North Clackamas Schools

EMPLOYEE BENEFITS HANDBOOK

2024

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Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices on page 26 for more details.

Benefiting You

At North Clackamas School District we believe that you, our employees, are our most important asset. Helping you and your families achieve and maintain good health is the reason NCSD offers you this benefits program. We are providing you with this overview to help you understand the benefits that are available to you and how best to use them. Please review it carefully and make sure to ask about any important issues that are not addressed here.

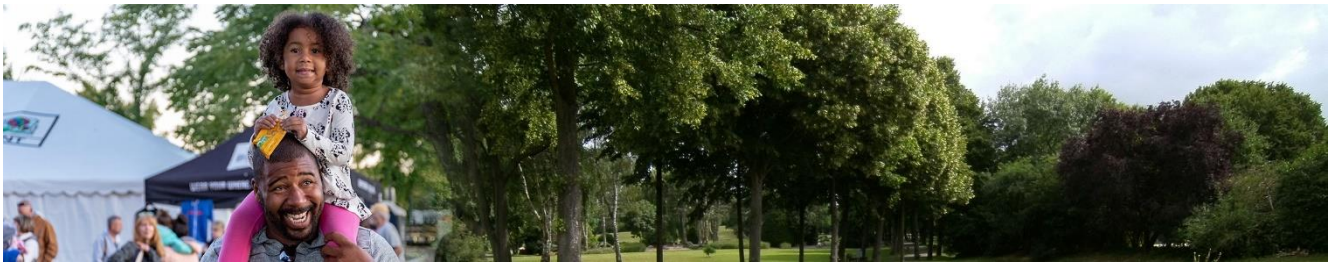
This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The SPD's will determine how all benefits are paid. In addition, we encourage members to visit the internal Benefits Intranet Site located at www.nclack.k12.or.us/business/page/employee-benefits.

A list of plan contacts is included in this guide.

The benefits in this summary are effective:

January 1, 2024 - December 31, 2024

Who Can You Cover?



WHO IS ELIGIBLE?

In general, all regular employees who meet the requirements established by the collective bargaining agreements and qualified retirees who have been enrolled in a North Clackamas Health Plan for 24 consecutive months immediately prior to retirement.

You can enroll the following family members in our medical, dental and vision plans.

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse.)
- Your domestic partner is eligible for coverage if you have completed a Domestic Partner Affidavit. Please review the affidavit guidelines. The Cost of Coverage section explains the tax treatment of domestic partner coverage.
- Your children (including your domestic partner's children):
    - Under age 26 that are a natural child, legally adopted or placed for adoption prior to age 18, step-children or children who have been placed under the legal guardianship of the employee or the employee's spouse. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
    - Dependent children that are incapable of self-support due to mental or physical incapacity prior to age 26 may remain on coverage with proof of incapacity if proof is submitted within 120 days of reaching the maximum age.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

WHEN MUST I ENROLL?

You must enroll within 30 days from the start of eligible position. If coverage is waived, coverage is not available again until the next open enrollment unless, when coverage was initially offered it was waived in writing because of coverage under another group health plan. If the other coverage is lost, employee and/or their dependents may qualify under special enrollment if they apply within 30 days of that loss. If other coverage is COBRA Continuation, special enrollment would only apply after COBRA is exhausted.

Notify Benefits Department within 30 days if you have a qualifying life event and need to add or drop dependents outside of Open Enrollment. Life events include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage or divorce

Medical – Kaiser Permanente

	KAISER TRAD PLAN	KAISER HDHP PLAN
	Kaiser In-Network	**Kaiser In-Network**
ANNUAL DEDUCTIBLE	$0 per individual $0 family limit	$3,200 per individual $6,400 family limit
ANNUAL OUT-OF-POCKET MAX	$600 per individual $1,200 family limit	$5,400 per individual $10,800 family limit
OFFICE VISIT	$10 copay then 100%	Plan pays 70% after deductible
PREVENTIVE SERVICES	Plan pays 100% (see contract for limitations)	Plan pays 100% (see contract for limitations)
CHIROPRACTIC CARE	$10 copay then 100% (up to 20 visits per year)	Not covered
LAB AND X-RAY	Plan pays 100%	Plan pays 70% after deductible
INPATIENT HOSPITALIZATION	Plan pays 100%	Plan pays 70% after deductible
OUTPATIENT SURGERY	$10 copay then 100%	Plan pays 70% after deductible
URGENT CARE	$30 copay then 100%	Plan pays 70% after deductible
EMERGENCY ROOM	$100 copay then 100% (copay waived if admitted)	Plan pays 70% after deductible
PRESCRIPTION DRUG DEDUCTIBLE	None	Prescriptions subject to medical plan deductible
PHARMACY (30 DAYS)		
GENERIC/PREFERRED/ NON-PREFERRED	$10/$20/$40	$20/$40/$60/($150 Specialty) copay after deductible
MAIL ORDER (90 DAYS)		
GENERIC/PREFERRED/ NON-PREFERRED	$20/$40/$80	$40/$80/$120 copay after deductible
VISION EXAMINATION		
UNDER AGE 19	$0 Copay (1 PCY)	Plan pays 70% after deductible (1 PCY)
AGE 19 & OVER	$10 Copay (1 PCY)	Plan pays 70% after deductible (1 PCY)
VISION HARDWARE		
UNDER AGE 19	Standard glasses or contact lenses; one pair PCY covered in full	Not Covered
AGE 19 & OVER	$150 Allowance every 2 calendar years	Not Covered

This is a brief summary of benefits and should be used for general comparison purposes only. Consult the Summary Plan Description (SPD) for complete and accurate information on the conditions, limitations, exclusions and coverage of benefits. In the event of a discrepancy, the SPD will prevail.

