanation of Benefits online

If you are not already registered, just go to **www.metlife.com/mybenefits** and follow the easy registration instructions.

Certain plan benefits are based on a percentage of the negotiated fee. This is the amount that participating dentists have agreed to accept as payment in full. If your plan benefits are based on a percentage of the Reasonable and Customary (R&C) charges, your out-of-pocket expenses may be more, since you will be responsible for paying any difference between the dentist's fee and your plan's payment for the approved service.

* If you are enrolled for dependent coverage, a maximum family deductible may apply.

Savings from enrolling in a dental benefits plan will depend on various factors, including the cost of the plan, how often participants visit the dentist and the cost of services rendered.

Selected Covered Services and Frequency Limitations*

Type A	
• Oral Examinations	2 in 1 year.
• Fluoride	Children to age 14 / 2 in 1 year.
• Bitewing X-rays	Adult - 1 in 12 months / Children - 1 in 12 months.
• Full Mouth X-rays	1 in 3 years.
• Space Maintainers	For dependent children to age 14. Limited to 1 per lifetime per area.
• Sealants (1st & 2nd permanent molars)	1 per tooth in 5 years of a dependent child up to 19th birthday.
• Cleanings	2 in 1 year.
Type B	
• Periodontal Maintenance	4 in 1 year less the number of teeth cleanings.
• Emergency Palliative Treatment	
• Crowns	1 in 5 years.
• Periodontal Root Planing & Scaling	1 per quadrant in any 24 months period.
• Periodontal Surgery	1 in 36 months.
• Amalgam & Composite Fillings	No Limit. Composites covered on anterior teeth Only.
• Simple Extractions	
• Root Canal	1 in 24 months.
• Surgical Extractions	
Type C	
• Dentures	1 in 5 years.
• Bridges	1 in 5 years.
• Repairs (Crowns)	1 in 12 months.
• Implants	1 in 10 years.
Orthodontia	
• Dependent children are covered up to their 26th birthday.	
• All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia. • Payments are on a repetitive basis. • 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the Plan Summary. • Orthodontic benefits end at cancellation of coverage.	

The service categories and plan limitations shown in this document represent an overview of your plan benefits, but are not a complete description of the plan. Before making any purchase or enrollment decision you should review the certificate of insurance which is available through MetLife or your employer. In the event of a conflict between this overview and your certificate of insurance, your certificate of insurance governs. Like most group dental insurance policies, MetLife group policies contain certain exclusions, limitations and waiting periods and terms for keeping them in force. The certificate of insurance sets forth all plan terms and provisions, including all exclusions and limitations.

***Alternate Benefits:** Your dental plan provides that if there are two or more professionally acceptable dental treatment alternatives for a dental condition, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pretreatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's reimbursement for those services, and your out-of-pocket expense. Actual

payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

[1.] The Reasonable and Customary charge is based on the lowest of the: "Actual Charge" (the dentist's actual charge); or "Customary Charge" (the 99th percentile charge of most dentists in the same geographic area for the same or similar services as determined by MetLife).

The service categories and plan limitations shown above represent an overview of your plan benefits. This document presents the majority of services within each category, but is not a complete description of the plan.

Exclusions

We will not pay Dental Insurance benefits for charges incurred for:

1. Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature.
2. Services for which You would not be required to pay in the absence of Dental Insurance.
3. Services or supplies received by You or Your Dependent before the Dental Insurance starts for that person.
4. Services which are primarily cosmetic (For residents of Texas, see notice page section in your certificate).
5. Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
   - scaling and polishing of teeth; or
   - fluoride treatments.
6. Services or appliances which restore or alter occlusion or vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion or erosion.
8. Restorations or appliances used for the purpose of periodontal splinting.
9. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
10. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
11. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
12. Missed appointments.
13. Services:
    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
14. Services covered under other coverage provided by the Employer.
15. Temporary or provisional restorations.
16. Temporary or provisional appliances.
17. Prescription drugs.
18. Services for which the submitted documentation indicates a poor prognosis.
19. The following when charged by the Dentist on a separate basis:
    - claim form completion;
    - infection control such as gloves, masks, and sterilization of supplies; or
    - local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
20. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.
21. Caries susceptibility tests.
22. Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
23. Other fixed Denture prosthetic services not described elsewhere in this certificate.
24. Precision attachments.
25. Adjustment of a Denture
26 Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota. [1]
27. Repair or replacement of an orthodontic device.[1]
28. Duplicate prosthetic devices or appliances.
29. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
30. Intra and extraoral photographic images.

[1] Some of these exclusions may not apply. Please see your plan design and certificate for details.

COMMON QUESTIONS… IMPORTANT ANSWERS

Who is a participating dentist?
A participating dentist is a general dentist or specialist who has agreed to accept MetLife's negotiated fees as payment in full for services provided to plan participants. Based on internal analysis by MetLife, negotiated fees typically range from 15-45% below the average fees charged for the same services by dentists in the same geographic area.

*Negotiated Fees refers to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

How do I find a participating dentist?
You can access a list of participating dentists with directions and mapping capabilities online at www.metlife.com/dental or call 1-800-ASK-4-MET (800-275-4638) to have a list faxed or mailed to you based upon the requested ZIP code. **Please Note:** Be sure to verify provider participation when you make your appointment.

May I choose a non-participating dentist?
Yes. You are always free to select the dentist of your choice. However, if you choose a dentist who does not participate in the MetLife program, your out-of-pocket expenses may be greater, since you will be responsible to pay for any difference between the dentist's fee and your plan's payment for the approved service. If you receive services from a participating dentist, you are only responsible for the difference between the in-network fee for the service provided and your plan's payment for the approved service. Please note: any plan deductibles must be met before benefits are paid.

Can my dentist apply for participation in network?
Yes. If your current dentist does not participate in the MetLife network and you would like to encourage him or her to apply, tell your dentist to visit www.metdental.com, or call 1-877-MET-DDS9 for an application. The website and phone number are designed for use by dental professionals only.

How are claims processed?
Dentists may submit your claims for you, which means you have little or no paperwork. You can track your claims online and even receive e-mail alerts when a claim has been processed. If you need a claim form, you can find one online at www.metlife.com/dental or request one by calling 1-800-ASK-4-MET (800-275-4638).

Can I find out what my out-of-pocket expenses will be before receiving a service?
Yes. With pre-treatment estimates, you never have to wonder what your out-of-pocket expense will be. MetLife recommends that you request a pre-treatment estimate for services in excess of $300 (This often applies to services such as crowns, bridges, inlays, and periodontics). To receive a benefit estimate, simply have your dentist submit a request for a pre-treatment estimate online at www.metdental.com or call 1-877-MET-DDS9 (638-3379). You and your dentist will receive a benefit estimate online or by fax for most procedures while you are still in the office so you can discuss treatment and payment options and have the procedure scheduled on the spot. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Do I need an ID card?
No, you do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you participate in MetLife's PDP. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

Do my dependents have to visit the same dentist that I select?
No, you and your dependents each have the freedom to choose any dentist.

If I do not enroll during my initial enrollment period can I still purchase Dental Insurance at a later date?
Yes, eligible employees who do not elect coverage during their 31-day application period may still elect coverage later. Dental coverage elected after the 31-day application period is subject to the following waiting periods:*

- No waiting period for Preventive Services
- 6 months on Basic Restorative (Fillings)

- 12 months on all other Basic Services
- 24 months on Major Services
- 24 months on Orthodontia Services (if applicable)

*If the policy holder participates in a section 125 plan and has an annual open enrollment period, the dental coverage will not be subject to any waiting periods. Please consult your Benefits Administrator or your certificate for this plan information.

Am I eligible for all benefits the first day of coverage?
Your plan may include benefit waiting periods. Please refer to the certificate of insurance or your Benefits Administrator for details about the services that are subject to the waiting periods and the length of time they apply.

How can I learn about what dentists in my area charge for different procedures?
If you have MyBenefits you can access the Dental Procedure Tool. You can use the tool to look up average in- and out-of-network fees for dental services in your area. * You'll find fees for services such as exams, cleanings, fillings, crowns, and more. Just log in at www.metlife.com/mybenefits.

* The Dental Procedure Fee Tool application is provided by VerifPoint, an independent vendor. Network fee information is supplied to VerifPoint by MetLife and is not available for providers who participate with MetLife through a third-party. Out-of-network fee information is provided by VerifPoint. This tool does not provide the payment information used by MetLife when processing your claims. Prior to receiving services, pretreatment estimates through your dentist will provide the most accurate fee and payment information

Can MetLife help me find a dentist outside of the U.S. if I am traveling?
Yes. Through MetLife's International Dental Travel Assistance program[1] you can obtain a referral to a local dentist by calling 1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network[2] benefits. Please remember to hold on to all receipts to submit a dental claim.

1 International Dental Travel Assistance services are administered by AXA Assistance USA, Inc. Certain benefits provided under the Travel Assistance program are underwritten by Virginia Surety Company, Inc. AXA Assistance and Virginia Surety are not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations.

2 Refer to your dental benefits plan summary your out-of-network dental coverage.

SUMMARY OF BENEFITS

Lane Council of Governments – OR73 – 1/1/2024

Willamette Dental Group

COVERED BENEFITS	COPAYS
Annual Maximum	No Annual Maximum*
Deductible	No Deductible
General or Orthodontic Office Visit	You Pay $5 per Visit
DIAGNOSTIC & PREVENTIVE SERVICES	
Routine & Emergency Exams	Covered with the Office Visit Copay
X-rays	Covered with the Office Visit Copay
Teeth Cleaning	Covered with the Office Visit Copay
Fluoride Treatment	Covered with the Office Visit Copay
Sealants (per Tooth)	Covered with the Office Visit Copay
Head and Neck Cancer Screening	Covered with the Office Visit Copay
Oral Hygiene Instruction	Covered with the Office Visit Copay
Periodontal Charting	Covered with the Office Visit Copay
Periodontal Evaluation	Covered with the Office Visit Copay
RESTORATIVE DENTISTRY	
Fillings	Covered with the Office Visit Copay
Porcelain-Metal Crown	Covered with the Office Visit Copay
PROSTHODONTICS	
Complete Upper or Lower Denture	Covered with the Office Visit Copay
Bridge (per Tooth)	Covered with the Office Visit Copay
ENDODONTICS & PERIODONTICS	
Root Canal Therapy - Anterior	Covered with the Office Visit Copay
Root Canal Therapy - Bicuspid	Covered with the Office Visit Copay
Root Canal Therapy - Molar	Covered with the Office Visit Copay
Osseous Surgery (per Quadrant)	Covered with the Office Visit Copay
Root Planing (per Quadrant)	Covered with the Office Visit Copay
ORAL SURGERY	
Routine Extraction (Single Tooth)	Covered with the Office Visit Copay
Surgical Extraction	Covered with the Office Visit Copay
ORTHODONTIA TREATMENT	
Pre-Orthodontia Treatment	You Pay a $150 Copay***
Comprehensive Orthodontia Treatment	You Pay a $1,500 Copay
DENTAL IMPLANTS	
Dental Implant Surgery	Implant benefit maximum of $1,500 per calendar year
MISCELLANEOUS	
Local Anesthesia	Covered with the Office Visit Copay
Dental Lab Fees	Covered with the Office Visit Copay
Nitrous Oxide	You Pay a $40 Copay
Specialty Office Visit	You Pay $30 per Visit
Out of Area Emergency Care Reimbursement	You pay charges in excess of $100

*Benefits for implant surgery have a benefit maximum, if covered. **Dental implant-supported prosthetics (crowns, bridges, and dentures) are not a covered benefit. ***Copay credited towards the Comprehensive Orthodontia Treatment copay if patient accepts treatment plan.

Underwritten by Willamette Dental Insurance, Inc.
Presented are just some of the most common procedures covered in your plan. The certificate of coverage contains a complete description of covered benefits and copays.

Administrative Office: 6950 NE Campus Way, Hillsboro, OR 97124
028-OR(7/20)

EXCLUSIONS AND LIMITATIONS

Willamette Dental Group

This is only a summary. The certificate of coverage contains a complete description of the limitations and exclusions.

Exclusions

- Bone grafting.
- Bridges, crowns, dentures, or prosthetic devices requiring multiple treatment dates or fittings if the prosthetic item is installed or delivered more than 60 days after termination of coverage.
- The completion or delivery of treatments or services initiated prior to the effective date of coverage.
- Cone beam CT X-rays and tomographic surveys.
- Dental implant-supported prosthetics or abutment-supported prosthetics (crowns, bridges, and dentures).
- A dental implant surgically placed prior to the member's effective date of coverage that has not received final restoration or a dental implant for treatment of a primary or transitional dentition.
- Endodontic services, prosthetic services, and implants that were provided prior to the effective date of coverage.
- Endodontic therapy completed more than 60 days after termination of coverage.
- Eposteal, transosteal, endodontic endosseous, or mini dental implants.
- Exams or consultations needed solely in connection with a service not listed as covered.
- Experimental or investigational services and related exams or consultations.
- Full mouth reconstruction, including the extensive restoration of the mouth with crowns, bridges, or implants; and occlusal rehabilitation, including crowns, bridges, or implants used for the purpose of splinting, altering vertical dimension, restoring occlusions or correcting attrition, abrasion, or erosion.
- General anesthesia or moderate sedation.
- Hospitalization care outside of a dental office for dental procedures, physician services, or facility fees.
- Maintenance, repair, replacement, or completion of an existing implant started or placed by a non-participating provider without a referral from a Willamette Dental Group provider.
- Maintenance, repair, replacement, or completion of an existing implant started or placed prior to the member's effective date of coverage.
- Nightguards.
- Orthognathic surgery.
- Personalized restorations.
- Plastic, reconstructive, or cosmetic surgery and other services, which are primarily intended to improve, alter, or enhance appearance.
- Prescription and over-the-counter drugs and pre-medications.
- Provider charges for a missed appointment or appointment cancelled without 24 hours prior notice.
- Replacement of lost, missing, or stolen dental appliances; replacement of dental appliances that are damaged due to abuse, misuse, or neglect.
- Replacement of sound restorations.
- Services and related exams or consultations that are not within the prescribed treatment plan or are not recommended and approved by a Willamette Dental Group dentist.
- Services and related exams or consultations to the extent they are not necessary for the diagnosis, care, or treatment of the condition involved.
- Services by any person other than a licensed dentist, denturist, hygienist, or dental assistant.
- Services for the diagnosis or treatment of temporomandibular joint disorders.
- Services for the treatment of an injury or disease that is covered under workers' compensation or that are an employer's responsibility.
- Services for treatment of injuries sustained while practicing for or competing in a professional athletic contest.
- Services for treatment of intentionally self-inflicted injuries.
- Services for which coverage is available under any federal, state, or other governmental program, unless required by law.
- Services not listed as covered in the contract.
- Services where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Limitations

- If alternative services can be used to treat a condition, the service recommended by the Willamette Dental Group dentist is covered.
- Services listed in the contract, which are provided to correct congenital or developmental malformations of the teeth and supporting structure will be covered if primarily for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring function.
- Crowns, casts, or other indirect fabricated restorations are covered only if dentally necessary and if recommended by the Willamette Dental Group dentist.
- When the initial root canal therapy was performed by a Willamette Dental Group dentist, the retreatment of such root canal therapy will be covered as part of the initial treatment for the first 24 months. When the initial root canal therapy was performed by a non-participating provider, the retreatment of such root canal therapy by a Willamette Dental Group dentist will be subject to the applicable copays.
- The services provided by a dentist in a hospital setting are covered if: a hospital or similar setting is medically necessary; the services are authorized in writing by a Willamette Dental Group dentist; the services provided are the same services that would be provided in a dental office; and applicable copays are paid.
- The replacement of an existing denture, crown, inlay, onlay, or other prosthetic appliance is covered if the appliance is more than 5 years old and replacement is dentally necessary.

