



2026 Employee Benefits Handbook

You can download a copy of this booklet to your computer or smart phone by following the link below:

<https://eb.alliant.com/ncsd26benefit-guid/full-view.html>

Or scanning the QR code:



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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 plan benefit booklets determine how all benefits are paid.



Getting Started

2026 Benefits

**Effective January 1, 2026 –
December 31, 2026**

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 Important Notices section for more details.

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/staff

A list of plan contacts is included in this guide.

Who's eligible for benefits?

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

Our Plans

Kaiser Traditional Plan

Kaiser HDHP Plan

HMA Plan V

HMA Plan 1X (Classified Only)

Which Plan Is Right For You?

That depends on your healthcare needs, favorite doctors, and budget. Think about these factors when choosing your medical plan:

- **Do you like your doctors?** Check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more, consider a plan with out-of-network coverage.
- **What are your healthcare needs?** Compare how each plan covers the services you need most often, such as office visits, specialists, or prescriptions.
- **What's your budget?** What will you pay for coverage? Is there a deductible? What is your share of the cost for office visits and prescriptions? All of these factors together affect your total cost for healthcare.

Medical – Kaiser Permanente

KAISER PERMANENTE	TRADITIONAL PLAN	HDHP PLAN
	Kaiser HMO Network Only	Kaiser HMO Network Only
ANNUAL DEDUCTIBLE	\$0 per individual \$0 family limit	\$3,300 per individual \$6,600 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

HMA	PLAN V	PLAN IX CLASSIFIED ONLY
	HMA In-Network	HMA 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)
PRESCRIPTION DRUG	\$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.

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.



Powered by **MDLIVE**

Create an account for fast, hassle-free health care. Anytime. Anywhere.

MDLIVE offers reliable 24/7 health care by phone or video for hundreds of medical and mental health needs.

How to create an account through the HMA Website

- 1 Visit www.accesshma.com/ and click "HMA Member Login."
- 2 Log in to your HMA account.
- 3 Click on "Explore Your Benefits" and click on: "See a doctor now" or "Schedule virtual therapy or psychiatry" or "Access virtual dermatologist," (options will vary based on what services employer has elected) this will redirect to MDLIVE page to register.
- 4 Enter your insurance member ID information and date of birth. If you're a dependent, enter the primary policy holder's ID information and your date of birth. Click "Continue."
- 5 Create your username and password and then complete your profile. Click "Submit."
- 6 Your secure MDLIVE account is now created. Now every time you log in to HMA you are automatically logged into MDLIVE.

How to create an account through the HMA App

- 1 Download the HMA app in the App Store or Google Play Store.
  
- 2 Log in to the HMA Mobile Portal. Click on: "See a doctor now" or "Schedule virtual therapy or psychiatry" or "Access virtual dermatologist," (options will vary based on what services employer has elected) this will redirect to MDLIVE page to register
- 3 Enter your insurance member ID information and date of birth. If you're a dependent, enter the primary policy holder's ID information and your date of birth. Click "Continue."
- 4 Your secure MDLIVE account is now created. Now every time you log in to HMA you are automatically logged into MDLIVE.

Easy ways to join for free:



MDLIVE.com/hma



877-596-0967



Meet Sophie, your personal assistant
Text HMA to 635483



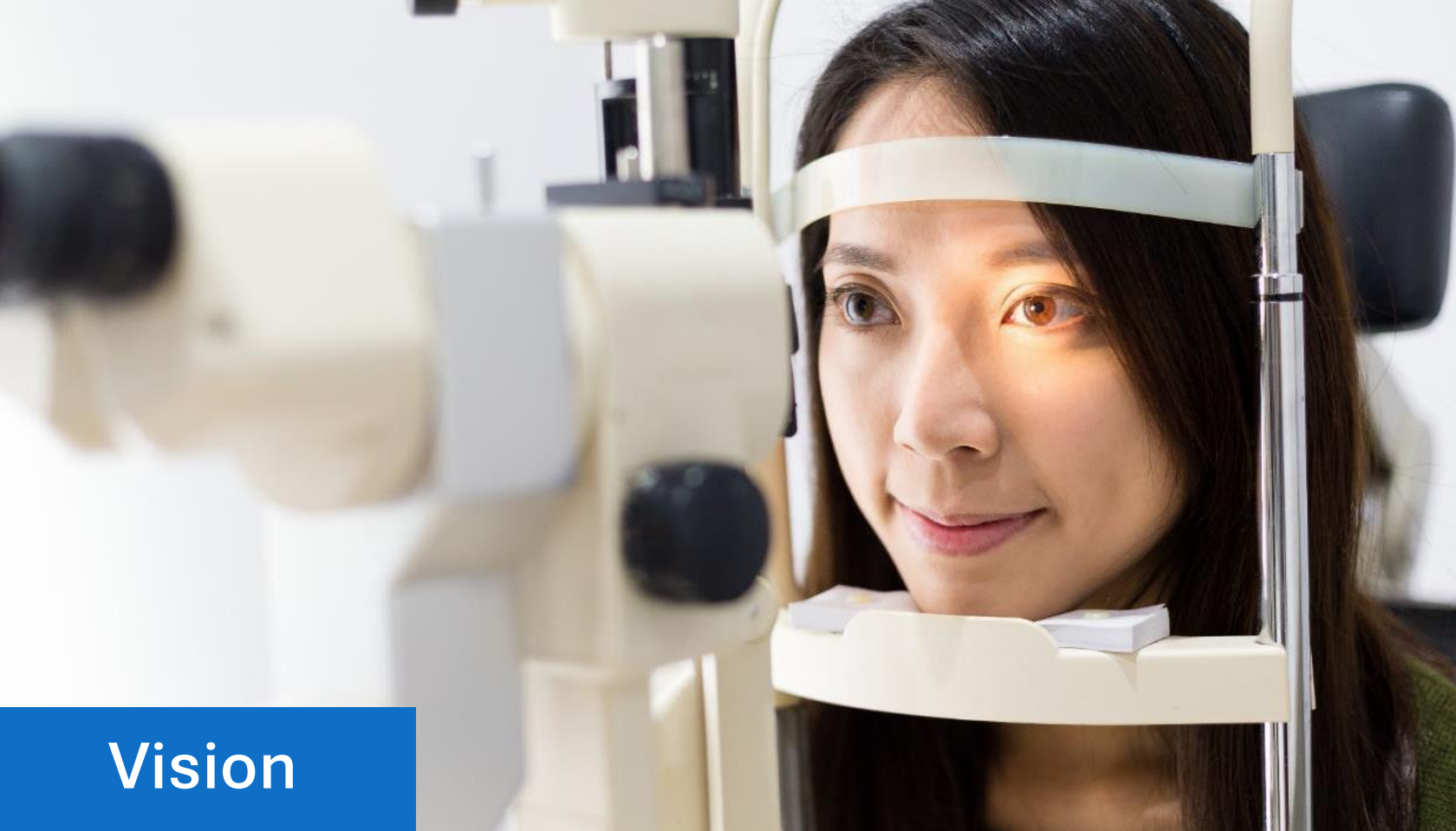
Get the app

MDLIVE is a separate and independent company that provides telehealth services for HMA members.

MDLIVE may not be available in certain states and is subject to state regulations. MDLIVE does not replace the primary care physician, is not an insurance product and may not be able to substitute for traditional in person care in every case or for every condition. MDLIVE does not prescribe DEA controlled substances and may not prescribe non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. MDLIVE does not guarantee patients will receive a prescription. Healthcare professionals using the platform have the right to deny care if based on professional judgment a case is inappropriate for telehealth or for misuse of services. MDLIVE and the MDLIVE logo are registered trademarks of MDLIVE, Inc. and may not be used without written permission. For complete terms of use visit <https://www.MDLIVE.com/terms-of-use/>.

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VISION	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

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

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 dentist 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.

DENTAL	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	Adults & Children Covered at 50% up to \$3,000 lifetime maximum	Adults & Children Covered at 50% up to \$1,500 lifetime maximum

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.



Healthcare FSA

Do you want to save 30% on health-related expenses this year? Enrolling in a healthcare flexible spending account (FSA) can save you up to \$900 a year.