Medical- HMA

	HEALTH CARE MANAGEMENT PLAN V	HEALTH CARE MANAGEMENT PLAN 1X – CLASSIFIED ONLY
	Regence In Network	Regence In Network
ANNUAL DEDUCTIBLE	$1,250 per individual $2,500 family limit	$0 per individual $0 family limit
ANNUAL OUT-OF-POCKET MAX	$2,000 per individual $4,000 family limit	$700 per individual $2,100 family limit
OFFICE VISIT	$25 copay then 100%	$15 copay then 100%
PREVENTIVE SERVICES	Plan pays 100% (see contract for limitations)	Plan pays 100% (see contract for limitations)
CHIROPRACTIC CARE	$25 copay then 100% (up to 30 visits per year)	$15 copay then 100% (up to 20 visits PCY)
LAB AND X-RAY	Plan pays 80% after deductible	Plan pays 100%
INPATIENT HOSPITALIZATION	Plan pays 80% after deductible	Plan pays 100%
OUTPATIENT SURGERY	Plan pays 80% after deductible	Plan pays 100%
URGENT CARE	$25 copay then 100%	$55 copay then 100%
EMERGENCY ROOM	Plan pays 80% after deductible	$105 copay then 100% (copay is waived if admitted)
PHARMACY		
ANNUAL OUT-OF-POCKET LIMIT	$4,600 per individual/$9,200 family limit	$5,050 per individual/$8,000 family limit
PHARMACY (30 DAYS)		
GENERIC/PREFERRED/NON-PREFERRED	$15/$30/$50	$10/$20/30%
MAIL ORDER (90 DAYS)		
GENERIC/PREFERRED/NON-PREFERRED	$30/$60/$100	$20/$40/30%

Pre-Authorization for inpatient medical facility admissions and outpatient surgeries is required for full benefits. Failure to pre-authorize will result in a $250 penalty which will not apply towards the out-of-pocket maximum.

Vision

Kaiser Vision is included as part of the Kaiser Traditional Medical Plan.

	HMA VISION PLAN (ACCOMPANIES EITHER PLAN V, PLAN 1X, OR KAISER HDHP)
	In-Network
EXAMINATION	
UNDER AGE 19	$15 Copay (1 PCY)
AGE 19 & OVER	$15 Copay (1 every 24 months)
HARDWARE	
UNDER AGE 19	$250 Allowance PCY
AGE 19 & OVER	$250 Allowance per 24 months

This is a brief summary of benefits and should be used for general comparison purposes only. Consult the Summary Plan Description (SPD) for complete and accurate information on the conditions, limitations, exclusions and coverage of benefits. In the event of a discrepancy, the SPD will prevail.

Dental

Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

North Clackamas School District gives you a choice of dental plans.

	KAISER DENTAL	HMA DENTAL PPO
	In-Network	In-Network
NETWORK	Kaiser Permanente Dental Clinics	Any licensed Dentist. No network, but additional discount may apply to Regence Preferred Providers.
CALENDAR YEAR DEDUCTIBLE	$0 per individual $0 family limit	$0 per individual $0 family limit
ANNUAL PLAN MAXIMUM	Unlimited	$1,500 per individual
DIAGNOSTIC AND PREVENTIVE	$5 copay then 100%	100% of UCR
PREVENTIVE/BASIC SERVICES	$5 copay then 100%	100% of UCR
MAJOR SERVICES	$45-$95 copay (varies by services; see contract for fee schedule)	Crowns and Onlays: 100% of UCR Prosthodontic Care (bridges, dentures): plan pays 50% of UCR*
ORTHODONTIC SERVICES	Not Covered	Not Covered

*UCR (Usual, Customary, and Reasonable): The amount paid for a medical/dental service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

PEAK ONE administration

Healthcare FSA

Don't lose the chance to put up to $800 back into your pocket this year!

Participating in a healthcare flexible spending account (FSA) is like receiving a 30% discount from your medical providers.

How does a healthcare FSA work?

A healthcare FSA is a flexible spending account that allows you to set aside pre-tax dollars for eligible medical, dental, and vision expenses for you and your dependents, even if they are not covered under your primary health plan.

You choose an annual election amount, up to $3,050. At the beginning of the plan year, your account is pre-funded and your full contribution is immediately available for use. Your election amount is then deducted from your paychecks in equal installments throughout the year.

Why should I enroll in a healthcare FSA?

Almost everyone has some level of predictable and non-reimbursable medical needs.

If you expect to incur medical expenses that won't be reimbursed by another plan, you'll want to take advantage of the savings this plan offers. Money contributed to a healthcare FSA is free from federal and state taxes and remains tax-free when it is spent on eligible expenses. On average, participants enjoy a 30% tax savings on their annual contribution. This means you could be saving up to $800 per year on healthcare expenses!

How do I use my FSA to pay for healthcare expenses?