Administrative Office: 6950 NE Campus Way, Hillsboro, OR 97124
028-OR(7/20)

PacificSource ADMINISTRATORS

LANE COUNCIL OF GOVERNMENTS

Flexible Spending Account Summary

January 1, 2024 – December 31, 2024

A Flexible Spending Account (FSA) is a type of plan that allows you to receive certain benefits on a pretax basis. Think of it as a tax-free and interest-free loan to yourself. The pretax contributions may be used for qualified healthcare and childcare expenses for you and your tax dependents. They also allow you to pay for your group's sponsored insurance premiums on a pretax basis.

Contributing to Your FSA

Component	Maximum Pay Period Election	Maximum Annual Election
General Purpose Health FSA	$127.08	$3,050
Dependent Daycare Expenses	N/A	$5,000 if married & filing a joint return or a single parent $2,500 if married but filing separately

The Plans: The following FSA components are available through your employer.

Premium Component

- Your employer will deduct your portion of the group-sponsored insurance plans, including premiums for medical, dental, vision, hospitalization, accident insurance, and/or other qualified benefits from your gross salary on a pre-tax basis. This reduces income taxes and results in an increase in take home pay and lower taxable salary.

Health FSA Component – includes the following account(s)

Health Related Expense Account (HRE) - the General Purpose FSA

- If you're eligible for your employer's health plan, you can set up an HRE account. With an HRE account, you can save pre-tax money for healthcare expenses, including medical, dental, and vision expenses that are either not covered or only partially covered by your insurance plan.
- These expenses are for your tax dependents. Examples include: you, your spouse, or child(ren), whether or not they are covered on your employer's group insurance plan.
- No changes in contribution will be allowed during the plan year.

Dependent Care Assistance Plan (DCAP) Component

Dependent Daycare Expense Account (DCE)

- Our Dependent Daycare Expense Account (DCE) allows you to save pre-tax dollars to pay for dependent care. This is specifically for expenses for a child up to age 13 or disabled taxable dependent who is unable to care for themselves, including elder care expenses.
- When you have a qualified change in status—such as if your spouse's employment changes—you can increase or decrease how much you put into your account.
- In many cases, this account will be more beneficial to you than the federal tax credit.

Claims Reimbursement

Reimbursement Time Frame

Reimbursements may be requested during the plan year or after it ends. Your claim submission period ends 90 days after the plan year ends. This is known as a run-out period. All eligible reimbursement claims for services you received between **January 1, 2024** and **December 31, 2024** must be submitted by **March 31, 2025** for reimbursement.

Submitting Claims

There are different ways you can submit expenses for reimbursement. These methods include manual submission or using your Prepaid Benefit Card. If you're reimbursed for a claim and it is later determined that the expense was not eligible for reimbursement, you will be liable for repaying the money to your FSA. Additional information is listed below.

Manual Claims

We offer several ways you can submit your claims for reimbursement:

1. Submit your claim online using our PSAConsumer portal: https://psa.consumer.pacificsource.com
2. Submit your claim via our Mobile App: myPacificSource Admin (PSA)
3. Mail or fax a Request for Reimbursement Form. You'll find the form at https://psa.pacificsource.com/Forms/

Prepaid Benefit Card

A Prepaid Benefits Debit Card gives you an easy, automatic way to pay for qualified healthcare expenses. When you enroll in the health FSA, you will automatically receive two benefits cards. Simply swipe your benefits card as you would a credit/debit card (and select "credit" rather than "debit"). When you use the card to make a purchase or payment, it deducts funds directly from your FSA. Date of service is important! It's assumed the date of service is the day the card is swiped. If you are paying for a prior service, only use your card if the service date is within your current plan year. Prior year services need to be submitted as manual claims for reimbursement. Replacements or additional cards can be purchased for $10 per set of two cards.

When you use your debit card, you should request an itemized receipt for reimbursement in case we need you to substantiate a charge. (*You must save all expense documentation, such as itemized receipts, per IRS regulations.)* You may occasionally receive a notice if your transaction is ineligible or needs additional documentation. You will be required to submit the documentation, refund the account, or "offset" the expense as indicated in the notice. If the transaction issue hasn't been resolved within the allotted time, the card will be suspended. Amounts for transactions that aren't properly documented or that have been deemed ineligible may be included as wages on your W-2.

Funds Remaining After the Plan Ends

If the plan year ends before you've used all of your Health FSA funds, you're allowed to have up to $610 carry over to the next FSA plan year. If you have more than the $610 remaining, you'll lose those additional funds, along with all other account balances. You will not be required to make a new election in order to have up to $610 carryover. Carryover funds will be automatically rolled after the prior plan year, and claims submission period ends. You may request an early roll by contacting Customer Service.

What Happens if I Terminate Employment during the Plan Year?

If you terminate employment or lose eligibility, your participation in the plan will end on the date of termination or on the last day of the pay period in which you have contributed, whichever gives the greatest period of coverage.

You can elect to have a final pre-tax final paycheck salary reduction withheld. In the alternative, you may elect to pay on an after-tax basis any remaining contributions for the Plan Year. The Premium Completion Agreement extends eligibility to incur qualified health related expenses.
You may be eligible to continue the Health FSA under COBRA.
Please check with your employer regarding options you may have.

Forms, Fliers and instructions

Available online. Examples include:

- FSA Participant Guide (general information)
- Request for Reimbursement Forms
- Direct Deposit Form
- Examples of Eligible Expenses
- Online Claim Submission Instructions
- Prepaid Benefits Card Flier (Benny/Wex)
- Authorization to Disclose PHI

PSA Consumer Portal: Online Account Access for Participants

Manage your FSA from the convenience of your home or office by utilizing our website:
www.psa.pacificsource.com/PSA or https://psa.consumer.pacificsource.com

- File a claim online.
- Access information on the most recent reimbursement payments.
- View payment details.
- Check your account balances, annual election, and year-to-date deposits.
- Change your address and other personal information.
- View FAQs and fliers.

Questions?
Our Customer Service team is happy to help. For more information about FSA details, please refer to your Plan Document and Summary Plan Description.

Phone
Direct: (541) 486-7488
Toll-free: (800) 422-7038

Email
psacustomerservice@pacificsource.com

PacificSource.com/PSA

PacificSource ADMINISTRATORS

Lane Council of Governments

Health Reimbursement Arrangement
January 1, 2024 – December 31, 2024

A Health Reimbursement Arrangement (HRA) is a tax-free employer-funded account managed by PacificSource Administrators. By utilizing the Health Reimbursement Arrangement, you could recover a portion of expenses covered under your employer-sponsored medical insurance. The HRA reimburses certain expenses as outlined in IRS Code 213.

Comprehensive Plan

Often referred to as a "Comp A", this plan reimburses all expenses as outlined in IRS Code 213, including long-term care and COBRA premiums. Reimbursable expenses include:

- Deductible Expenses
- Copay Expenses
- Coinsurance Expenses
- Medical Expenses
- Prescription Expenses
- Dental Expenses
- Orthodontia Expenses
- Vision Expenses
- Alternative Care Expenses
- Long-term Care and COBRA Premiums

- Dates of service from prior plan years must occur within your HRA eligibility period in order to be reimbursed.
- Mid-year hires and terminations will be prorated.
- If you are also enrolled in a Flexible Spending Account, the FSA will pay out before the HRA.
- If you terminate during the plan year, your HRA participation would end on the last day of the month of termination.

Expense Allocations

	Employer Contribution
Employee	$1,700 annually, for all unreimbursed medically necessary health expenses
Employee and Family	$2,400 annually, for all unreimbursed medically necessary health expenses

How to Get Reimbursed

Your claim for reimbursement must include a statement from the service provider that you have incurred the expense and the amount of your expense. **Note:** A statement from the provider may be required to show that an expense is medically necessary.

Questions?
Our Customer Service Team is happy to help.

Phone
Direct: (541) 485-7488
Toll-free: (800) 422-7038

Email
psacustomerservice@pacificsource.com

Forms and Materials
https://psa.pacificsource.com/Forms_Flex.aspx

PacificSource.com/PSA

Prepaid Benefits Card

A Prepaid Benefits Card gives you an easy, automatic way to pay for qualified healthcare expenses. Simply swipe your benefits card as you would a credit/debit card (and select "credit" rather than "debit"). When you use the card to make a purchase or payment, it deducts funds directly from your HRA. When you enroll, you will automatically receive two benefits cards.

If you make a payment or purchase for a qualified healthcare expense and do not use your benefits card, you must get an itemized receipt for reimbursement. *You must save all expense documentation, such as receipts, per IRS regulations.* For more information, see our Benny card flier available on our website.

Manual Claims

We offer several ways you can submit your claims for reimbursement:

1. Submit your claim online using our PSAConsumer portal: https://psa.consumer.pacificsource.com
2. Submit your claim via our Mobile App: myPacificSource Admin (PSA)
3. Mail or fax a Request for Reimbursement Form. You'll find the form at https://psa.pacificsource.com/Forms/

Reimbursement Time Frame

Reimbursements may be requested during the plan year or after it ends. Any eligible claims for services between **January 1, 202**4 **and December 31, 202**4, which are submitted prior to **March 31, 202**5, are reimbursable.

Leftover Funds

Your claim submission period ends 90 days after the plan year ends. This is known as a run-out period. Sometimes though, you may not use all of the funds you set aside for your HRA within the plan year.

If you have unused account balances at the end of the plan year, they will be carried over into the next plan year.

Reimbursement Tips

- PacificSource Administrators will mail a check or deposit your funds after the request for reimbursement has been processed and accepted.
- Request for Reimbursement forms are available on our website: https://psa.pacificsource.com/Forms/.
- Your medical and dental group health plan provides you an EOB whenever you have a billable service.
- If you have misplaced your EOB, call the medical or dental group health plan's customer service department and request a copy or you may be able to receive a copy from their online system for members.

Forms, Fliers and instructions

Available online. Examples include:

- FSA Participant Guide (general information)
- Request for Reimbursement Forms
- Direct Deposit Form
- Examples of Eligible Expenses
- Online Claim Submission Instructions
- Prepaid Benefits Card Flier (Benny/Wex)
- Authorization to Disclose PHI

PSA Consumer Portal: Online Account Access for Participants

Manage your FSA from the convenience of your home or office by utilizing our website:
www.psa.pacificsource.com/PSA or https://psa.consumer.pacificsource.com

- File a claim online.
- Access information on the most recent reimbursement payments.
- View payment details.
- Check your account balances, annual election, and year-to-date deposits.
- Change your address and other personal information.
- View FAQs and fliers.

Basic Term Life / AD&D

Metropolitan Life Insurance Company

Plan Design for: Lane Council of Governments
Original Plan Effective Date: January 1, 2024
For All Active Full Time Employees working at least 20 hours per week

Basic Life	An amount equal to 2 times Your Basic Annual Earnings, rounded to the next higher $1,000.
Accidental Death & Dismemberment	An amount equal to Your Basic Life Insurance.
Plan Maximum	$100,000
Non-Medical Maximum	$100,000
Age Reduction Formula (reduces by)	Other
Employee Contribution • **Basic Life** • **AD&D**	 0% 0%

Term Life Features (1):

- Continuation of Life insurance while totally disabled as defined by the Group Policy (2)
- Accelerated Benefits Option (3)
- Life Settlement Account (4)
- Portability (5)
- Grief Counseling (6)
- Funeral Discounts and Planning Services (7)

Additional Features:

- WillsCenter.com (8)

AD&D Features (1):

- Seat Belt Benefit (9)
- Child Care Benefit
- Life Settlement Account (4)
- Air Bag Benefit
- Common Carrier Benefit

What Is Not Covered?
Like most insurance plans, this plan has exclusions. In addition, a reduction schedule may apply. Please see your benefits administrator or certificate for specific details.

Accidental Death & Dismemberment insurance does not include payment for any loss which is caused by or contributed to by: physical or mental illness, diagnosis of or treatment of the illness; an infection, unless caused by an external wound accidentally sustained; suicide or attempted suicide; injuring oneself on purpose; the voluntary intake or use by any means of any drug, medication or sedative, unless taken as prescribed by a doctor or an over-the-counter drug taken as directed; voluntary intake of alcohol in combination with any drug, medication or sedative; war, whether declared or undeclared, or act of war, insurrection, rebellion or riot; committing or trying to commit a felony; any poison, fumes or gas, voluntarily taken, administered or absorbed; service in the armed forces of any country or international authority, except the United States National Guard; operating, learning to operate, or serving as a member of a crew of an aircraft; while in any aircraft for the purpose of descent from such aircraft while in flight (except for self preservation); or operating a vehicle or device while intoxicated as defined by the laws of the jurisdiction in which the accident occurs.

Life and AD&D coverages are provided under a group insurance policy (Policy Form GPNP99 or G2130-S) issued to your employer by MetLife. Life and AD&D coverages under your employer's plan terminates when your employment ceases when your Life and AD&D contributions cease, or upon termination of the group insurance policy. Should your life insurance coverage terminate for reasons other than non-payment of premium, you may convert it to a MetLife individual permanent policy without providing medical evidence of insurability.