What is a healthcare FSA?

A healthcare FSA is an account that lets you set aside money before taxes to pay for many medical expenses for yourself, your spouse, or eligible dependents.

What can it be used for?

Eligible expenses include things like insurance copayments and deductibles, prescription drugs, vision and dental expenses.

How does it work?

1. During open enrollment, sign up for a healthcare FSA.
2. Choose how much money you'd like to set aside for medical expenses.
3. The amount you've chosen is divided equally and deducted from your paycheck over the course of the year.
4. When paying for eligible expenses, you can use your Peak One Debit Card to pay direct or use your personal funds and get reimbursed.

When can I use it?

Conveniently, the total amount you've chosen to put in your FSA is available to start spending on the first day of your plan.

Helpful Tips

Plan ahead to maximize your healthcare FSA and use all your funds each year.

- Review what you paid for health-related expenses last year – are there any reoccurring items?
- Think about the upcoming year – does anyone in your family need orthodontia or vision care? Are you thinking of having a child?
- Use the information to figure out how much you'd like to have in your FSA.

Did You Know?

You can use your FSA for:

- Medical procedures and surgeries
- Exercise and wellness expenses
- Family planning and care
- Many prescription drugs, vitamins, and probiotics

**Sign up for a
healthcare FSA and
start saving today!**

www.PeakOneAdmin.com

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





Dependent Care FSA

Do you want to save 30% on daycare or caregiving expenses? Enrolling in a dependent care flexible spending account (FSA) can save you up to \$1,500 a year.

What is a dependent care FSA?

A dependent care FSA is an account that lets you set aside money before taxes to pay care providers who watch your children and eligible dependents while you're at work.

What can it be used for?

Eligible expenses include before- or after-school care for children 12 or younger, custodial care for dependent adults, licensed daycare centers, a nanny or au pair, preschools, and day camps.

How does it work?

1. During open enrollment, sign up for a dependent care FSA.
2. Choose how much money you'd like to set aside for daycare or caregiving expenses.
3. The amount of money you've chosen will be divided equally and deducted from your paycheck over the course of the year.

When can I use it?

Reimbursement won't be processed until you have enough funds in your account.

Helpful Tips

Plan ahead to maximize your dependent care FSA and use all your funds each year.

- Calculate how much you would normally spend on your dependents' care for 12 months.
- Note that there is an annual contribution limit of \$7,500.
- Set up direct deposit to receive reimbursements faster.
- Download the Peak1 Admin mobile app to check your account balance and send your claim by uploading a photo of your detailed receipt.

Did You Know?

- You can also use funds for a licensed after-school program or summer camp if your child is age 12 or younger or is disabled.
- If you experience a qualifying event, like having a baby or assuming care for an elderly person, you can sign up outside of the annual enrollment period.
- If your care provider changes rates or fees, you may also adjust the amount you set aside.

**Sign up for a
dependent care FSA
and start saving today!**

www.PeakOneAdmin.com

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





North Clackamas School District Funded HRA Fact Sheet

What is a Funded HRA?

The Funded HRA is an account established for those enrolled in **NC-plan V** and funded by North Clackamas School District once a year. The 2026 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 7:00am – 4:00pm PT and Friday from 7:00am to 3:00pm PT, excluding holidays.

Only applies to **Plan V Medical Participants**
enrolled during the Open Enrollment window for Plan
Year 2026. Funds available 1/1/2026.

**Kaiser members and Mid-Year New Hires are not
eligible for funded HRA.**



Peak1 Admin Mobile App

Make better healthcare spending and saving decisions.