You can use your Peak One Debit Card to pay your providers for eligible healthcare expenses, or pay with your personal funds and submit a claim for reimbursement.

Qualifying expenses

What qualifies?

Healthcare FSA funds can cover costs for:

- Copays, deductible payments, coinsurance
- Doctor office visits, exams, lab work, x-rays
- Hospital charges
- Prescription drugs
- Dental exams, x-rays, fillings, crowns, orthodontia
- Vision exams, frames, contact lenses, contact lens solution, laser vision correction
- Physical therapy
- Chiropractic care
- Medical supplies and first aid kits
- Over-the-counter medications
- And much more…

What doesn't qualify?

Certain expenses are not eligible, for instance:

- Expenses incurred in a prior plan year
- Cosmetic procedures or surgery
- Dental products for general health
- Hygiene products
- Insurance premiums
- Late payment fees charged by healthcare providers

A comprehensive list of eligible expenses can be found at www.peakoneadmin.com.

Online & mobile access

Get instant access to your account with the **WealthCare Portal** and **Mobile App**.

- View your account balance and transaction history
- Submit and view claims
- Upload and store receipts
- View important alerts and communications
- Sign up for direct deposit
- Sign up for text message alerts

Register for the WealthCare Portal at https://peak1.wealthcareportal.com/

Download the Mobile App at the App Store or Google Play.

Helpful hints

- Your full election amount is available on the first day of the plan year, which means you'll have access to the money you need, when you need it.
- You can't change your election amount during the plan year, unless you experience a change in status or qualifying event.
- Save your receipts when you spend your healthcare FSA dollars. You may need itemized invoices to verify the eligibility of expenses or for reimbursement requests.
- The easiest way to manage your account is online at https://peak1.wealthcareportal.com/ or through the Mobile App.
- You may carry over up to $610 of unused healthcare FSA dollars to the next plan year, allowing you to enjoy tax savings without risk.

www.PeakOneAdmin.com

3903 E Primrose Lane, Suite 102 • Post Falls, ID 83854 • 866.315.1777

PEAKONE administration

PEAK ONE administration

Save up to $1,500 on dependent care expenses this year!

Participating in a dependent care flexible spending account (FSA) is like receiving a 30% discount from your care provider.

How does a dependent care FSA work?

A dependent care FSA is a flexible spending account that allows you to set aside pre-tax dollars for dependent care expenses, such as daycare, that allow you to work or look for work.

You choose an annual election amount, up to $5,000 per family. The money is placed in your account via payroll deduction, in equal installments, and then used to pay for eligible dependent care expenses incurred during the plan year.

Why should I enroll in a dependent care FSA?

Child and dependent care is a large expense for many families. Millions of people rely on child care to be able to work, while others are responsible for older parents or disabled family members.

If you pay for care of dependents in order to work, you'll want to take advantage of the savings this plan offers. Money contributed to a dependent care account is free from federal and state taxes and remains tax-free when it is spent on eligible expenses. On average, participants enjoy a 30% tax savings on their annual contribution. This means you could be saving up to $1,500 per year on dependent care expenses!

How do I use my FSA to pay for dependent care expenses?

You can use your Peak One Debit Card to pay your provider for eligible dependent care expenses, or pay with your personal funds and submit a claim for reimbursement.

Qualifying expenses

What qualifies?

Dependent care FSA funds can cover costs for:

- Before school or after school care for children 12 and younger
- Custodial care for dependent adults
- Licensed day care centers
- Nanny / Au Pair
- Nursery schools or preschools
- Late pick-up fees
- Summer or holiday day camps

What doesn't qualify?

Certain expenses are not eligible, for instance:

- Expenses incurred in a prior plan year
- Expenses for non-disabled children 13 and older
- Educational expenses including kindergarten or private school tuition fees
- Food, clothing, sports lessons, field trips, and entertainment
- Overnight camp expenses
- Late payment fees for child care

A comprehensive list of eligible expenses can be found at www.PeakOneAdmin.com.

Online & mobile access

Get instant access to your account with the **WealthCare Portal** and **Peak One Mobile App**.

- View your account balance and transaction history
- Submit and view claims
- Upload and store receipts
- View important alerts and communications
- Sign up for direct deposit
- Sign up for text message alerts

Register for the WealthCare Portal at https://peak1.wealthcareportal.com/

Download the Peak One Mobile App at the App Store or Google Play.

Helpful hints

- You must have funds in your dependent care FSA before you can spend them.
- You can't change your election amount during the plan year, unless you experience a change in status or qualifying event.
- Keep your receipts, you will need an itemized invoice for all reimbursement requests.
- The easiest way to manage your account is online at https://peak1.wealthcareportal.com/ or through the Peak One Mobile App.
- Any unused funds that remain in your account at the end of the year will be forfeited. Plan carefully and use all the money in your dependent care FSA by the end of the plan year.

www.PeakOneAdmin.com

3903 E Primrose Lane, Suite 102 • Post Falls, ID 83854 • 866.315.1777

PEAK ONE administration

North Clackamas School District
Funded HRA Fact Sheet

What is a Funded HRA?