This summary provides an overview of your plan's benefits. These benefits are subject to the terms and conditions of the contract between MetLife and your employer. Specific details regarding these provisions can be found in the certificate. If you have additional questions regarding the Life Insurance program underwritten by MetLife, please contact your benefits administrator or MetLife. Like most group life insurance policies, MetLife group policies contain exclusions, limitations, terms and conditions for keeping them in force. Please see your certificate for complete details.

Nothing in these materials is intended to be advice for a particular person or individual. Please consult with your own advisors for such advice.

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(1) Features may vary depending on jurisdiction.
(2) Total disability or totally disabled means your inability to do your job and any other job for which you may be fit by education, training or experience, due to injury or sickness. Please note that this benefit is only available after you have participated in the Basic/Supplemental Term Life Plan for 1 year and it is only available to the employee.
(3) When life expectancy is certified by a physician to be 12 months or less. The Accelerated Benefits Option (ABO) is subject to state availability and regulation. The ABO benefits are intended to qualify for favorable federal tax treatment in which case the benefits will not be subject to federal taxation. This information was written as a supplement to the marketing of life insurance products. Tax laws relating to accelerated benefits are complex and limitations may apply. You are advised to consult with and rely on an independent tax advisor about your own particular circumstances. Receipt of ABO benefits may affect your eligibility, or that of your spouse or your family, for public assistance programs such as medical assistance (Medicaid), Temporary Assistance to Needy Families (TANF), Supplementary Social Security Income (SSI) and drug assistance programs. You are advised to consult with social service agencies concerning the effect that receipt of ABO benefits will have on public assistance eligibility for you, your spouse or your family.
(4) Subject to state law, and/or group policyholder direction, the Total Control Account is provided for all Life and AD&D benefits of $5,000 or more. The TCA is not insured by the Federal Deposit Insurance Corporation or any government agency. The assets backing TCA are maintained in MetLife's general account and are subject to MetLife's creditors. MetLife bears the investment risk of the assets backing the TCA, and expects to earn income sufficient to pay interest to TCA Accountholders and to provide a profit on the operation of the TCAs. Guarantees are subject to the financial strength and claims paying ability of MetLife.
(5) Subject to state availability. To take advantage of this benefit, coverage of at least $20,000 must be elected.
(6) Grief Counseling services are provided through an agreement with LifeWorks US Inc. LifeWorks is not an affiliate of MetLife, and the services LifeWorks provides are separate and apart from the insurance provided by MetLife. LifeWorks has a nationwide network of over 30,000 counselors. Counselors have masters or doctoral degrees and are licensed professionals. The Grief Counseling program does not provide support for issues such as: domestic issues, parenting issues, or marital/relationship issues (other than a finalized divorce). For such issues, members should inquire with their human resources department about available company resources. This program is available to insureds, their dependents and beneficiaries who have received a serious medical diagnosis or suffered a loss. Events that may result in a loss are not covered under this program unless and until such loss has occurred. Services are not available in all jurisdictions and are subject to regulatory approval. Not available on all policy forms.
(7) Services and discounts are provided through a member of the Dignity Memorial® Network, a brand name used to identify a network of licensed funeral, cremation and cemetery providers that are affiliates of Service Corporation International (together with its affiliates, "SCI"), 1929 Allen Parkway, Houston, Texas. The online planning site is provided by SCI Shared Resources, LLC. SCI is

not affiliated with MetLife, and the services provided by Dignity Memorial members are separate and apart from the insurance provided by MetLife. Not available in some states. Planning services, expert assistance, and bereavement travel services are available to anyone regardless of affiliation with MetLife. Discounts through Dignity Memorial's network of funeral providers are pre-negotiated. Not available where prohibited by law. If the group policy is issued in an approved state, the discount is available for services held in any state except KY and NY, or where there is no Dignity Memorial presence (AK, MT, ND, SD, and WY). For MI and TN, the discount is available for "At Need" services only. Not approved in AK, FL, KY, MT, ND, NY and WA.

(8) WillsCenter.com is a document service provided by SmartLegalForms, Inc., an affiliate of Epoq Group, Ltd. SmartLegalForms, Inc. is not affiliated with MetLife and the WillsCenter.com service is separate and apart from any insurance or service provided by MetLife. The WillsCenter.com service does not provide access to an attorney, does not provide legal advice, and may not be suitable for your specific needs. Please consult with your financial, legal, and tax advisors for advice with respect to such matters.

(9) The Seat Belt Benefit is payable if an insured person dies as a result of injuries sustained in an accident while driving or riding in a private passenger car and wearing a properly fastened seat belt _or a child restraint if the insured is a child_. In such case, his or her benefit can be increased by 10 percent of the Full Amount — but not less than $1,000 or more than $25,000.

Supplemental Term Life

Metropolitan Life Insurance Company

Plan Design for: Lane Council of Governments
Original Plan Effective Date: January 1, 2024
For All Active Full Time Employees working at least 20 hours per week

Build Your Benefit With MetLife's Supplemental Term Life insurance, your employer gives you the opportunity to buy valuable life insurance coverage for yourself, your spouse and your dependent children -- all at affordable group rates.

	Employee	Spouse & Child	
		Spouse[1]	Child
Life Coverage: provides a benefit in the event of death Schedules:	Increments of $10,000	Increments of $5,000	Flat Amount: $1,000, $2,000, $4,000, $5,000, or $10,000
Non Medical Maximum	$100,000	$25,000	$10,000
Overall Benefit Maximum	$500,000	$250,000	$10,000
AD&D Coverage: provides a benefit in the event of death or dismemberment resulting from a covered accident Schedules:	Yes (benefit amount is same as Supplemental Term Life coverage)	Yes (benefit amount is same as Supplemental Term Life coverage)	Yes (benefit amount is same as Supplemental Term Life coverage)
AD&D Maximum	Maximum amount is same as Supplemental Term Life coverage	Maximum amount is same as Supplemental Term Life coverage	Maximum amount is same as Supplemental Term Life coverage
Employee Contribution	100%	100%	100%

Any purchase or increase in benefits, which does not take place within 31 days of employee's or dependent's eligibility effective date is subject to evidence of insurability. Coverage is subject to the approval of MetLife.

To request coverage:

1. Choose the amount of employee coverage that you want to buy.
2. Look up the premium costs for your age group for the coverage amount you are selecting on the chart below.
3. Choose the amount of coverage you want to buy for your spouse. Again, find the premium costs on the chart below. Note: Premiums are based on your age, not your spouse's.
4. Choose the amount of coverage you want to buy for your dependent children. The premium costs for each coverage option are shown below.
5. Fill in the enrollment form with the amounts of coverage you are selecting. (To request coverage over the non-medical maximum, please see your Human Resources representative for a medical questionnaire that you will need to complete.) Remember, you must purchase coverage for yourself in order to purchase coverage for your spouse or children.

Employee Age	Employee & Spouse Coverage -- Monthly Premium For:						
	$1,000	**$10,000**	**$20,000**	**$40,000**	**$50,000**	**$100,000**	
Under 30	$0.10	$0.99	$1.98	$3.96	$4.95	$9.90	
30-34	$0.11	$1.10	$2.20	$4.40	$5.50	$11.00	
35-39	$0.14	$1.41	$2.82	$5.64	$7.05	$14.10	
40-44	$0.20	$1.98	$3.96	$7.92	$9.90	$19.80	
45-49	$0.29	$2.95	$5.90	$11.80	$14.75	$29.50	
50-54	$0.46	$4.57	$9.14	$18.28	$22.85	$45.70	
55-59	$0.70	$7.05	$14.10	$28.20	$35.25	$70.50	
60-64	$0.95	$9.51	$19.02	$38.04	$47.55	$95.10	
65-69	$1.58	$15.76	$31.52	$63.04	$78.80	$157.60	
70+	$3.11	$31.06	$62.12	$124.24	$155.30	$310.60	

Due to rounding, your actual payroll deduction amount may vary slightly.

Dependent Child Coverage[2] Monthly Premium For:	
$1,000	$0.29
$2,000	$0.58
$4,000	$1.16
$5,000	$1.46
$10,000	$2.91

Features available with Supplemental Life

Grief Counseling[3]: You, your dependents, and your beneficiaries access to grief counseling sessions and funeral related concierge services to help cope with a loss – at no extra cost. Grief counseling services provide confidential and professional support during a difficult time to help address personal and funeral planning needs. At your time of need, you and your dependents have 24/7 access to a work/life counselor. You simply call a dedicated 24/7 toll-free number to speak with a licensed professional experienced in helping individuals who have suffered a loss. Sessions can either take place in-person or by phone. You can have up to five face-to-face grief counseling sessions per event to discuss any situation you perceive as a major loss, including but not limited to death, bankruptcy, divorce, terminal illness, or losing a pet.3 In addition, you have access to funeral assistance for locating funeral homes and cemetery options, obtaining funeral cost estimates and comparisons, and more. You can access these services by calling 1-1-888-319-7819 or log on to www.metlifegc.lifeworks.com (Username: metlifeassist; Password: support).

Funeral Discounts and Planning Services[4]: As a MetLife group life policyholder, you and your family may have access to funeral discounts, planning and support to help honor a loved one's life - at no additional cost to you. Dignity Memorial provides you and your loved ones access to discounts of up to 10% off of funeral, cremation and cemetery services through the largest network of funeral homes and cemeteries in the United States.

When using the Dignity Memorial Network you have access to convenient planning services - either online at www.finalwishesplanning.com, by phone (1-866-853-0954), or by paper - to help make final wishes easier to manage. You also have access to assistance from compassionate funeral planning experts to help guide you and your family in making confident decisions when planning ahead as well as bereavement travel services - available 24 hours, 7 days a week, 365 days a year - to assist with time-sensitive travel arrangements to be with loved ones.

Digital Estate Planning[7]: Helping to ensure final wishes are clear. Employees can choose to complete wills and other important estate planning documents quickly and easily online with access to online notary services.

Will Preparation[5]:Like life insurance, a carefully prepared Will is important. With a Will, you can define your most important decisions such as who will care for your children or inherit your property. By enrolling for Supplemental Term Life coverage, you will have in person access to MetLife Legal Plans' network of 18,000+ participating attorneys for preparing or updating a will, living will and power of attorney. When you enroll in this plan, you may take advantage of this benefit at no additional cost to you if you use a participating plan attorney. To obtain the legal plan's toll-free number and your company's group access number, contact your employer or your plan administrator for this information.

MetLife Estate Resolution Services (ERS)[4] :is a valuable service offered under the group policy. A MetLife Legal Plan attorney will consult with your beneficiaries by telephone or in person regarding the probate process for your estate. The attorney will also handle the probate of your estate for your executor or administrator.. This can help alleviate the financial and administrative burden upon your loved ones in their time of need.

Portability[6]: Should you leave [Customer Name] for any reason, and your Basic and Supplemental/Optional and Dependent Term Life and Personal and Supplemental/Optional and Dependent and Voluntary Accidental Death and Dismemberment insurance under this plan terminates, you will have an opportunity to continue group term coverage ("portability") under a different policy, subject to plan design and state availability. Rates will be based on the experience of the ported group and MetLife will bill you directly. Rates may be higher than your current rates. To take advantage of this feature, you must have coverage of at least[$10,000 NewPort] [$20,000 Enhanced Port] up to a maximum of [$2,000,000 NewPort] [$1,000,000 Enhanced Port].

What Is Not Covered?

Like most insurance plans, this plan has exclusions. Supplemental and Dependent Life Insurance do not provide payment of benefits for death caused by suicide within the first two years (one year in North Dakota) of the effective date of the certificate, or payment of increased benefits for death caused by suicide within two years (one year in North Dakota or Colorado) of an increase in coverage. In addition, a reduction schedule may apply. Please see your benefits administrator or certificate for specific details.

Accidental Death & Dismemberment insurance does not include payment for any loss which is caused by or contributed to by: physical or mental illness, diagnosis of or treatment of the illness; an infection, unless caused by an external wound accidentally sustained; suicide or attempted suicide; injuring oneself on purpose; the voluntary intake or use by any means of any drug, medication or sedative, unless taken as prescribed by a doctor or an over-the-counter drug taken as directed; voluntary intake of alcohol in combination with any drug, medication or sedative; war, whether declared or undeclared, or act of war, insurrection, rebellion or riot; committing or trying to commit a felony; any poison, fumes or gas, voluntarily taken, administered or absorbed; service in the armed forces of any country or international authority, except the United States National Guard; operating, learning to operate, or serving as a member of a crew of an aircraft; while in any aircraft for the purpose of descent from such aircraft while in flight (except for self preservation); or operating a vehicle or device while intoxicated as defined by the laws of the jurisdiction in which the accident occurs.

Life and AD&D coverages are provided under a group insurance policy (Policy Form GPN99/G2130-S) issued to your employer by MetLife. Life and AD&D coverages under your employer's plan terminates when your employment ceases, when your Life and AD&D contributions cease, or upon termination of the group insurance policy. Dependent Life coverage will terminate when a dependent no longer qualifies as a dependent or when a dependent spouse reaches age 70. Should your life insurance coverage terminate, for reasons other than non-payment of premium, you may convert it to a MetLife individual permanent policy without providing medical evidence of insurability.

This summary provides an overview of your plan's benefits. These benefits are subject to the terms and conditions of the contract between MetLife and your employer and are subject to each state's laws and availability. Specific details regarding these provisions can be found in the certificate.

If you have additional questions regarding the Life Insurance program underwritten by MetLife, please contact your benefits administrator or MetLife. Like most group life insurance policies, MetLife group policies contain exclusions, limitations, terms and conditions for keeping them in force. Please see your certificate for complete details.