A simple, intuitive, powerful mobile app experience

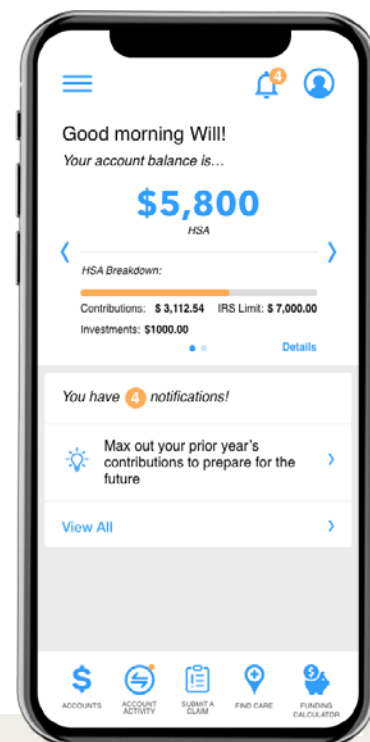
The Peak One Administration Peak1 Admin Mobile App takes the guesswork out of your healthcare spending and saving decisions. Access and manage your Health Benefit Accounts on the go, and take advantage of the app's powerful money-saving tools.

Get the most out of every dollar you spend or save

- **Virtual medicine cabinet** to help you find ways to save on your prescriptions
- **Personalized recommendations** to help you make informed decisions about where to best spend and save your healthcare dollars
- **Find care** to help you search for providers or procedure and drug prices
- **Funding calculator** to help you save for the future

On-the-go access

- Check your balance
- Submit claims for reimbursement
- View claims status
- Manage account activity
- Store receipts
- Use a pharmacy discount card
- Check item eligibility



Download today!

The Peak One Administration Peak1 Admin Mobile App is available on the App Store and Google Play.



Employee Wellness

At NCSD, we believe that health and wellness are essential to a thriving professional culture. When our employees are well—physically, mentally, and emotionally—our entire community benefits.

Through our Employee Wellness Program (funded by payroll contributions), you have access to:

Examples of building level work:	Examples of program level costs:
<ul style="list-style-type: none">• Staff Room makeovers• Produce Delivery• On site classes Workshops/Health and Wellness Speakers• Massage Therapists• Health and wellness challenges• Staff wellness rooms	<ul style="list-style-type: none">• District wide challenges• Health campaigns and screening events• Discounted products and services

Plus, 50% of your contribution goes directly back to your building to support wellness efforts that matter most to your team.

Your participation helps build a healthier, more supportive workplace for everyone.



EAP Summary of Services

The Employee Assistance Program (**EAP**) is a **FREE** and **CONFIDENTIAL** benefit for you and your family members provided by **North Clackamas School District #12**

Counseling

Ten (10) sessions in-person, on the phone or virtually for concerns such as:

- **Depression**
- **Anxiety**
- **Relationships and family**
- **Workplace challenges**
- **Stress management**
- **Alcohol or substance misuse**
- **Grief and loss**
- **Professional development**

Resources for Life

Assistance in finding childcare, adult care, caregiving resources, and more.

Legal Consultations/Mediation

Free 30-minute consultation and a 25% discount on services thereafter.

Financial Coaching

Unlimited guidance to improve spending, debt reduction, credit enhancement, savings, and retirement planning.

Identity Theft

60-minute consultation with a Fraud Resolution Specialist™ to restore identity and credit.

Home Ownership and Housing Support

Aid and discounts for home transactions and housing assistance resources.

Coaching

Three (3) phone or video sessions with a Coach for goal setting, healthy habits, and personal development.

Pet Parent Resources

Information, support, and discounts for pet owners.

Wellbeing Tools

Fertility health support, wellness resources, and gym discounts.

Member Site

Personal and professional development videos, webinars, self-assessments, online legal tools and more at **my.canopywell.com**. Log-in or register as a new user with organization name: **NCS**

Self-Scheduling Portal

Register with your work email address for online provider search and appointment management.

Enlight

Access digital therapy and wellness tools to improve the way you feel. **Download the Canopy app** by searching for "Canopy EAP" in Google Play or the App Store.

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

Crisis Counselors are
available by phone
24/7/365



800-433-2320



503-850-7721



my.canopywell.com



Life & Disability

Name Your Beneficiaries

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.

Is your family protected?

Life, AD&D, and disability insurance can fill financial gaps due to a loss of income. Consider your day-to-day costs and bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (housing, education, loans, credit cards, etc.) after the death of a spouse or partner.

If you need more

In addition to company-provided coverage, we offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Life Plan for details.