The Funded HRA is an account established for those enrolled in plan V and funded by North Clackamas School District once a year. The 2023 HRA tiers are $1500 and $3000. The plan provides a tax-free way for you to accumulate funds to pay for qualified medical and health-related expenses for you and your actively enrolled family members of plan V. Your unused account balance will roll over from year to year, allowing you to accumulate dollars for future use.

What are eligible expenses?

Eligible expenses include, but are not limited to, copays, co-insurance, deductibles, out of pocket dental expenses, out of pocket vision expenses, prescription medications, certain over-the-counter expenses and COBRA premiums. Upon retirement, you can add health, dental, vision, long-term care, Medicare Part B & D, Medigap or Medicare Advantage coverage (Part C) premiums to the list of eligible expenses.

Are there fees associated with this plan?

Yes, there is a service fee of $3.00 charged to the account on a monthly basis.

Can I invest my HRA funds?

Yes! You can invest your HRA funds using your online participant portal at www.peakoneadmin.com. Funds over your $500 cash balance can be invested at any time you choose.

How do I submit a claim for reimbursement?

You can submit a request for reimbursement online, through the mobile app, fax, email or mail. If you submit a manual claim form, you must include the Funded HRA claim form and attach the necessary documentation to substantiate your claim. Your claim will be processed and approved within 3-5 business days.

How do I access my account?

Accessing your account is easy! You can log in to your participant portal or use the free mobile app to access your account 24 hours a day, 7 days a week. You may also call the Peak One MemberCare Department for assistance at 866-315-1777 Monday through Thursday from 7:30am – 4:30pm PT and Friday from 7:30am to 3:30pm PT, excluding holidays.

Employee Wellness

North Clackamas School District is committed to creating an environment where health and wellness are integral components of the professional culture. Dependent upon employee payroll contributions and outside funding, the Employee Wellness Program plays a critical role in developing programs designed to improve the physical and emotional health of all employees.

Fifty percent of your contribution goes DIRECTLY BACK TO YOUR BUILDING!

Examples of building level work:	Examples of program level costs:
Staff Room makeovers	District wide Challenges
Produce Delivery	Health campaigns and screening events
On site classes	Workshops/Health and Wellness Speakers
Massage Therapists	Discounted products and services
Health and wellness challenges	Gym memberships
Staff wellness rooms	Yoga studio discounts

NCSD's Employee Wellness Program is your partner in health.

EAP Summary of Services

A benefit for you and your family members provided by North Clackamas School District #12

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

Counseling with an EAP Professional

Ten (10) counseling sessions face to face, over the phone, or virtually for concerns such as:

- **Relationship conflict**
- **Conflict at work**
- **Depression**
- **Stress management**
- **Family relationships**
- **Anxiety**
- **Alcohol or drug abuse**
- **Grieving a loss**
- **Professional development**

Resources for Life

Canopy will help locate resources and information related to childcare, eldercare, caregiving, and anything else you may need.

Legal Consultations / Mediation

Contact Canopy for a free thirty-minute office or telephone consultation. A 25% discount from the attorney's/mediator's normal hourly rate is available thereafter.

Financial Coaching

Coaches will provide unlimited financial coaching to help develop better spending habits, reduce debt, improve credit, increase savings, and plan for retirement.

Identity Theft

Up to a 60-minute free consultation with a highly trained Fraud Resolution Specialist™ (FRS) who will conduct emergency response activities and assist with restoring their identity, good credit, and dispute fraudulent debts.

Home Ownership and Housing Support

Assistance and discounts for buying, selling, and refinancing. Resource retrieval for housing assistance.

Coaching

Access phone or video sessions with a Coach to support goal setting, healthy habits, and personal development.

Wellbeing Tools

- Fertility health support
- Online legal tools
- Pet parent resources
- Gym membership discounts

Member Site

Innovative educational tools, chat for support, take self-assessments, view videos and webinars, access courses, download documents and more. Access at **my.canopywell.com**, and register as a new user or log-in. Enter **NCSD** for company name when you register.

WholeLife Directions

Take a confidential survey and get connected to interactive tools to improve the way you feel. Log onto the Member Site or search ***WholeLife Directions*** in the App Store or Google Play.

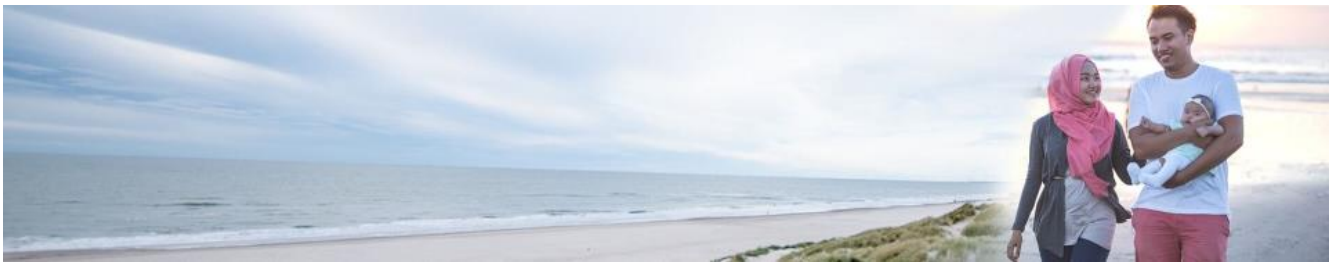
canopy

Crisis Counselors are available by phone 24/7/365

call: 800-433-2320 text: 503-850-7721 email: info@canopywell.com

Canopy is committed to creating a safe, inclusive, and equitable society for all.