1. Spouse amount cannot exceed 50% of the employee's Supplemental Life benefit.
2. Child benefits for children under 6 months old are limited.
3. Grief Counseling services are provided through an agreement with LifeWorks US Inc. LifeWorks is not an affiliate of MetLife, and the services LifeWorks provides are separate and apart from the insurance provided by MetLife. LifeWorks has a nationwide network of over 30,000 counselors. Counselors have master's or doctoral degrees and are licensed professionals. The Grief Counseling program does not provide support for issues such as: domestic issues, parenting issues, or marital/relationship issues (other than a finalized divorce). For such issues, members should inquire with their human resources department about available company resources. This program is available to insureds, their dependents and beneficiaries who have received a serious medical diagnosis or suffered a loss. Events that may result in a loss are not covered under this program unless and until such loss has occurred. Services are not available in all jurisdictions and are subject to regulatory approval. Not available on all policy forms.
4. Services and discounts are provided through a member of the Dignity Memorial® Network, a brand name used to identify a network of licensed funeral, cremation and cemetery providers that are affiliates of Service Corporation International (together with its affiliates, "SCI"), 1929 Allen Parkway, Houston, Texas. The online planning site is provided by SCI Shared Resources, LLC. SCI is not affiliated with MetLife, and the services provided by Dignity Memorial members are separate and apart from the insurance provided by MetLife. Not available in some states. Planning services, expert assistance, and bereavement travel services are available to anyone regardless of affiliation with MetLife. Discounts through Dignity Memorial's network of funeral providers are pre-negotiated. Not available where prohibited by law. Not approved for group policies situsued in AK, FL, KY, MT, ND, NY and WA. If the group policy is issued in an approved state, the discount is available for services offered in any state except KY and NY, or where there is no Dignity Memorial presence (AK, MT, ND, SD, and WY). For MI and TN, the discount is available for "At Need" services only.
5. Will Preparation and Estate Resolution Services are offered by MetLife Legal Plans, Inc., Cleveland, Ohio. In certain states, legal services benefits are provided through insurance coverage underwritten by Metropolitan General Insurance Company, Warwick, Rhode Island. For New York situsued cases, the Will Preparation service is an expanded offering that includes office consultations and telephone advice for certain other legal matters beyond Will Preparation. Tax Planning and preparation of Living Trusts are not covered by the Will Preparation Service.
   Certain services are not covered by Estate Resolution Services, including matters in which there is a conflict of interest between the executor and any beneficiary or heir and the estate; any disputes with the group policyholder, MetLife and/ or any of its affiliates; any disputes involving statutory benefits; will contests or litigation outside probate court; appeals; court costs, filing fees, recording fees, transcripts, witness fees, expenses to a third party, judgments or fines; and frivolous or unethical matters.

6. All coverage amounts are subject to applicable state laws. To take advantage of this benefit, coverage of at least [$10,000][$20,000] must be elected.

7. Digital Estate Planning is not available for customers situsedin FL or located in GU, PR and VI. It is not included with dependent life coverages. Domestic Partnerships are not currently supported however members in a domestic partnership may use a MetLife Legal Plans attorney for their planning needs. Online Notary is not available in all states. Group legal plans are provided by MetLife Legal Plans, Inc., Cleveland, OH. In certain states, group legal plans are provided through insurance coverage underwritten by Metropolitan General Insurance Company and Affiliates, Warwick, RI.

   Nothing in these materials is intended to be advice for a particular situation or individual. Please consult with your own advisors for such advice. Like most group insurance policies, insurance policies offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Please contact your benefits administrator or MetLife for costs and complete details.

Short Term Disability

Metropolitan Life Insurance Company

Lane Council of Governments Plan Benefits
Original Plan Effective Date: January 1, 2024

Explore the coverage that helps you protect your income and your lifestyle.

What is Short Term Disability insurance?

Short Term Disability (STD) insurance may help you replace a portion of your income during the initial weeks of a Disability.

Eligibility Requirements

Short Term Disability:
All Active Full Time Employees working at least 20 hours per week are eligible to participate.

How is "Disability" defined under the Plan?

Generally, you are considered disabled and eligible for short term benefits if, due to sickness, pregnancy or accidental injury, you are receiving appropriate care and treatment and are complying with the requirements of the treatment and you are unable to earn more than 80% of your predisability earnings at your own occupation.

For a complete description of this and other requirements that must be met, refer to the Certificate of Insurance/Summary Plan Description provided by your Employer or contact your MetLife benefits administrator with any questions.

What is the benefit amount?

Short Term Disability:

The Short Term Disability benefit may help replace a portion of your predisability earnings, less the income that was actually paid to you for the same Disability from other sources[1] (e.g., state disability benefits, no-fault auto laws, sick pay, vacation pay etc.).

The Benefit amount is 60% of your predisability weekly earnings subject to the plan's maximum weekly benefit of $1,000.

Special Considerations

If you work in a state with state-mandated disability or paid medical leave benefits (“State Benefits”), you should carefully consider whether to enroll for this coverage. In California, Connecticut Hawaii, Massachusetts, New Jersey, New York, Puerto Rico, Rhode Island, Washington (Oregon starting 9/3/23, and Colorado starting 1/1/24), if eligible, you must apply for State Benefits. Your STD benefit will be reduced by State Benefits or other government benefits that apply. Depending on your compensation, the amount of the State Benefit, and other factors, you may only receive the minimum weekly benefit. Please consider, based on your individual circumstances, whether you need additional coverage beyond the State Benefit.

When do benefits begin and how long do they continue?

Short Term Disability:

Benefits begin after the end of the elimination period. The elimination period begins on the day you become disabled and is the length of time you must wait, while disabled, before you are eligible to receive a benefit. The elimination period is as follows:

For Injury: 7 days.

For Sickness (includes pregnancy): 7 days.

Benefits continue for as long as you are disabled up to a maximum duration of 12 weeks of Disability.

Your plan's maximum benefit period and any specific limitations are described in the Certificate of Insurance/Summary Plan Description provided by your Employer.

Additional Disability Plan Benefits:

Coverage with Your Best Interests in Mind...

When you are ill or injured for a short period, MetLife believes you need more than a supplement to your income. That's why we offer return-to-work services, and financial incentives.

Services to Help You Get Back to Work Can Include:

Nurse Consultant or Case Manager Services:
Specialists who personally contact you, your physician and your employer to coordinate an early return-to-work plan when appropriate.

Vocational Analysis:
Help with identifying job requirements and determining how your skills can be applied to a new or modified job with your employer.

Job Modifications:
Adjustments (e.g., redesign of work station tools) that enable you to return to work.

Retraining:
Development programs to help you return to your previous job or educate you for a new one.

Financial Incentives:
Allow you to receive Disability benefits or partial benefits while attempting to return to work

Answers to Some Important Questions...

Q. Can I still receive benefits if I return to work part time?

A. Yes. As long as you are disabled and meet the terms of your Disability plan, you may qualify for adjusted Disability benefits.

Your plan offers financial and Rehabilitation incentives designed to help you to return to work when appropriate, even on a part-time basis when you participate in an approved Rehabilitation Program. While disabled, you may receive up to 100% of your predisability earnings when combining benefits, Rehabilitation Incentives and other income sources such as Social Security Disability Benefits and State Disability Benefits, and part-time earnings.

With the Rehabilitation Incentive you can get a 10% increase in your weekly benefit.
Following the 4th weekly benefit payment, the Family Care Incentive provides reimbursement up to $100 per week for eligible expenses, such as child care.
You may be eligible for the Moving Expense Incentive if you incur expenses in order to move to a new residence recommended as part of the Rehabilitation Program. Expenses must be approved in advance.

Q. Is there a pre-existing conditions provision?

A. Yes. Your plan may not cover a sickness or accidental injury that arose in the months prior to your participation in the plan. A complete description of the pre-existing condition exclusion is included in the Certificate of Insurance/Summary Plan Description provided by your Employer or contact your MetLife benefits administrator with any questions.

Q. Are there any exclusions to my coverage?

A. Yes. Your plan does not cover any Disability which results from or is caused or contributed to by:

- Elective treatment or procedures, such as cosmetic surgery, reversal of sterilization, liposuction, visual correction surgery or in vitro fertilization, embryo transfer procedure, artificial insemination, or other specific procedures. However, pregnancies and complications from any of these procedures will be treated as a sickness.
- War, whether declared or undeclared, or act of war, insurrection or rebellion;
- Active participation in a riot;
- Intentionally self-inflicted injury or attempted suicide;
- Commission of or attempt to commit a felony.

Additionally, no payment will be made for a Disability caused or contributed to by any injury or sickness for which you are entitled to benefits under Workers' Compensation or a similar law.

Other limitations or exclusions to your coverage may apply. Please review your Certificate of Insurance for specific details or contact your benefits administrator with any questions.

The "Plan Benefits" provides only a brief overview of the STD plan. A more complete description of the benefits provisions, conditions, limitations, and exclusions will be included in the Certificate of Insurance. If any discrepancies exist between this information and the legal plan documents, the legal plan documents will govern.

Short Term Disability ("STD") coverage is provided under a group insurance policy (Form GPNP99) issued to your employer by MetLife. This STD coverage terminates when your employment ceases, when you cease to be an eligible employee, when your STD contributions cease (if applicable) or upon termination of the group contract by your employer. Like most insurance policies, insurance policies offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations, and terms for keeping them in force. Please contact MetLife or your plan administrator for complete details. State variations may apply.

[1] Under certain circumstances, MetLife may estimate the amount of income you may receive from other sources.

Long Term Disability

Metropolitan Life Insurance Company

Lane Council of Governments Plan Benefits
Original Plan Effective Date: January 1, 2024

Explore the coverage that helps you protect your income and your lifestyle.

What is Long Term Disability insurance?

Long Term Disability (LTD) insurance helps replace a portion of your income for an extended period of time.

Eligibility Requirements

Long Term Disability:
All Active Full Time Employees working at least 20 hours per week are eligible to participate.

How is "Disability" defined under the Plan?

Generally, you are considered disabled and eligible for long term benefits if due to sickness, pregnancy or accidental injury, you are receiving appropriate care and treatment and are complying with the requirements of the treatment and you are unable to perform each of the material duties of your own occupation for any employer in your local economy.

Following the Own Occupation period, you are considered disabled if, due to sickness, pregnancy or accidental injury, you are receiving appropriate care and treatment and complying with the requirements of the treatment and you are unable to perform the duties of any gainful occupation for which you are reasonably qualified taking into account your training, education and experience for any employer in your local ecomony.

For a complete description of this and other requirements that must be met, refer to the Certificate of Insurance/Summary Plan Description provided by your Employer or contact your MetLife benefits administrator with any questions.

What is the benefit amount?

Long Term Disability:

The Long Term Disability benefit replaces a portion of your predisability monthly earnings, less other income you may receive from other sources[1] during the same Disability (e.g., Social Security, Workers' Compensation, vacation pay etc.).

The Benefit amount is 66.67% of your predisability monthly earnings.

What is the maximum monthly benefit?

The amount of Long Term Disability benefit may not exceed the maximum monthly benefit established under the plan, regardless of your annual salary amount. The maximum under this plan is $5,000.

When do benefits begin and how long do they continue?

Long Term Disability:

Benefits begin after the end of the elimination period. The elimination period begins on the day you become disabled and is the length of time you must wait while being disabled before you are eligible to receive a benefit. Your elimination period for Long Term Disability is 90 days.

Your plan's maximum benefit period and any specific limitations are described in the Certificate of Insurance provided by your Employer.

Additional Disability Plan Benefits:

Coverage with Your Best Interests in Mind…

When you are ill or injured for a long time, MetLife® believes you need more than a supplement to your income. That's why we offer return-to-work services and financial incentives and assistance in obtaining Social Security Disability Benefits to help you get the maximum benefits from your coverage.

Services to Help You Get Back to Work Can Include:

Nurse Consultant or Case Manager Services:
Specialists who personally contact you, your physician and your employer to coordinate an early return-to-work plan when appropriate.

Vocational Analysis:
Help with identifying job requirements and determining how your skills can be applied to a new or modified job with your employer.

Job Modifications:
Adjustments (e.g., redesign of work station tools) that enable you to return to work.

Retraining:
Development programs to help you return to your previous job or educate you for a new one.

Financial Incentives:
Allow employees to receive Disability benefits or partial benefits while attempting to return to work.

The Services of Social Security Specialists:
Once you are approved for Disability benefits, Metlife can help you obtain Social Security Disability benefits. Our specialists can guide you through the initial application and appeals processes and may also help you access legal assistance from attorneys or vendors to pursue Social Security benefits.

Answers to Some Important Questions…

Q. Can I still receive benefits if I return to work part time?

A. Yes. As long as you are disabled and meet the terms of your Disability plan, you may qualify for adjusted disability benefits.

Your plan offers financial and Rehabilitation incentives designed to help you to return to work when appropriate, even on a part-time basis when you participate in an approved Rehabilitation Program. While disabled, you may receive up to 100% of your predisability earnings when combining benefits, Rehabilitation Incentives and other income sources such as Social Security Disability Benefits and state disability benefits, and part-time earnings.

With the Rehabilitation Incentive you can get a 10% increase in your monthly benefit.

The Family Care Incentive provides reimbursement up to $400 per month for eligible expenses, such as child care during the first 24 months of disability.

You may be eligible for the Moving Expense Incentive if you incur expenses in order to move to a new residence recommended as part of the Rehabilitation Program. Expenses must be approved in advance.

Q. Is there a pre-existing conditions provision?

A. Yes. Your plan may not cover a sickness or accidental injury that arose in the months prior to your participation in the plan. A complete description of the pre-existing condition exclusion is included in the Certificate of Insurance/Summary Plan Description provided by your Employer.

Q. Are there any exclusions to my coverage?

A. Yes. Your plan does not cover any Disability which results from or is caused or contributed to by:

- War, whether declared or undeclared, or act of war, insurrection or rebellion;
- Active participation in a riot;
- Intentionally self-inflicted injury or attempted suicide;
- Commission of or attempt to commit a felony.

For Long Term Disability, limited benefits apply for specific conditions, such as, mental or nervous disorders or diseases, alcohol, drug, or substance abuse or addiction.

Other limitations or exclusions to your coverage may apply. Please review your Certificate of Insurance provided by your Employer for specific details or contact your benefits administrator with any questions.

The "Plan Benefits" provides only a brief overview of the LTD plan. A more complete description of the benefits provisions, conditions, limitations, and exclusions will be included in the Certificate of Insurance. If any discrepancies exist between this information and the legal plan documents, the legal plan documents will govern.

Long Term Disability ("LTD") coverage is provided under a group insurance policy (Form GPNP99) issued to your employer by MetLife. This LTD coverage terminates when your employment ceases, when you cease to be an eligible employee, when your LTD contributions cease (if applicable) or upon termination of the group contract by your employer. Like most insurance policies, insurance policies offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations, and terms for keeping them in force. Please contact MetLife or your plan administrator for complete details. State variations may apply.