Life and AD&D Insurance



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 Symetra 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

Guaranteed Maximum & Evidence of Insurability

If you select a coverage amount above \$200,000 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 \$200,000 guaranteed maximum requires you to complete and submit an evidence of insurability form for approval by Symetra.

*Age reductions may apply

Voluntary Life

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

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

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.

Coverage is provided by Symetra Life Insurance Company.



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, or 5 years whichever is shorter

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

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.

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

What Plans Are Offered? 403(b) and 457(b) (Pretax and Roth accounts offered in both plans)

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 (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.

How?: Penserv Plan Services administers these programs on behalf of NCSD. Contact Penserv with any questions, to verify eligibility for Special Catch-ups, to learn more about vendors, and for the enrollment steps for these plans. **Contact Penserv at 803.791.4923 or email service@penserv.com.**



	403(b) aka TSA	457(b) aka DCP
2025 Limits (You may contribute to both plans concurrently and max out in)	\$23,500, under age 50 \$31,000, age 50 or older	\$23,500, under age 50 \$31,000, age 50 or older
Special Catch-ups	15 Years of Service Catch-up: Up to \$3,000 per year (5 year max)	3 Year Pre-Retirement Catch-up: Up to \$47,000 per year (3 year max)
Traditional vs. Roth Deferrals	Traditional Pre-tax dollars – Taxable upon withdrawal. Roth After-tax dollars – Deferrals 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
Cecile Nguyen 503.310.5822 cecile.nguyen@corebridgefinancial.com
Fiona Cosmann 541.414.5015 fiona.cosmann@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
Tim Ertz 503.789.9216 tim.ertz@voya.com

Vanguard 403(b), Roth (Self-Managed, employer #437595)
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
Joshua Bostic, or Rolf Ellingsen—see contact info above



2026 Domestic Partnership Imputed Income Rates

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, 2026, 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	\$1,021.95	\$1,844.32
Kaiser Traditional	\$1,025.95	\$1,733.78
Kaiser High Deductible	\$492.42	\$795.80
NC Dental	\$46.79	\$110.25
Kaiser Dental	\$79.77	\$143.96
NC Vision	\$11.94	\$22.71
North Clackamas Plan 1X (Classified Only)	\$1,497.07	\$2,585.62

Licensed and Administrative Employees

Plans	Adding Domestic Partner (DP)	Adding DP + Children
North Clackamas Plan V	\$1,017.09	\$1,835.08
Kaiser Traditional	\$1,016.36	\$1,727.81
Kaiser High Deductible	\$509.40	\$865.98
NC Dental	\$48.26	\$110.31
Kaiser Dental	\$88.76	\$160.14
NC Vision	\$12.02	\$22.73

Your January 2026 paycheck will reflect this amount in taxable income and will continue monthly through December 2026. 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 Department at 503-353-5366 or ncbenefits@nclack.k12.or.us



Important Plan Information

In this section, you'll find important plan information, including:

- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.

Plan contacts and resources

North Clackamas School District

Payroll and Benefits

12400 SE Freeman Way

Milwaukie, OR 97222

<http://www.nclack.k12.or.us/business/page/employee-benefits>

NICOLE HIRAI-STINNETT: BENEFITS LEAD	503-353-6022 503-353-5366	hiraistinnett@nclack.k12.or.us ncbenefits@nclack.k12.or.us	Benefit Eligibility, Enrollment & Qualifying Events, Supplemental Retirement Contributions, Retirement
DANNA OXMAN: PAYROLL BENEFITS LEAD (A-Z)	503-353-1905	oxmand@nclack.k12.or.us ncbenefits@nclack.k12.or.us	Benefit Eligibility, Enrollment & Qualifying Events, Supplemental Retirement Contributions, Retirement
SHELLY ADELHART: PAYROLL BENEFITS SPECIALIST (L-Z)	503-353-6026	adelharts@nclack.k12.or.us ncbenefits@nclack.k12.or.us	Benefit Eligibility, Enrollment & Qualifying Events, Supplemental Retirement Contributions, Retirement
CATHY STRUCK: PAYROLL COMPENSATION SPECIALIST (A-K)	503-353-6024	struckc@nclack.k12.or.us ncpayroll@nclack.k12.or.us	Earnings, PERS, Tax withholding, Direct Deposit
NICK BENDER: PAYROLL COMPENSATION SPECIALIST (L-Z)	503-353-6023	bendern@nclack.k12.or.us ncpayroll@nclack.k12.or.us	Earnings, PERS, Tax withholding, Direct Deposit
EUNICE SCOTTO: EMPLOYEE SERVICES MANAGER	503-353-6030	scottoe@nclack.k12.or.us ncbenefits@nclack.k12.or.us	
MATT MAKARA: EXECUTIVE DIRECTOR OF FINANCE AND BUSINESS	503-353-6030	makarama@nclack.k12.or.us	