Life Insurance



If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security and pay for large expenses such as housing and education, as well as day-to-day living expenses.

BASIC LIFE AND AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. Coverage is provided by The Standard and paid for by North Clackamas School District.

Basic Life Amount	Admin & Confidential: $50,000 Licensed: $6,000 Classified: $12,000
Basic AD&D Amount	Admin & Confidential: $50,000 Licensed: $6,000 Classified: $12,000

VOLUNTARY LIFE

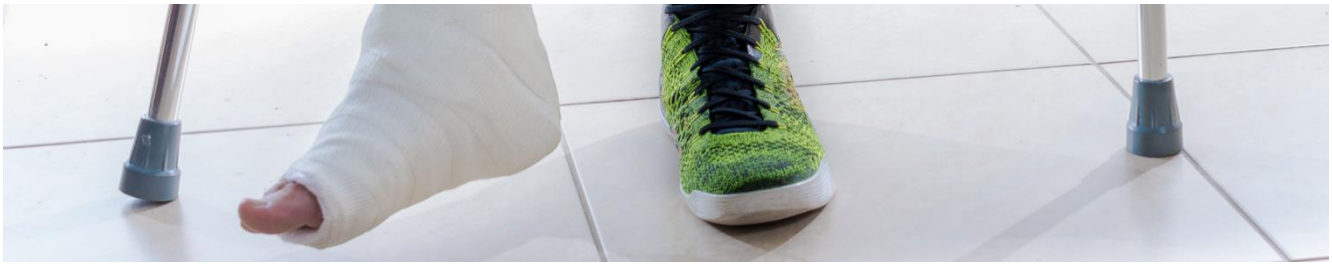
Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by The Standard.

Employee Voluntary Life Amount	Increments of $10,000, up to Lesser of 5 x covered annual earnings or $500,000
Spouse Voluntary Life Amount	Increments of $5,000 up to a maximum of $50,000
Child(ren) Voluntary Life Amount	Increments of $1,000 (age may affect benefit) up to $10,000

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit and update this annually. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

Guaranteed Maximum & Evidence of Insurability: If you select a coverage amount above $150,000 you will need to submit an Evidence of Insurability form with additional information about your health in order for the insurance company to approve this higher amount of coverage. If previously enrolled for a coverage amount less than the guaranteed maximum and less than 5X your annual earnings, you may increase your coverage level by $10,000 during each Open Enrollment period. Any requested increase above $10,000 or above the $150,000 guaranteed maximum requires you to complete and submit an evidence of insurability form for approval by The Standard. *Age reductions may apply

Disability Insurance



VOLUNTARY LONG-TERM DISABILITY INSURANCE

Long-Term Disability (LTD) coverage pays you a certain percentage of your income if you cannot work because an injury or illness prevents you from performing any of your job functions over a long time. It is important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security.

If you qualify, long-term disability benefits begin after short-term disability benefits end. Coverage is provided by The Standard. Includes additional value adds of EAP and Travel Assistance**

Monthly Benefit Amount	60% of pre-disability earnings
Maximum Monthly Benefit	$5,000
Benefits Begin After:	
Accident	90 days
Sickness	90 days
Maximum Payment Period*	To age 65

*The age at which the disability begins may affect the duration of the benefit

**By electing Voluntary Long Term Disability, you are eligible for both Standard Insurance Group's Employee Assistance Program (888.293.6948, TDD: 800.327.1833, workhealthlife.com/Standard3 and Travel Assistance (800.872.1414, text: 609.334.0807 medservices@assistamerica.com, standard.com/travel)

OPSRP Overview and Benefit Calculation

PERS-covered employees hired on or after August 29, 2003 are Oregon Public Service Retirement Plan (OPSRP) members unless membership was previously established in PERS. OPSRP has two components: the Pension Program and the Individual Account Program (IAP).

What is the OPSRP Pension Program?

The OPSRP Pension Program is funded by your employer and provides a lifetime pension. It is designed to provide approximately 45 percent of your **final average salary** at retirement (for a general service member with a 30-year career or a police and firefighter member with a 25-year career).

Final average salary is generally the average of the highest three consecutive years (or less if you were employed for less than three years) or 1/3 of total salary in the last 36 months of employment.

General service member benefit information for the OPSRP Pension Program

Unless you are in a police or firefighter position, you are considered a general service member. When you retire**,** PERS will calculate your monthly benefit using the following formula:

General service: 1.5 percent x years of retirement credit x final average salary. Normal retirement age for general service members is age 65, or age 58 with 30 years of retirement credit.

General Service Benefit Calculation Example (you can estimate your benefit using any number of years and any final average salary)

Final average salary: $45,000
Retirement credit: 30 years as an OPSRP member
30 (years) x 1.5 percent = 45 percent
45 percent x $3,750 (final average monthly salary) = $1,687.50
Single Life Option monthly benefit = $1,687.50 ($20,250 annual benefit)

Police and firefighter (P&F) benefit information for the OPSRP Pension Program

To be classified as a P&F member at retirement, you must have been employed continuously as a P&F member for at least five years immediately preceding your retirement. When you retire, PERS will calculate your monthly benefit using the following formula:

Police and firefighter (P&F): 1.8 percent x years of retirement credit x final average salary. Normal retirement age for P&F members is age 60, or age 53 with 25 years of retirement credit.