[1] Under certain circumstances, MetLife may estimate the amount of income you may receive from other sources.

Accident Insurance

Benefits that may help cover costs such as those not covered by your medical plan.

Lane Council of Governments

Accident Insurance Benefits

With MetLife, you'll have a choice of two plans (called the "Low Plan" and the "High Plan") that provide payments in addition to any other insurance payments you may receive[1]. Here are just some of the covered events/services[2].

Benefit Type	Low Plan Benefits	High Plan Benefits
Accidental Injury Benefits		
Fracture Benefit*	$100 – $8,000 depending on the fracture and type of repair	$200 – $10,000 depending on the fracture and type of repair
Dislocation Benefit*	$100 – $8,000 depending on the dislocation and type of repair	$200 – $10,000 depending on the dislocation and type of repair
Second or Third Degree Burn Benefit	$75 – $10,000 depending on the degree of the burn and the percentage of burnt skin	$100 – $20,000 depending on the degree of the burn and the percentage of burnt skin
Concussion Benefit	$250	$500
Coma Benefit	$10,000	$15,000
Laceration Benefit	$50 – $400 depending on the length of the cut and type of repair	$75 – $700 depending on the length of the cut and type of repair
Broken Tooth Benefit	Crown: $300 Filling: $25 Extraction: $75	Crown: $400 Filling: $50 Extraction: $150
Eye Injury Benefit	$100	$200
Accident - Medical Services & Treatment Benefits		
Ambulance Benefit	Ground: $300 Air: $1,000	Ground: $400 Air: $2,000
Emergency Care Benefit	$75 – $150 depending on location of care	$100 – $300 depending on location of care
Non-Emergency Initial Care Benefit	$75	$100
Physician Follow-Up Visit Benefit	$100	$150
Therapy Services Benefit (including physical therapy)	$35	$50
Medical Testing Benefit	X-rays: $50 All other tests: $200	X-rays: $75 All other tests: $400
Medical Appliance Benefit	$75 – $750 depending on the appliance	$150 – $1,000 depending on the appliance
Transportation Benefit	$300	$400
Pain Management Benefit (for epidural anesthesia)	$75	$100
Prosthetic Device Benefit	One device: $750 More than one device: $1,500	One device: $1,000 More than one device: $2,000
Modification Benefit	$1,000	$1,500
Blood/Plasma/Platelets Benefit	$400	$500

MetLife

ADF# AI2166.19

Accident Insurance

Surgical Repair Benefit	$150 – $1,500 depending on the type of surgery	$200 – $2,000 depending on the type of surgery
Exploratory Surgery Benefit	$150	$200
Other Outpatient Surgery Benefit	$300	$400
Hospital Benefits		
Admission Benefit	$1,000 for the day of admission	$2,000 for the day of admission
ICU Supplemental Admission Benefit	$500 for the day of admission	$1,000 for the day of admission
Confinement Benefit (paid for up to 365 days per accident)	$200 per day	$300 per day
ICU Supplemental Confinement Benefit (paid for up to 30 days per accident)	$200 per day	$300 per day
Inpatient Rehabilitation Benefit (paid for up to 30 days per accident)	$150 per day	$200 per day
Accidental Death Benefit		
Accidental Death Benefit*	$50,000 $100,000 for accidental death on common carrier	$100,000 $200,000 for accidental death on common carrier
Accidental Dismemberment, Functional Loss & Paralysis Benefits		
Dismemberment/Functional Loss	$750 – $20,000 depending on the injury	$1,000 – $40,000 depending on the injury
Paralysis	$10,000 – $20,000 depending on the number of limbs	$20,000 – $40,000 depending on the number of limbs
Other Benefits		
Health Screening Benefit* - benefit provided for certain screening/prevention tests	$50 Paid 1 time per calendar year	$50 Paid 1 time per calendar year
Lodging Benefit* - for a companion of a covered person who is hospitalized	$100 per day	$200 per day
Waiver of Premium Benefit – if you become disabled, premiums will be waived if requirements for waiver are met	Not Included	Not Included

Organized Sports Activity Injury Benefit Rider
This coverage includes an Organized Sports Activity Benefit Rider. The rider increases the amount payable under the Certificate for certain benefits by 25% for injuries resulting from an accident that occurred while participating as a player in an organized sports activity. The rider sets forth terms, conditions and limitations, including the covered persons to whom the rider applies.

* Notes Regarding Certain Benefits

- Fracture and Dislocation benefits - Chip fractures are paid at 25% of the applicable fracture benefit and partial dislocations are paid at 25% of the applicable dislocation benefit.
- Accidental Death Benefit – The benefit amount will be reduced by the amount of any accidental dismemberment/functional loss/paralysis benefits and modification benefit paid for injuries sustained by the covered person in the same accident for which the accidental death benefit is being paid.
- Accidental Death Benefit – Common carrier refers to airplanes, trains, buses, trolleys, subways and boats.
- In certain states, the Health Screening Benefit is provided by MetLife Consumer Services as a separate service and is not part of the insurance coverage. This does not impact the Health Screening Benefit's availability, cost, or the way in which the service is accessed. The covered health screenings are: Routine health check-up exam (annual physical exam), biopsies for cancer, blood chemistry panel, blood test to determine total cholesterol, blood test to determine triglycerides, bone marrow testing, breast MRI, breast ultrasound, breast sonogram, cancer antigen 15-3 blood

test for breast cancer (CA 15-3), cancer antigen 125 blood test for ovarian cancer (CA 125), carcinoembryonic antigen blood test for colon cancer (CEA), carotid doppler, complete blood count (CBC), chest x-rays, clinical testicular exam, colonoscopy, coronavirus testing, dental exam , digital rectal exam (DRE), Doppler screening for cancer, Doppler screening for peripheral vascular disease, Echocardiogram, electrocardiogram (EKG), electroencephalogram (EEG), endoscopy, eye exam, fasting blood glucose test, fasting plasma glucose test, flexible sigmoidoscopy, hearing test, hemoccult stool specimen, hemoglobin A1C, human papillomavirus (HPV) vaccination, immunization, lipid panel, mammogram, oral cancer screening, pap smears or thin prep pap test, prostate-specific antigen (PSA) test, serum cholesterol test to determine LDL and HDL levels, serum protein electrophoresis, skin cancer biopsy, skin cancer screening, skin exam, stress test on bicycle or treadmill , successful completion of smoking cessation program, tests for sexually transmitted infections (STIs), thermography , two hour post-load plasma glucose test, ultrasounds for cancer detection, ultrasound screening of the abdominal aorta for abdominal aortic aneurysms and virtual colonoscopy.

- Lodging Benefit - The lodging must be at least 50 miles from the insured's primary residence.

Benefit Payment Example

Kathy's daughter, Molly, was riding her bike to school. On her way there she fell to the ground, was knocked unconscious, and was taken to the local emergency room (ER) by ambulance for treatment. The ER doctor diagnosed a concussion and a broken tooth. He ordered a CT scan to check for facial fractures too, since Molly's face was very swollen. Molly was released to her primary care physician for follow-up treatment, and her dentist repaired her broken tooth with a crown. Depending on her health insurance, Kathy's out-of-pocket costs could run into hundreds of dollars to cover expenses like insurance co-payments and deductibles. MetLife Group Accident Insurance payments can be used to help cover these unexpected costs.

Covered Event[3]	Benefit Amount
Ambulance (ground)	**$400**
Emergency Care	**$300**
Physician Follow-Up ($150 x 2)	**$300**
Medical Testing	**$400**
Concussion	**$500**
Broken Tooth (repaired by crown)	**$400**
Benefits paid by MetLife Group Accident Insurance	**$2,300**

Benefit amount is based on a sample MetLife plan design. Actual plan design and benefits may vary.

Questions & Answers

Q. Who is eligible to enroll for this accident coverage?

A. You are eligible to enroll yourself and your eligible family members![4] You need to enroll during your Enrollment Period and to be actively at work for your coverage to be effective.

Q. How do I pay for my accident coverage?

A. Premiums will be paid through payroll deduction, so you don't have to worry about writing a check or missing a payment.

Q. What happens if my employment status changes? Can I take my coverage with me?

A. Yes, you can take your coverage with you.[5] You will need to continue to pay your premiums to keep your coverage in force. Your coverage will only end if you stop paying your premium or if your employer offers you similar coverage with a different insurance carrier.

Q. Who do I call for assistance?

A. Contact a MetLife Customer Service Representative at 1 800- GET-MET8 (1-800-438-6388), Monday through Friday from 8:00 a.m. to 8:00 p.m., EST. Or visit our website: mybenefits.metlife.com.

Insurance Rates

MetLife offers group rates and payroll deduction, so you don't have to worry about writing a check or missing a payment! Your employee rates are outlined below.

Accident Insurance	Monthly Cost to You	
Coverage Options	Low Plan	High Plan

Accident Insurance

Employee	$13.05	$20.38
Employee & Spouse	$25.55	$39.71
Employee & Child(ren)	$30.52	$47.25
Employee & Spouse/Child(ren)	$36.09	$55.92

[1] Covered services/treatments must be the result of a covered accident or sickness as defined in the group policy/certificate. See your Disclosure Statement or Outline of Coverage/Disclosure Document for full details.
[2] Availability of benefits varies by state. See your Disclosure Statement or Outline of Coverage/Disclosure Document for state variations.
[3] Benefits and amounts are based on sample MetLife plan design. Plan design and plan benefits may vary.
[4] Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Children may be covered to age 26. There are benefit reductions that may begin at age 65.
[5 Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.]

METLIFE'S ACCIDENT INSURANCE IS A LIMITED BENEFIT GROUP INSURANCE POLICY. The policy is not intended to be a substitute for medical coverage and certain states may require the insured to have medical coverage to enroll for the coverage. The policy or its provisions may vary or be unavailable in some states.Like most group accident and health insurance policies, policies offered by MetLife may include waiting periods and contain certain exclusions, limitations and terms for keeping them in force. For complete details of coverage and availability, please refer to the group policy form GPNP12-AX or contact MetLife.

Benefits are underwritten by Metropolitan Life Insurance Company, New York, NY. Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See MetLife's Disclosure Statement or Outline of Coverage/Disclosure Document for full details.

Allstate SM
IDENTITY PROTECTION

stay connected, stay protected

Since so much of daily life is now spent online, it's more important than ever to stay connected. But more sharing online means more of your personal data may be at risk. In fact, 1 in 6 Americans were impacted by an identity crime in 2020.[1]

Identity theft can happen to anyone. That's why your company is offering you Allstate Identity Protection as a benefit. So you can be prepared and help protect your identity and finances from a growing range of threats.

For 90 years, Allstate has been protecting what matters most. Prepare for what's next with:

- Financial account and credit monitoring
- 24/7 alerts and fraud recovery
- Up to $1 million identity theft expense coverage†

Sign up during open enrollment

Questions? 1.800.789.2720

Plans and pricing

Allstate Identity Protection Pro+

$9.95 per person / month
$17.95 per family / month

1: 2021 Identity Fraud Study, Javelin Strategy & Research

With Allstate Identity Protection Pro+, get new and enhanced features designed to help you defend yourself from today's risks*

- See and control your personal data with privacy insights and privacy management in our unique tool, Allstate Digital Footprint℠
- Learn more about your risk potential by checking your Identity Health Status
- Receive personalized threat insights to help you protect yourself against the latest trends in scams and fraud
- Protect yourself and your loved ones with a family plan that includes senior family coverage for parents, in-laws, and grandparents over the age of 65 (everyone "under your roof and wallet")
- Get reimbursed for many of your out-of-pocket costs, with additional coverage for:
  - Home title fraud expense reimbursement up to $1 million†
  - Professional fraud expense reimbursement up to $1 million†
  - Stolen wallet emergency cash up to $500†

You'll also be able to:

- Monitor social media accounts for questionable content and signs of account takeover
- View and manage alerts in real time
- Catch fraud early with tri-bureau monitoring and an annual tri-bureau credit report and score
- Lock your TransUnion credit report in a click and get credit freeze assistance
- See if your IP addresses have been compromised
- Receive alerts for cash withdrawals, balance transfers, and large purchases
- Get reimbursed for fraud-related losses, like stolen 401(k) & HSA funds, with our identity theft expense coverage†

*Terms and conditions apply. Certain features require additional activation and will not be available until a later date. Product may be updated or modified prior to availability.

†Identity theft insurance covering expense and stolen funds reimbursement is underwritten by American Bankers Insurance Company of Florida, an Assurant company. The description herein is a summary intended for informational purposes only and does not include all terms, conditions and exclusions of the policies described. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions.

Allstate Identity Protection is offered and serviced by InfoArmor, Inc., a subsidiary of The Allstate Corporation.

It's easy to get started

1. **Choose your plan**
   You're protected from your effective date.
2. **Activate key features**
   Explore additional features in our easy-to-use portal.
3. **Live your best life online**
   We've got you covered with 24/7 alerts.

Allstate℠
IDENTITY PROTECTION

PLAN FEATURES

at a glance

Family protection	Pro+
Protection for family (“under roof, under wallet”)**	✓
Senior family coverage (parents, grandparents, and in-laws age 65+)**	✓
NEW FOR 2023 Elder fraud protection**	✓
- **NEW FOR 2023** Elder Fraud Center**	✓
- **NEW FOR 2023** Scam Support**	✓
NEW FOR 2023 Family digital safety tools**	✓
- **NEW FOR 2023** Web filtering**	✓
- **NEW FOR 2023** Screen time management**	✓
- **NEW FOR 2023** Parental monitoring**	✓
- **NEW FOR 2023** Location tracking**	✓
Deceased family member coverage† **	✓
Identity and financial monitoring	**Pro+**
Auto-on monitoring‡	✓
Rapid alerts	✓
ENHANCED Identity Health Status*	✓
Allstate Security Pro℠ emerging threats and scam alerts	✓
High-risk transaction monitoring	✓
Credit and debit card monitoring	✓
Bank account transaction monitoring	✓
401(k) and HSA account monitoring	✓
Student loan activity alerts	✓
Financial transaction monitoring	✓
Lost wallet protection	✓
Dark web monitoring	✓
Human-sourced intelligence	✓
Mobile app with biometric authentication security	✓
Social media account takeover monitoring	✓
Sex offender alerts	✓
Help Center	✓
IP address monitoring	✓
Privacy and data monitoring	**Pro+**
Allstate Digital Footprint℠	✓
- Personalized online account discovery	✓
- Privacy insights	✓
- Privacy management tools	✓
- Data breach notifications	✓
NEW FOR 2023 Robocall blocker	✓
NEW FOR 2023 Ad blocker	✓
Solicitation reduction	✓

Credit	Pro+
TransUnion credit monitoring	✓
Credit score tracking	✓
Unlimited TransUnion credit scores	✓
Credit freeze assistance	✓
Tri-bureau credit monitoring	✓
Credit lock (adults & minors)	✓
Annual tri-bureau report and score	✓
Credit report disputes	✓
Restoration	**Pro+**
U.S.-based, 24/7 customer care	✓
Full-service remediation support	✓
Remediation for pre-existing conditions	✓
NEW FOR 2023 Fraud resolution tracker	✓
Specialized unemployment fraud support	✓
Unemployment Fraud Center	✓
Stolen tax refund advance	✓
Financial protection	✓
- Identity theft expense reimbursement†	Up to $1M
- Stolen fund reimbursement†	Up to $1M
- 401(k)/HSA fraud reimbursement†	Up to $1M
- Deceased family member fraud expense reimbursement†**	Up to $1M
- Home title fraud expense reimbursement†	Up to $1M
- Professional fraud expense reimbursement†	Up to $1M
- Stolen wallet emergency cash†	Up to $500
Tap-to-call from mobile app	✓

* Available 1/1/2023

**Only available with a family plan.

‡Level of automatic monitoring dependent on enrollment method and information shared with Allstate Identity Protection

†Identity theft insurance covering expense and stolen funds reimbursement is underwritten by American Bankers Insurance Company of Florida, an Assurant company. The description herein is a summary and intended for informational purposes only and does not include all terms, conditions and exclusions of the policies described. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions.

Product may be updated or modified prior to availability. Certain features require additional activation.
Allstate Identity Protection is offered and serviced by InfoArmor, Inc., a subsidiary of The Allstate Corporation.

MetLife | Critical Illness Insurance

CIS citycounty insurance services

Why Critical Illness Insurance matters

Contrary to what many people believe, medical insurance may only cover a portion of the expenses associated with treating a serious illness. Plus, additional costs that often come with recovering, like childcare, transportation, and grocery delivery, may be left up to you. Critical Illness Insurance can provide you with a benefit that can help you pay for unexpected costs, such as those that your existing medical insurance may not cover.

Handling the emotions that come up when experiencing illnesses such as a cancer[1] diagnosis, heart attack,[2] or stroke[3] is difficult enough. Worrying about your financial stability on top of this can obviously be overwhelming. With Critical Illness Insurance, MetLife can help you and your family have the financial stability necessary to completely focus on healing during a difficult time.

When critical illness affects your family, you'll have the financial support when it matters most.

Help protect yourself, your family and your budget from the financial impact of a critical illness.

An example of how Critical Illness Insurance can help.

I never would have expected to suffer a heart attack. But one day while teaching English class, I felt an intense shortness of breath and pain in my jaw. Luckily, the school nurse called 911. The last thing I needed was to worry about was finances — I just had to focus on getting better. ***Critical Illness Insurance*** *helped me pay for things that medical insurance didn't cover, like specialist co-pays and extra help around the house, while I recovered.**

Enroll in Critical Illness Insurance during annual enrollment

Critical Illness Insurance

Get financial support when you or a loved one becomes seriously ill.

Help complete your healthcare coverage with Critical Illness Insurance.

Receive benefit payments directly and use the funds however you wish.

Financial support so you can focus on getting well.

Critical Illness Insurance is coverage that can help safeguard your finances by providing you with a lump-sum payment — one convenient payment all at once — when you or your family may need it most. The extra cash can help you focus on getting back on track — without worrying about finding the money to cover some of your expenses.

And best of all, the payment is made directly to you, and is made regardless of any other insurance you may have. It's yours to spend however you like, including for you or your family's everyday living expenses.

While recovering, Critical Illness Insurance is there to help make life a little easier.

When it comes to critical illnesses…

For less than the cost of your daily coffee,[4] you can get coverage for you and your family.

Your benefits in action

If you experience a critical illness, submitting a claim doesn't have to be difficult. Here's what to expect:

Call, visit **mybenefits.metlife.com** or download the MetLife Mobile App to view your certificate of insurance and initiate your claim.

Answer a few simple questions about what happened and upload your medical documentation to support your claim. Once we have everything, claims are typically processed within 10 business days. You only need one claim form per critical illness and every claim is reviewed by a claims professional.

Once your claim is approved, you'll receive a check made out to you to use however you like.

Enroll in Critical Illness Insurance during annual enrollment

Supplement your healthcare coverage with MetLife Critical Illness Insurance.

Benefit overview	Critical Illness Insurance is coverage that can help safeguard your finances by providing you with a lump-sum payment — one convenient payment all at once — when you or your family may need it most.
Why needed	Pay for whatever you need, such as expenses that may not be covered by your main medical plan(s). For example: co-pays, deductibles, childcare, mortgage, groceries and experimental treatments.
Who is covered	You can enroll both yourself and eligible family members.[5] All you need to do is enroll during your enrollment period and be actively at work.[6] • Employee Only • Employee & Eligible Family Members
Covered services	If you meet the group policy and certificate requirements, **Critical Illness Insurance provides you with a lump-sum payment upon a verified diagnosis of a covered condition, including**: • Cancer[1] • Heart attack[2] • Stroke[3] Your plan pays a Recurrence Benefit[7] for certain conditions. **Please see your Plan Summary for details and a list of covered conditions.**
Cost of coverage	• Competitive group rates • Costs will be based on your coverage option and who you're covering under your plan.
Guaranteed coverage	You and your family members are guaranteed[6] coverage as long as you are actively at work. There are no medical exams to take and no health questions to answer.

Please see your Plan Summary for more information.

Frequently Asked Questions

Q. I have a medical plan at work, so why do I need Critical Illness Insurance?

A. Even the best medical and disability income plans can leave you with extra expenses like medical plan deductibles and co-pays or extra costs for out-of-network care. And if you're out of work because of a disability, it might be that only a portion of your pre-disability income is being paid to you. Many people aren't prepared to handle the extra costs that can come with a critical illness, so having this extra cash as a lump-sum payment may mean less worry for you and your family.

Q. Can I enroll for this insurance without having a medical exam?

A. Yes. Your critical illness coverage is guaranteed,[6] regardless of your health. You need to be actively at work to be covered. There are no medical exams to take and no health questions to answer, so the whole process might be easier than you think.

Enroll in Critical Illness Insurance during annual enrollment

Q. Are benefits paid directly to me or my healthcare provider?

A. Benefits will be paid directly to you, not to the doctors, to the hospitals, or to any other healthcare providers. There's no need to coordinate with any other insurance you may have. Benefits are paid no matter what your other insurance plans may cover or pay.

Q. When does my coverage begin?

A. Your coverage starts on the effective date. There are no waiting periods for it to begin.

Q. How do I pay for my coverage and how much will it cost?

A. You pay premiums through payroll deductions, so you don't have to worry about writing any checks or missing payments. **Critical Illness Insurance may be more affordable than you think.** It's designed to be a way to supplement your healthcare and disability plans. Exact rates can be found in the enrollment materials provided by your employer.

Q. If my employment status changes, can I take my coverage with me?

A. Yes. This coverage is portable, meaning you can take it wherever you go. Your coverage will only end if you stop paying your premium or if your employer offers you similar coverage with a different insurance carrier.[8]

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* This is a hypothetical example for informational purposes only. Your costs and savings could vary based on your plan design, where you live and whether your plan requires a deductible or coinsurance. Please see your Plan Summary for details about your coverage.

1. Please review the certificate for specific information about cancer benefits. In most states, not all types of cancer are covered.
2. The Heart Attack Covered Condition pays a benefit for the occurrence of a myocardial infarction, subject to the terms of the certificate. A myocardial infarction does not include sudden cardiac arrest.
3. In certain states, the Covered Condition is Severe Stroke.
4. https://www.numbeo.com/cost-of-living/country_result.jsp?country=United+States. Updated July 2021.
5. Eligible Family Members means all persons eligible for coverage as defined in the Certificate.
6. Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage.
7. Please review the Disclosure Document or Outline of Coverage/Disclosure Document for information on which Covered Condition may be eligible for a Recurrence Benefit. There may be a Benefit Suspension Period between recurrences of the same Covered Condition, as well as occurrences of different Covered Conditions. There may be a limitation on the number of Recurrence Benefits payable per Covered Condition. We will not pay a benefit for a Covered Condition that is subject to a Benefit Suspension Period. If a Recurrence Benefit is payable for a Cancer Covered Condition, we will not pay such benefit unless the Covered Person has not had symptoms of or been treated for the same cancer for which we paid a benefit during the Treatment Free Period.
8. Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.

METLIFE CRITICAL ILLNESS INSURANCE (CII) IS A LIMITED BENEFIT GROUP INSURANCE POLICY. Like most group accident and health insurance policies, MetLife's CII policies contain certain exclusions, limitations and terms for keeping them in force. Product features and availability vary by state. There may be a preexisting condition exclusion. There may be a Benefit Reduction Due to Age provision. There may be a Benefit Suspension Period between recurrences of the same Covered Condition or occurrences of different Covered Conditions. MetLife offers CII on both an Attained Age basis, where rates will increase when a Covered Person reaches a new age band, and an Issue Age basis, where rates will not increase due to age. Rates are subject to change. MetLife reserves the right to raise premium rates for Issue Age CII on a class-wide basis. A more detailed description of the benefits, limitations, and exclusions applicable to MetLife's CII product can be found in the applicable Disclosure Statement or Outline of Coverage/Disclosure Document available at time of enrollment. For complete details of coverage and availability, please refer to the group policy form GPNP07-CI, GPNP09-CI, GPNP10-CI, GPNP14-CI, GPNP19-CI or contact MetLife for more information. Please contact MetLife for more information. Benefits are underwritten by Metropolitan Life Insurance Company, New York, New York.

MetLife's Critical Illness Insurance is not intended to be a substitute for Medical Coverage providing benefits for medical treatment, including hospital, surgical and medical expenses. MetLife's Critical Illness Insurance does not provide reimbursement for such expenses.

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CIS Critical Illness Insurance

Benefits that may help cover costs such as those not covered by your medical plan.

Critical Illness Insurance Benefits

Eligible Individual	Benefit Amount	Requirements
Coverage Options		
Employee	**$10,000, $20,000 or $30,000**	Coverage is guaranteed provided you are actively at work. [1]
Spouse/Domestic Partner[2]	**50% of the Employee's Initial Benefit**	Coverage is guaranteed provided the employee is actively at work and the spouse/domestic partner is not subject to a medical restriction as set forth on the enrollment form and in the Certificate. [1]
Dependent Child(ren)[3]	**50% of the Employee's Initial Benefit**	Coverage is guaranteed provided the employee is actively at work and the dependent is not subject to a medical restriction as set forth on the enrollment form and in the Certificate. [1]

Benefit Payment

Your plan pays a lump-sum **Initial Benefit** upon the first verified diagnosis of a Covered Condition. Your plan also pays a lump-sum **Recurrence Benefit**[4] for a subsequent diagnosis of certain Covered Conditions as shown in the table below. A Recurrence Benefit is only available if an Initial Benefit has been paid for the same Covered Condition. There is a Benefit Suspension Period that applies to Recurrence Benefits. In addition, there is a Benefit Suspension Period that applies to Initial Benefits for different conditions.

Please refer to the table below for the percentage benefit payable for each Covered Condition.

Covered Conditions*	Initial Benefit	Recurrence Benefit
Benign Tumor Category		
Benign Brain Tumor	100% of Benefit Amount	100% of Initial Benefit Amount
Cancer Category		
Invasive Cancer	100% of Benefit Amount	100% of Initial Benefit Amount
Non-Invasive Cancer	25% of Benefit Amount	100% of Initial Benefit Amount
Cardiovascular Disease Category		
Coronary Artery Bypass Graft (CABG) - *where surgery involving either a median sternotomy or minimally invasive procedure is performed*	50% of Benefit Amount	100% of Initial Benefit Amount
Childhood Disease Category		
Cerebral Palsy	100% of Benefit Amount	None
Cleft Lip or Cleft Palate	100% of Benefit Amount	None
Cystic Fibrosis	100% of Benefit Amount	None
Diabetes (Type 1)	100% of Benefit Amount	None

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Critical Illness Insurance

Down Syndrome	100% of Benefit Amount	None
Sickle Cell Anemia	100% of Benefit Amount	None
Spina Bifida	100% of Benefit Amount	None
Functional Loss Category		
Coma	100% of Benefit Amount	100% of Initial Benefit
Loss of: Ability to Speak; Hearing; or Sight	100% of Benefit Amount	None
Paralysis of 2 or More Limbs	100% of Benefit Amount	100% of Initial Benefit
Functional Loss Category		
Heart Attack	100% of Benefit Amount	100% of Initial Benefit
Infectious Disease Category		
Bacterial Cerebrospinal Meningitis	25% of Benefit Amount	None
Diphtheria	25% of Benefit Amount	None
Encephalitis	25% of Benefit Amount	None
Legionnaire's Disease	25% of Benefit Amount	None
Malaria	25% of Benefit Amount	None
Necrotizing Fasciitis	25% of Benefit Amount	None
Osteomyelitis	25% of Benefit Amount	None
Rabies	25% of Benefit Amount	None
Tetanus	25% of Benefit Amount	None
Tuberculosis	25% of Benefit Amount	None
Kidney Failure Category		
Kidney Failure	100% of Benefit Amount	None
Major Organ Transplant Category		
Major Organ Transplant *For bone marrow, heart, lung, pancreas, and liver*	100% of Benefit Amount	None
Progressive Disease Category		
ALS	100% of Benefit Amount	None
Alzheimer's Disease	100% of Benefit Amount	None
Multiple Sclerosis	100% of Benefit Amount	None
Muscular Dystrophy	100% of Benefit Amount	None
Systemic Lupus Erythematosus (SLE)	100% of Benefit Amount	None
Severe Burn Category		
Severe Burn	100% of Benefit Amount	100% of Initial Benefit
Stroke Category		
Stroke	100% of Benefit Amount	100% of Initial Benefit

* Notes Regarding Covered Conditions

MetLife will not pay a benefit for a Covered Condition that is diagnosed prior to the coverage effective date.