P&F Benefit Calculation Example (you can estimate your benefit using any number of years and any final average salary)

Final average salary: $45,000
Retirement credit: 25 years as an OPSRP member
25 (years) x 1.8 percent = 45 percent
45 percent of $3,750 (final average monthly salary) = $1,687.50
Single Life Option monthly benefit = $1,687.50 ($20,250 annual benefit)

What is the Individual Account Program (IAP)?

The Individual Account Program (IAP) is an account-based benefit for all Tier One/Tier Two and Oregon Public Service Retirement Plan (OPSRP) members who have worked in a qualifying position since January 1, 2004.

Contributions
Until July 1, 2020, contributions equaling 6% of your salary were placed in your IAP account. Beginning July 1, 2020, if you earn more than the monthly salary threshold, less money is going into your IAP due to Senate Bill (SB) 1049.

How much money is going into your IAP now depends on whether you are a Tier One/Tier Two or OPSRP member:

- Tier One/Tier Two members (hired before August 29, 2003)
- OPSRP members (hired after August 28, 2003)

However, if you earn less than the monthly salary threshold in any calendar month, your contribution percentage has not changed.

You are automatically vested in your IAP account when your account is established.

Earnings

Earnings or losses are credited annually to member accounts. Administrative fees are deducted from the fund's earnings as part of the annual crediting process. Your IAP is subject to earnings or losses until you receive the funds.

PERS works with employers to ensure that member contributions are accurate and complete before allocating earnings on a year-end balance basis so members are not adversely affected by posting delays or corrections.

Beginning in 2018, IAP accounts shifted from a one-size-fits-all investment format to customized IAP Target-Date Funds designed by the Oregon Investment Council for Oregon public employees.

At retirement

Since January 1, 2011, any retiring members must retire their pension (Tier One, Tier Two, or OPSRP) **and** IAP at the same time, as part of the retirement process.

However, members who only retired from their Tier One, Tier Two, or OPSRP pension prior to January 1, 2011, can retire from the IAP at any time.

Regardless of which of the above applies to you, there are several important factors to keep in mind when you apply for distribution of your IAP:

- IAP accounts are credited with investment earnings and losses based on your IAP Target-Date Fund and are subject to potential losses until you remove the funds.
- IAP accounts have no guaranteed rate of return.

Distribution options at and during retirement
You have the option to roll over your IAP balance into a traditional IRA; an eligible employer plan; a 457 deferred compensation plan, such as the Oregon Savings Growth Plan; or another qualified plan.

When you retire from the IAP, you can also elect to receive your IAP account balance as a lump-sum payment or in equal installments over 5, 10, 15, or 20 years, or over your expected lifetime. You can use the IAP Balance and Installment Calculator to estimate your IAP distribution at retirement. Note: As of

January 1, 2020, PERS retirees receiving installment payments or electing installment payments have their remaining IAP balance invested in the Retirement Installments Fund, which is based on the Oregon Short Term Fund.

If a retired member dies before all installment payments are completed, the beneficiary will receive the remaining amount in a lump-sum payment.

Background
The Oregon Legislature created the IAP in 2003 to provide an individual account-based retirement benefit for new workers hired on or after August 29, 2003, and for Tier One/Tier Two members active on and after January 1, 2004. The IAP benefit is in **addition** to the member's pension benefit (Tier One, Tier Two, or OPSRP).

The IAP was established to receive member contributions on salary paid beginning January 1, 2004.

If you are a Tier One or Tier Two member, you retained your existing Tier One or Tier Two regular and variable accounts, but as of January 1, 2004, no additional member contributions have been placed into those accounts. Instead, your member contribution is now placed in your IAP, with the exception of any portion subject to the redirect under SB 1049.

Supplemental Retirement Benefits

Who is Eligible? Any NCSD staff member with earned income reported via W2.

What Plans Are Offered? 403(b) (Pretax and Roth), 457(b) (Pretax and Roth)

What is a 403(b)? The 403(b) Plan is a voluntary retirement savings plans and are called Tax Sheltered Annuities (TSA for short).

What is a 457(b) plan? The 457(b) Plan is a voluntary retirement savings plans similar to 403(b) Plans, 457(b) Plans are called Deferred Compensation Plans (DCP for short).

What is a Roth contribution? Roth contributions, unlike Traditional pretax 403(b) or 457(b) elective deferral contributions, are subject to Federal and State income tax withholdings (also referred to as after-tax deferrals). The distribution of an employee's contributions from a Roth 403(b) or 457(b) account are tax-free at distribution if qualified, since taxes were paid on the contributions to the account in the year they were deferred.

Why: The 403(b) and 457(b) Plans provide an opportunity for employees to save and supplement PERS and Social Security income in retirement.

How: Carruth Compliance Consulting (CCC) administers these programs on behalf of NCSD. They can provide more information on the plans, verify eligibility for Special Catch-ups, and their website provides detailed information on the vendors and the enrollment steps. Contact CCC at 503.968.8961 or visit www.ncompliance.com.

CARRUTH COMPLIANCE CONSULTING, INC.