In most states there is a preexisting condition limitation. The preexisting condition limitation may not apply to all covered conditions and may vary by state. Refer to the Disclosure Document/Outline of Coverage for details.

- Alzheimer's Disease – Please review the Outline of Coverage/Disclosure Document for specific information about Alzheimer's disease.
- Cancer – Please review the certificate for specific information about cancer benefits. In most states, not all types of cancer are covered.
- Coronary Artery Bypass Graft – In certain states, the Covered Condition is Coronary Artery Disease.
- Heart Attack – The Heart Attack Covered Condition pays a benefit for the occurrence of a myocardial infarction, subject to the terms of the certificate. A myocardial infarction does not include sudden cardiac arrest.

Critical Illness Insurance

- Major Organ Transplant – In most states, we will not pay a Major Organ Transplant benefit if a covered person is placed on the organ transplant list prior to coverage taking effect and subsequently undergoes a transplant procedure for the same organ while coverage is in effect. Covered organs may vary by state; refer to the Certificate for details. In some states, the condition is Major Organ Failure.
- Stroke – In certain states, the Covered Condition is Severe Stroke.
- The following benefits are not available in all states. Please review the Disclosure Statement or Outline of Coverage/Disclosure Document for details.
    - Aortic Valve or Mitral Valve Repair or Replacement
    - Coma
    - Congenital Heart Disease (for which Surgery has been recommended for treatment)
    - Coronary Angioplasty
    - ICD
    - Loss of: Ability to Speak; Hearing; or Sight
    - Major Organ Transplant Donation
    - Pacemaker
    - Paralysis
    - Severe Burn

Health Screening Benefit

MetLife will provide an annual benefit of $50 per calendar year for taking one of the eligible screening/prevention measures. The Health Screening Benefit is not available in certain states.

Example of How Benefits are Paid

The example below illustrates an employee who elected a Benefit Amount of $20,000.

Illness – Covered Condition	Payment
Heart Attack — first verified diagnosis	Initial Benefit payment of $20,000 or 100%
Kidney Failure – first verified diagnosis, two years later	Initial Benefit payment of $20,000 or 100%
Heart Attack — second verified diagnosis, four years later	Recurrence Benefit payment of $20,000 or 100%

This example is for illustrative purposes only. The MetLife Group Policy and Certificate are the governing documents with respect to all matters of insurance, including coverage for specific illnesses. The specific facts of each claim must be evaluated in conjunction with the provisions of the applicable Policy and Certificate to determine coverage in each individual case.

Questions & Answers

Q. Who is eligible to enroll for this critical illness coverage?

A. You are eligible to enroll yourself and your eligible family members![4] You need to enroll during your Enrollment Period and to be actively at work for your coverage to be effective.

Q. How do I pay for my critical illness coverage?

A. Premiums will be paid through payroll deduction, so you don't have to worry about writing a check or missing a payment.

Q. What happens if my employment status changes? Can I take my coverage with me?

A. Yes, you can take your coverage with you.[5] You will need to continue to pay your premiums to keep your coverage in force. Your coverage will only end if you stop paying your premium or if your employer offers you similar coverage with a different insurance carrier.

Q. Who do I call for assistance?

A. Contact a MetLife Customer Service Representative at 1-800-GET-MET8 (1-800-438-6388) Monday through Friday from 8:00 a.m. to 8:00 p.m., EST.

MetLife | Hospital Indemnity Insurance

CIS citycounty insurance services

Why Hospital Indemnity Insurance matters

Hospital[1] stays can be pricey and often unexpected. Studies show that the average cost of a three-day hospital stay in the U.S. is $30,000.[2] Even quality healthcare plans don't cover all expenses, so taking steps to help protect yourself can make a big difference.

While in the hospital, it's likely you'll need various treatments, tests and therapies to get up and about again. Expenses like plan deductibles, co-pays for doctor visits and extra costs for out-of-network care can add up fast. Having help with the financial support you may need when the time comes means less worry for you and your family.

In addition, unexpected hospital bills are especially difficult to manage when you lose your income or when your income becomes seriously reduced because of an injury or illness. Household expenses like your mortgage or rent payments, car payments, childcare payments, or household maintenance costs may become even harder to keep up with while you focus on recovering.

Help protect yourself, your family and your budget from the financial impact of a hospital stay.

How Hospital Indemnity Insurance can help.

*I was driving to work when I was hit by a large truck. My car was totaled, I was injured, and an ambulance had to take me to the emergency room. I was admitted to the Intensive Care Unit and, after two days, moved to a standard room for five more days. I was then transferred for inpatient care at a rehab facility for a week. I was panicking about how I was going to pay my hospital, ambulance and other medical bills not covered by my health insurance. But luckily, my **Hospital Indemnity Insurance** helped pay for those costs, plus other expenses like rent and groceries.**

Enroll in Hospital Indemnity Insurance during annual enrollment

Hospital Indemnity Insurance

Coverage to help pay for expenses associated with hospitalizations that may not be covered under your medical plan.

Help complete your healthcare coverage with Hospital Indemnity Insurance.

Receive benefit payments directly to help prevent financial stress.

How this coverage works

Hospital Indemnity Insurance can help safeguard your finances by providing you with a lump-sum payment — one payment all at once — when you or your family may need it most. A flat amount is usually paid for a hospital admission[3] and a per-day amount for your entire hospital stay.

And best of all, the payment is made directly to you and is in addition to any other insurance you may have. It's yours to spend however you like, including for your or your family's everyday living expenses.

Whatever you need while recovering from a hospital stay, Hospital Indemnity Insurance is there to help make life a little easier.

When it comes to hospital stays…

For less than the cost of your daily coffee,[4] you can get coverage for you and your family.

Your benefits in action

If you are admitted to the hospital, submitting a claim doesn't have to be difficult. Here's what to expect:

Visit **mybenefits.metlife.com** or download the MetLife Mobile App to view your certificate of insurance and initiate your claim.

Answer a few simple questions about what happened and upload your medical documentation to support your claim. Once we have everything, claims are typically processed within 10 business days.[5] You only need one claim form per hospital admission and every claim is reviewed by a claims professional.

Once your claim is approved, you'll receive a check made out to you to use however you like.

Enroll in Hospital Indemnity Insurance during annual enrollment

Supplement your healthcare coverage with MetLife Hospital Indemnity Insurance.

Benefit overview	Hospital Indemnity Insurance pays you benefits when you are confined to a hospital, whether for planned or unplanned reasons.[3]
Why needed	This benefit may supplement both health insurance and disability insurance if a covered incident causes you to have expenses that your health insurance doesn't cover — or causes you to lose income due to being out of work.
Who is covered	You can choose a plan that best suits you and your family.
Covered services	This plan provides benefits for hospitalization due to accidents and sicknesses,[6] such as: • Admission to a hospital[3] • Hospital stays A flat amount is paid for the day that you're admitted to a hospital, and a per-day amount is paid for each day of a covered hospital stay from the very first day of your stay.
Cost of coverage	• Competitive group rates • Costs will be based on your coverage option and who you're covering under your plan.
Guaranteed coverage	You and your family members are guaranteed[7] coverage as long as you are actively at work. There are no medical exams to take and no health questions to answer.

Please see your Plan Summary for more information.

Enroll in Hospital Indemnity Insurance during annual enrollment

Frequently Asked Questions

Q. I have a medical plan at work, so why do I need Hospital Indemnity Insurance?

A. Hospital stays can be pricey and are often unexpected. Even the best medical plans can leave you with extra expenses to pay or with services that just aren't covered such as plan deductibles, co-pays, extra costs for out-of-network care or non-covered services. Having this extra financial support when the time comes may mean less worry for you and your loved ones.

Q. Can I enroll for this insurance without having a medical exam?

A. Yes. Your coverage is guaranteed,[7] regardless of your health. You just need to be actively at work. There are no medical exams to take and no health questions to answer, so the whole process might be easier than you first thought.

Q. How much will coverage cost and how do I pay for it?

A. Hospital Indemnity Insurance may cost less than you think. It's designed to be a way for you to supplement your healthcare plan. Exact rates can be found in the enrollment materials provided by your employer. **You pay premiums through payroll deductions,** so you don't have to worry about writing any checks or missing payments.

Q. When does my coverage begin?

A. Your coverage starts on the effective date. There are no waiting periods for it to begin.

Q. Are benefits paid directly to me or my healthcare provider?

A. Payments go directly to you, not to the doctors, to the hospitals or to any other healthcare providers. And to make things even easier, the check is made payable to you. There's no need to coordinate with any other insurance you may have. Benefits are paid no matter what your other insurance plans may cover.

Q. If my employment status changes, can I take my coverage with me?

A. Yes. This coverage is portable, meaning you can take it with you wherever you go so long as you continue paying your premiums.[8]

Q. Is the claims process simple?

A. Yes. Once we've received all the necessary information, claims are generally processed within 10 business days. You only need one claim form per admission or hospital stay and every claim is reviewed by a professional.[5]

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* This is a hypothetical example for informational purposes only. Your costs and savings could vary based on your plan design, where you live and whether your plan requires a deductible or coinsurance. Please see your Plan Summary for details about your coverage.

1. Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See your Disclosure Statement or Outline of Coverage/Disclosure Document for full details.
2. Why health insurance is important: protection from high medical costs. https://www.healthcare.gov/why-coverage-is-important/protection-from-high-medical-costs/. Accessed July 2020.
3. The Admission Benefit is not payable for Emergency Room treatment or outpatient treatment. The payment of the admission benefit requires a Confinement. Hospital Confinement requires the assignment to a bed as a resident inpatient in a Hospital (including an Intensive Care Unit of a Hospital) on the advice of a Physician or confinement in an observation area within a Hospital for a period of no less than 20 continuous hours on the advice of a Physician. Please consult your Certificate for details.
4. Why the price of your morning coffee could get more expensive. https://www.marketwatch.com/story/why-your-latte-costs-nearly-5-despite-plummeting-coffee-bean-prices-2019-04-26. Published July 2019.
5. Applies only to "clean" claims. A clean claim is a claim submitted with all the required information necessary to process the claim — no missing information requiring additional follow up with the subscriber. It generally takes 10 business days to process "clean" claims.
6. Covered services/treatments must be the result of a covered accident or sickness as defined in the group policy/certificate. There is a pre-existing exclusion for covered sicknesses. See your Disclosure Statement or Outline of Coverage/Disclosure Document for full details.
7. Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the armed forces or living overseas.
8. Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.

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ADF# HI2654.21

Enroll in Hospital Indemnity Insurance during annual enrollment

CIS Hospital Indemnity Insurance Plan Summary

HOSPITAL INDEMNITY INSURANCE BENEFITS

With MetLife, you'll have a comprehensive plan which provide payments in addition to any other insurance payments you may receive. Here are just some of the covered benefits/services, when an accident or illness puts you in the hospital.[A]

COVERED BENEFITS[B]

Please contact MetLife for detailed definitions and state variations of covered benefits.

Hospital Benefits			
Subcategory	**Benefit Limits (Applies to Subcategory)**	**Benefit**	**Benefit Amounts**
Admission Benefit	1 time(s) per calendar year	Admission	$1,000
		ICU Supplemental Admission (Benefit paid concurrently with the Admission benefit when a Covered Person is admitted to ICU)	$1,000
Confinement Benefit	15 days per calendar year ICU Supplemental Confinement will pay an additional benefit for 15 of those days	Confinement[2]	$100
		ICU Supplemental Confinement (Benefit paid concurrently with the Confinement benefit when a Covered Person is admitted to ICU)	$100
Newborn Confinement Benefit	2 day(s) per confinement	Newborn Confinement[3]	$50
Inpatient Rehabilitation Benefit*	15 days per calendar year	Inpatient Rehabilitation (For Injury Only)	$200
Other Benefits			
Health Screening Benefit	1 time(s) per calendar year per covered person	Health Screening	$50

*Benefit(s) that requires prior Admission or Confinement

[2] The Confinement Benefit will begin to be payable the day of Admission.
[3] The period of newborn confinement, immediately following the child's birth.

Please contact MetLife for detailed definitions and state variations of covered benefits

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BENEFIT PAYMENT EXAMPLE FOR PLAN

Susan has chest pains at home and after contacting her doctor she is instructed to head to her local hospital. Upon arrival, the doctor examines Susan and advises that she requires immediate admission to the Intensive Care Unit for further evaluation and treatment. After 2 days in the Intensive Care Unit, Susan moves to a standard room and spends 2 additional days recovering in the hospital. Susan was released from the hospital, and her primary doctor is now keeping a close watch over her overall health. Depending on her health insurance, Susan's out-of-pocket costs could run into hundreds of dollars to cover expenses like insurance co-payments and deductibles. MetLife Hospital Indemnity Insurance payments can be used to help cover these unexpected costs or in any other way Susan sees fit.

Covered Benefit	Plan Benefit Amount[C]
Regular Hospital Admission 1x	**$1,000**
ICU Supplemental Admission 1x	**$1,000**
Regular Hospital Confinement 3 total days	**$300**
ICU Supplemental Confinement 1 day	**$100**
Benefits paid by MetLife Group Hospital Indemnity Insurance	**$2,400**

QUESTIONS & ANSWERS

How do I enroll?
Enroll for coverage at Employer website.

Who is eligible to enroll for this Hospital Indemnity coverage?
You are eligible to enroll yourself and your eligible family members.[D] You need to enroll during your Enrollment Period and be actively at work for your coverage to be effective. Dependents to be enrolled may not be subject to a medical restriction as set forth in the Certificate. Some states require the insured to have medical coverage.

How do I pay for my Hospital Indemnity coverage?
Premiums will be paid through payroll deduction, so you don't have to worry about writing a check or missing a payment.

What happens if my employment status changes? Can I take my coverage with me?
Yes, you can take your coverage with you. You will need to continue to pay your premiums to keep your coverage in force. Your coverage will only end if you stop paying your premium, or if your employer cancels the group policy and offers you similar coverage with a different insurance carrier.[E]

What is the coverage effective date?
The coverage effective date is 1/1/2021.

Who do I call for assistance?
Please call MetLife directly at 1-800-GET-MET8 (1-800-438-6388) and talk with a benefits consultant.

[A] Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See your Disclosure Statement or Outline of Coverage/Disclosure Document for full details.
[B] Covered services/treatments must be the result of an accident or sickness as defined in the group policy/certificate. See your Disclosure Statement or Outline of Coverage/Disclosure Document for more details.
[C] Benefit amount is based on a sample MetLife plan design. Plan design and plan benefits may vary.
[D] Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth in the Certificate. Some states require the insured to have medical coverage.
[E] Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.