	403(b) aka TSA	457(b) aka DCP
2023 Limits (You may contribute to both plans concurrently)	$22,500, under age 50 $30,000, age 50 or older	$22,500, under age 50 $30,000, age 50 or older
Special Catch-ups	15 Years of Service Catch-up: $3,000 per year (5 year max)	3 Year Pre-Retirement Catch-up: $19,000 per year (3 year max)
Traditional vs. Roth Deferrals	Pre-tax dollars – Taxable upon withdrawal. After-tax dollars – Tax-free upon withdrawal, if qualified.	
In-Service Distributions	Age 59 ½	Age 70 ½
Early Withdrawal Penalty	Yes 10% before age 59 ½	No

Representatives

Corebridge Financial (formerly AIG, VALIC) 403(b)/457(b), Roth
Todd McKee 971-334-6191 todd.mckee@corebridgefinancial com
Cecile Nguyen 503.867.3736 cecile.nguyen@corebridgefinancial.com

Penselect/Foresters Financial 403(b)/457(b), Roth
Joshua Bostic 503.296.7676 ext. 282 joshua.bostic@ceterainvestors.com
Anna Pomykala 503.296.7676 ext. 277 anna.pomykala@ceterainvestors.com

Oregon Savings Growth Plan 457(b), Roth
Gladys Salguero 503.937.0357 gladys.salguero@voya.com

Vanguard 403(b), Roth
Customer Service: 1.800.569.4903 or investor.vanguard.com/403b-plans/

Voya 403(b)/457(b); Roth
Rolf Ellingsen 503.517.9363 rolf.ellingsen@voyafa.com
Pam Young 503.257.4637 pamela.young@voyafa.com

Invesco/Oppenheimer Funds
Todd McKee, Joshua Bostic, or Rolf Ellingsen—see contact info above

Tami Booth
Fiscal Services Manager
boothta@nclack.k12.or.us
12400 SE Freeman Way, Milwaukie, Oregon 97222
503-353-6030

DATE: October 2, 2023
TO: Employees Who Have Elected Domestic Partner Coverage
FROM: Tami Booth
RE: Imputed Income

As required by the Internal Revenue Service, employees who have added their domestic partners (and their partner's dependent children) to their health insurance will have the fair market value (FMV) of the premium added to their taxable income. Effective, January 1, 2024, the fair market value of the District's medical, dental, and vision premiums are listed below:

Classified & Confidential Employees

Plans	Adding Domestic Partner (DP)	Adding DP + Children
North Clackamas Plan V	$858.17	$1,548.71
Kaiser Traditional	$781.10	$1,319.43
Kaiser High Deductible	$408.01	$659.39
NC Dental	$46.92	$110.49
Kaiser Dental	$78.01	$140.78
NC Vision	$12.53	$22.61
North Clackamas Plan 1X (Classified Only)	$1,317.27	$2,276.49

Licensed and Administrative Employees

Plans	Adding Domestic Partner (DP)	Adding DP + Children
North Clackamas Plan V	$853.82	$1,540.45
Kaiser Traditional	$777.17	$1,321.19
Kaiser High Deductible	$422.08	$717.54
NC Dental	$48.26	$110.31
Kaiser Dental	$86.80	$156.60
NC Vision	$12.61	$22.63

Your January 2024 paycheck will reflect this amount in taxable income and will continue monthly through December 2024. This amount is subject to FICA, unemployment, federal taxes, and state taxes. It is also subject to PERS for OPSRP members hired into a PERS-eligible position on or after August 29, 2003. Because of the complexity of tax situations, you may consider reviewing with your tax professional.

If you have questions or concerns, please follow up with your Benefits Specialist, Nicole Hirai-Stinnett at 503.353.6022 (Last Names A-K), Shelly Adelhart at 503.353.6026 (Last Names L-Z).

For Assistance

NCSD Payroll and Benefits Contact Information

NCSD
Payroll and Benefits
12400 SE Freeman Way
Milwaukie, OR 97222
http://www.nclack.k12.or.us/business/page/employee-benefits

NICOLE HIRAI-STINNETT: PAYROLL BENEFITS SPECIALIST (A-K)	503-353-6022	hiraistinnettn@nclack.k12.or.us	Benefit Eligibility, Enrollment & Qualifying Events, Payroll Benefit Deductions, Direct Deposit
SHELLY ADELHART: PAYROLL BENEFITS SPECIALIST (L-Z)	503-353-6026	adelharts@nclack.k12.or.us	Benefit Eligibility, Enrollment & Qualifying Events, Payroll Benefit Deductions, Direct Deposit
NE'JUAN THOMPSON: PAYROLL BENEFITS LEAD	503-353-1905	thompsonne@nclack.k12.or.us	Benefit Eligibility, Enrollment & Qualifying Events, Payroll Benefit Deductions, Direct Deposit, PERS
CATHY STRUCK: PAYROLL COMPENSATION SPECIALIST (A-K)	503-353-6024	struckc@nclack.k12.or.us	Earnings, PERS, Tax withholding
NICK BENDER: PAYROLL COMPENSATION SPECIALIST (L-Z)	503-353-6023	bendern@nclack.k12.or.us	Earnings, PERS, Tax withholding
TAMI BOOTH: FISCAL SERVICES MANAGER	503-353-6030	ncbenefits@nclack.k12.or.us	
MATT MAKARA: EXECUTIVE DIRECTOR OF FINANCE AND BUSINESS	503-353-6030	makarama@nclack.k12.or.us	