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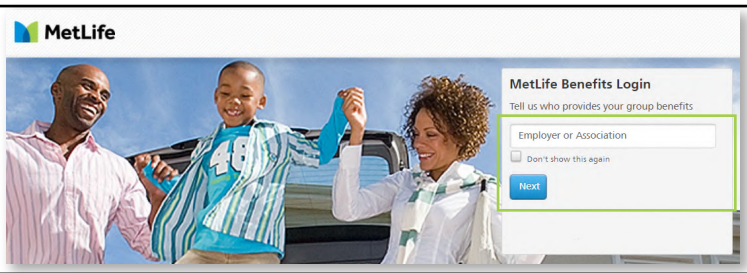
How To Register On MyBenefits

MyBenefits provides you with a personalized, integrated and secure view of your MetLife delivered benefits. You can take advantage of a number of self-service capabilities as well as easy to access information. As a first-time user, you will need to register on MyBenefits by following the steps outlined below:

Registration Process For MyBenefits:

STEP 1 – Provide A Group Name

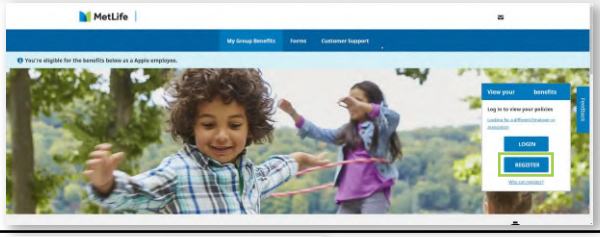
Access MyBenefits at mybenefits.metlife.com. Enter **CIS Trust**, select it in the drop down and select 'Next'. Save this URL to access your MyBenefits account in the future.



STEP 2 – Register

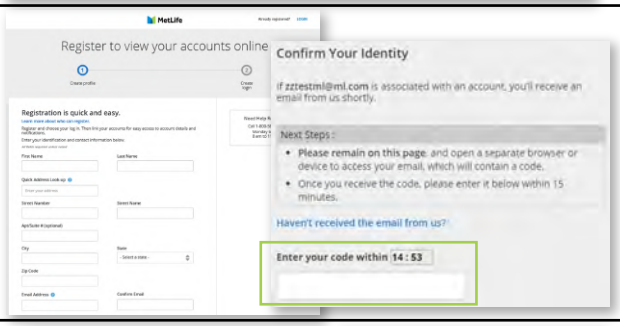
Once you have selected **CIS Trust**, from the MyBenefits Home Page you will then select the 'Register' button.

Note – Current users will select 'Log In' and enter their username and password.



STEP 3 – Enter Authentication Information

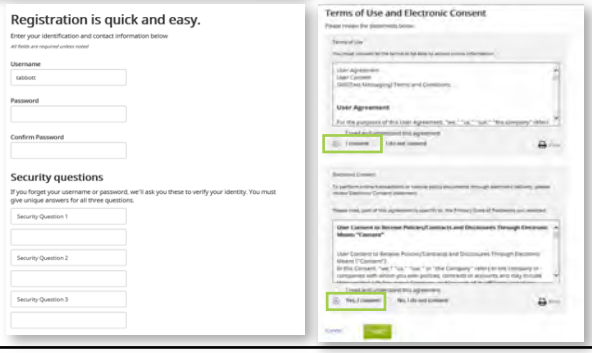
The next screen will begin by entering your name, address, phone number, e-mail (required) and unique security identifiers to confirm your identity. You will then receive a security code, via email or text, that you will need to enter to continue the registration process.



STEP 4 – Establish Account Credentials

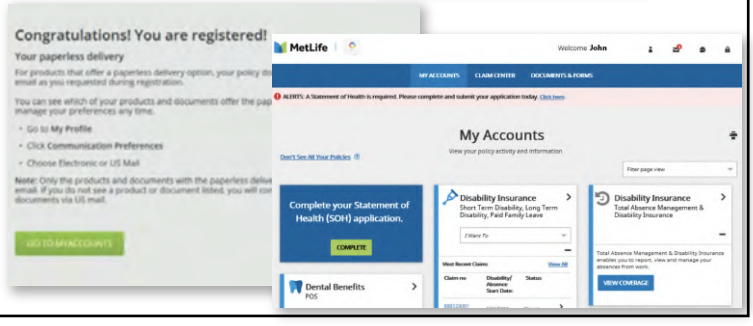
You will then be prompted to create a unique username and password for future access to MyBenefits, as well as choose and answer three identity verifications questions that will be used in the event you forget your password.

In addition to reading and agreeing to the Terms of Use, you will be asked to opt into electronic consent.



STEP 5 – Registration Is Complete

Once you have completed the process a 'congratulations' message window will display. You are now registered on MyBenefits! A registration confirmation email will be sent to the email address provided for your registration. You can immediately access your account information by selecting the 'Go To My Account' button within the congratulations window.



MetLife Online Services capabilities may vary by product and may not be available to all customers. Please contact your MetLife representative for more information.

Trauma Coverage® helps empower the recovery of individuals and families after a traumatic incident by providing financial security, physical recuperation, and emotional well-being. Covered incidents include injuries anywhere in the United States as the result of an aggravated assault, sexual assault, mass shooting or act of terror. Coverage is extended to provide benefits for witnessing a violent act, or contracting an infectious disease while working.

Trauma Counseling

Trauma Counseling is therapy re-invented for the way we live. A confidential, measurement-based program empowering recovery after every day and workplace incidents. Talk with a Master's level therapist 24/7 via video conferencing on multiple devices.

Recovery Care

Reimbursement for out of pocket expenses. This includes copays and deductibles for medical, dental, vision, hearing, and pharmaceuticals. Family members providing supportive services can also receive 100% of their regular pay as a part of this benefit.

Financial Security

Receive 100% of your regular pay while you're unable to work due to a trauma without a waiting period to receive benefits. Beneficiaries of each insured will receive their policy maximum due to their loss of life from an accidental death.

SEE PAGE 2 FOR PLAN OPTIONS ›

TAKING TIME TO HEAL

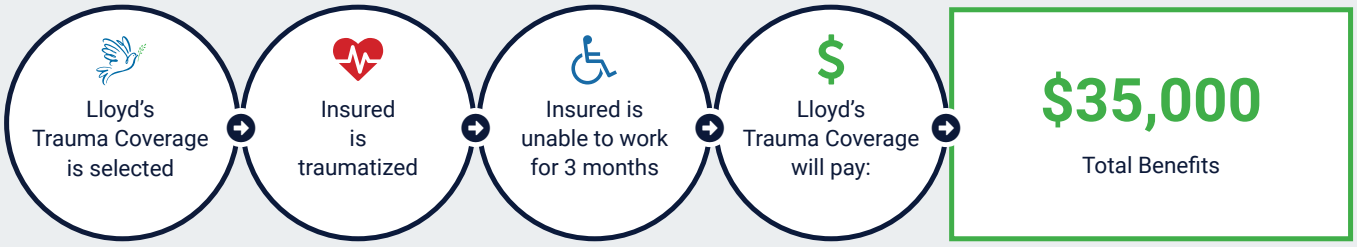
Mary's Story

"I was assaulted while out with friends. I went to the hospital and was treated for injuries and tested for diseases. I needed time to deal with everything...it was all just too much."

Mary needed time to heal and feel secure but, like most people, she couldn't afford the additional out of pocket costs for trauma recovery care or afford to miss work and survive on the reduced pay from disability insurance.

Trauma coverage provided Mary with financial security–100% of her normal pay and reimbursement for the out of pocket medical costs. It also provided Mary with trauma counseling and provided lost wages to her mother for supportive services.

For illustrative purposes, below please find an example of maximum benefits paid to an Insured who experiences an assault and is unable to work for 3 months while undergoing recovery care and counseling. If regular earnings are $60,000 a year ($165 a day), a Trauma Coverage Gold Plan would provide them $15,000 in recovery benefits, $15,000 in financial benefits, and $5,000 of trauma counseling for them and all of their immediate family members.



BRONZE $10.00/Month	SILVER $15.00/Month	GOLD $20.00/Month	FAMILY $25.00/Month
$5,000 Individual and family counseling	**$5,000** Individual and family counseling	**$5,000** Individual and family counseling	**$5,000 / Insured** Individual and family counseling
$5,000 Maximum in lost wages[1]	**$10,000** Maximum in lost wages[1]	**$15,000** Maximum in lost wages[1]	**$20,000 / Insured** Maximum in lost wages[1]
$5,000 Maximum for expense reimbursement[2] or lost wages of a family member	**$10,000** Maximum for expense reimbursement[2] or lost wages of a family member	**$15,000** Maximum for expense reimbursement[2] or lost wages of a family member	**$20,000 / Insured** Maximum for expense reimbursement[2] or lost wages of a family member
$50,000 Accidental death benefit	**$100,000** Accidental death benefit	**$150,000** Accidental death benefit	**$200,000 / Insured** Accidental death benefit[3]
$50,000 Maximum benefit per policy period (1 year)	**$100,000** Maximum benefit per policy period (1 year)	**$150,000** Maximum benefit per policy period (1 year)	**$200,000 / Insured** Maximum benefit per policy period (1 year)

Coverage Details

[1] *100% of lost wages from all income sources*

[2] *Expense reimbursement includes any medical, dental, vision, hearing, pharmaceutical, and addiction to prescribed drugs expenses*

[3] *The accidental death benefit for the Family Plan is up to $200,000 ($150,000 for employed Insureds and $25,000 for non-employed Insureds)*

Family Plan Added-benefit: Family coverage includes the insured; spouse (if applicable); and dependent, unmarried children to age 19 (26 if full-time students). This includes the relationship created by a domestic partnership. Newborn children are automatically insured from the moment of birth. A dependent child must be under the age of 19 at the time of application to be eligible for coverage. In addition, the Family Plan provides families of traumatized students with $100 in financial assistance per day while the student is unable to attend school due to a trauma.

UNDERWRITING

Guaranteed issue
No age limitations for coverage
Approved in and limited to the 50 United States
Coverage is underwritten by Lloyd's of London

POLICY ISSUANCE

Policy periods are one (1) year
No waiting period to receive trauma benefits

POLICY & CLAIM ADMINISTRATION

Trauma Coverage Administration
6329 Jessie Lane
Clemmons, NC 27012

Monday–Friday 8 A.M. to 5 P.M. Central
(Excluding U.S. Holidays)
admin@traumacoverage.com
855-631-1421

TRAUMA COVERAGE®
EMPOWERING RECOVERY™

cascade HEALTH

NEED HELP?

Call your Employee Assistance Program!

Cascade Behavioral Health & EAP is pleased to offer you and all members of your household free, confidential counseling services. We are staffed by licensed psychologists, licensed masters level social workers, counselors and marriage and family therapists, offering treatment for ages six and older. Some common issues that bring people to counseling include:

- Stress and Anxiety
- Depression
- Family Problems
- Grief and Loss
- Drug and Alcohol Abuse
- Child/Adolescent Problems
- Relationship Conflict
- Workplace Stress

If you or any member of your household find that you are facing a problem that is interfering with your well-being, our counselors are just a phone call away. **Up to five counseling sessions per year** are provided with your Employee Assistance Program. In case of mental health emergency, we offer 24 hour on-call assistance.

To schedule an appointment, please call 541-345-2800

from 8:30-5:00 p.m. Monday through Friday.

Appointments are available:

Monday-Thursday, 8:00 a.m. – 6:00 p.m.

Friday, 9:00 a.m. – 4:00 p.m.

Cascade Behavioral Health & EAP offices are located at

2650 Suzanne Way Suite 120, Eugene OR 97408

2650 Suzanne Way, Suite 120, Eugene, OR 97408
(541) 345-2800 cascadehealth.org

Help Available

Call Your Employee Assistance Program

cascade HEALTH

You and all members of your household can receive free, confidential counseling services through your workplace's partnership with the Cascade Behavioral Health Employee Assistance Program.

Regardless of what you are going through personally or professionally, we are here to help. Professional counseling can assist you in dealing with challenges before they become overwhelming.

We serve individuals, couples and families ages 6 and up. Our counselors provide guidance, support, and action plans to help you live your happiest and healthiest life possible.

For more information or to schedule an appointment, contact us today:

541.345.2800

To Schedule an Appointment:

Call 541-345-2800
Monday – Friday
8:30 a.m. – 5:00 p.m.

Appointments are Available:

Monday – Thursday
8:00 a.m. – 7:00 p.m.

Friday
8:00 a.m. – 5:00 p.m.

In case of a mental health emergency, call us 24 hours a day for assistance.

2650 Suzanne Way, Suite 120, Eugene Oregon 97408 * 541-345-2800
cascadehealth.org

Image: Freepik.com

EAP Summary of Services

Helping you get to your happy place

The Employee Assistance Program (EAP) is a **FREE** and **CONFIDENTIAL** benefit that can assist you, your dependents, and household family members with any personal life problems, large or small.

Confidential Coaching and Counseling access to masters-level counselors in person, over the phone, or online for concerns such as:

- **Stress and Burnout**
- **Depression and Anxiety**
- **Relationships and Family**
- **Alcohol and Drug Use**

Work/ Life Balance Services

Canopy will help locate resources related to Eldercare, Childcare, Identity Theft, Housing, Pet Parent Support or anything else you may need.

Legal

Call for a free consultation, and then receive a discount thereafter.

Financial Coaching

Access to unlimited financial coaching to help you develop a plan to improve your financial wellbeing.

Wellbeing Tools

- Fertility Health Support
- Online Legal Tools
- Will Kit Questionnaire
- Coaching
- Gym Membership Discounts

EAP Member Site

Access innovative tools, chat for support, view videos and webinars, and more. Access at: **my.canopywell.com**, and register as a new user or log-in. Enter your company name when you register as: CIS

WholeLife Directions

Take a confidential survey and get connected to interactive tools to improve the way you feel. Access in the EAP member site or search *WholeLife Directions* in the App Store or Google Play.

Crisis Counselors are available 24/7/365
call: 800-433-2320 text: 503-850-7721 email: info@canopywell.com

canopy

Summary Provided by the Broker of Record for

Lane Council of Governments:

USI Northwest

975 Oak Street, Ste 900

Eugene, OR 97401

541-685-5300

This brochure summarizes the benefit plans that are available to Lane Council of Governments' eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.