Plan Contacts

If you need to reach our plan providers, here is their contact information:

PROVIDER	PHONE NUMBER	WEBSITE	POLICY/GROUP #
HMA MEDICAL, RX, VISION, DENTAL	Customer Care 800-869-7093 CVS/Caremark 800-552-8159	www.accesshma.com www.caremark.com	020256
KAISER PERMANENTE MEDICAL, RX, VISION, DENTAL	503-813-2000	www.kp.org	1595
PEAK 1 HRA, VEBA, FSA, COBRA	866-315-1777 Fax: 855-495-3669	www.mypeak1.com	North Clackamas School District Employer ID: PK10698
THE STANDARD LIFE & DISABILITY INSURANCE	888-937-4783 Fax: 888-878-3686	www.standard.com	155439
CANOPY WELL EMPLOYEE ASSISTANCE PROGRAM (EAP)	800-433-2320 Text: 503-850-7721	My.canopywell.com info@canopywell.com	North Clackamas School District
ALLIANT EMPLOYEE BENEFITS BENEFIT CONSULTANTS, ADVOCATES	509-343-9516	Jessica.russo@alliant.com	North Clackamas School District

Words You Need to Know

Health insurance seems to have its own language. You will get more out of your plans if understand the most common terms, explained below in plain English.

MEDICAL

OUT-OF-POCKET COST - A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

DEDUCTIBLE - The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

COINSURANCE - After you meet the deductible amount, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70% coinsurance, you are responsible for paying your coinsurance share, 30% of the cost.

COPAY - A set fee you pay whenever you use a particular healthcare service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.

IN-NETWORK / OUT-OF-NETWORK - Network providers (doctors, hospitals, labs, etc.) are contracted with your health plan and have agreed to charge lower fees to plan members, as negotiated in their contract with the health plan. Services from out-of-network providers can cost you more because the providers are under no obligation to limit their maximum fees. With some plans, such as HMOs and EPOs, services from out-of-network providers are not covered at all.

OUT-OF-POCKET MAXIMUM - The most you would pay from your own money for covered healthcare expenses in one year. Once you reach your plans out-of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year.

PRESCRIPTION DRUG

BRAND NAME - A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs.

GENERIC DRUG - A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor. You generally pay a lower copay for generic drugs.

PREFERRED DRUG - Each health plan has a list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

DENTAL

BASIC SERVICES - Dental services such as fillings, routine extractions and some oral surgery procedures.

DIAGNOSTIC AND PREVENTIVE SERVICES - Generally include routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

MAJOR SERVICES - Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Important Plan Notices and Documents

CURRENT HEALTH PLAN NOTICES

Notices must be provided to plan participants on an annual basis and are available in this packet of open enrollment materials and on our benefits website and include:

- Medicare Part D Notice
  Describes options to access prescription drug coverage for Medicare eligible individuals.
- Women's Health and Cancer Rights Act
  Describes benefits available to those that will or have undergone a mastectomy.
- Newborns' and Mothers' Health Protection Act
  Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery.
- HIPAA Notice of Special Enrollment Rights
  Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment.
- HIPAA Notice of Privacy Practices
  Describes how health information about you may be used and disclosed.
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
  Describes availability of premium assistance for Medicaid eligible dependents.
- Nondiscrimination and Accessibility Requirements Notice
  Describes organization's compliance with Federal non-discrimination laws along with communication and language assistance services.
- COBRA Continuation Coverage
  You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this Notice carefully to make sure you understand your rights and obligations.

CURRENT PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available on our benefits website and include:

Summary Plan Descriptions

A Summary Plan Description (SPD) is the legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

Summary of Benefits and Coverage

A Summary of Benefits and Coverage (SBC) is a document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format.

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the NCSD Group Health Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference. The SPD is available to employees upon request. Please share these materials with your covered family members.

Medicare Part D Notice

Important Notice from North Clackamas School District About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. North Clackamas School District has determined that the prescription drug coverage offered by the HMA and Kaiser Permanente plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your North Clackamas School District coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under the HMA and Kaiser Permanente plans are creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your North Clackamas School District prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with North Clackamas School District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did

not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through North Clackamas School District changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	10/01/2023
Name of Entity:	North Clackamas School District
Contact-Position/Office:	Employee Benefits
Address:	12400 SE Freeman Way, Milwaukie, OR 97222
Phone Number:	(503) 353-6000

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan (888) 901-4636.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at (888) 901-4636.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in North Clackamas School District's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in North Clackamas School District's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective on the date of birth, adoption or placement for adoption date. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in North Clackamas School District's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan

coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for North Clackamas School District describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Human Resources.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2024 of your modified adjusted household income.

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ | Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html

Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ | Phone: 1-877-438-4479
All other Medicaid Website: https://www.in.gov/medicaid/ | Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx | Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll-free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs

Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

The 'No Surprises' Rules

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

General Notice of COBRA Continuation Coverage Rights

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

Introduction

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

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

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Name of Entity:	North Clackamas School District
Contact-Position/Office:	Employee Benefits
Address:	12400 SE Freeman Way, Milwaukie, OR 97222
Phone Number:	(503) 353-6000