Provider Contact Information

PROVIDER	PHONE NUMBER	WEBSITE	POLICY/GROUP #
HMA	Customer Care	www.accesshma.com	020256
MEDICAL, RX, VISION, DENTAL	800-869-7093 Prime Therapeutics 800-424-0472	www.primetherapeutics.com	
KAISER PERMANENTE	503-813-2000	www.kp.org	1595
MEDICAL, RX, VISION, DENTAL			
PEAK 1	866-315-1777	www.mypeak1.com	North Clackamas School District
HRA, VEBA, FSA, COBRA	Fax: 855-495-3669		Employer ID: PK10698
SYMETRA	1-800-426-7784	www.symetra.com	01-021261-00
LIFE & DISABILITY INSURANCE			
CANOPY WELL	800-433-2320	My.canopywell.com	North Clackamas School District
EMPLOYEE ASSISTANCE PROGRAM (EAP)	Text: 503-850-7721	info@canopywell.com	
ALLIANT EMPLOYEE BENEFITS	509-343-9516	Jessica.russo@alliant.com	North Clackamas School District
BENEFIT CONSULTANTS, ADVOCATES			
SYMETRA	1-800-426-7784	www.symetra.com	01-021261-00
PAID LEAVE OREGON			

Glossary

Accumulation Period

The period of time during which you can incur eligible expenses toward your deductible, out-of-pocket maximum, and visit limitations. The accumulation period for your deductible and OOP maximum may differ from the period for visit limitations.

Aggregate Deductible

A type of family deductible in which a family must meet the entire family deductible before the plan covers eligible expenses for any individual.

Aggregate Out-of-Pocket Max

A type of family out-of-pocket maximum in which a family must meet the entire family out-of-pocket maximum before the plan pays 100% of eligible expenses for any individual.

Allowed Amount

The maximum amount your insurance plan will pay for an eligible expense. In-network providers cannot bill you for more than the allowed amount.

Ambulatory Surgery Center

A healthcare facility that specializes in same-day surgical procedures.

Annual Limit

The maximum dollar amount or number of visits your plan will cover for a specific service during a plan year. If you reach an annual limit, you must pay all associated costs for that service for the rest of the plan year.

Balance Billing

Balance billing is when an out-of-network provider bills you for more than your plan's allowed amount. For example, if the provider charges \$100 but the plan's allowed amount is only \$70, an out-of-network provider can bill you for the \$30 difference. Balance billing may not be allowed for all services; consult your insurance plan documents for details.

Beneficiary

The people or entities you select to receive a benefit if you die. You must name beneficiaries for life, AD&D, and retirement plans to ensure the money is distributed according to your wishes.

Brand-Name Drug

A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. Your coinsurance for brand-name drugs may be higher if there is a generic equivalent available.

Claim

A request for payment that you or your provider submits to your insurance plan after you receive services.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that allows you to temporarily keep your health insurance after your employment ends, based on certain qualifying events. If you elect COBRA coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Coinsurance

The percentage of the allowed amount you must pay for an eligible expense. Coinsurance will always add up to 100%. For example, if the plan pays 70% of the allowed amount, your coinsurance is 30%. If your plan has a deductible, you pay 100% of most costs until you have paid the deductible amount.

Copayment (Copay)

A flat fee you pay for some services, such as a doctor's office visit. You pay the copayment at the time you receive care. In most cases, copays do not count toward your deductible.

Deductible

The dollar amount you must pay for eligible expenses before your insurance starts covering a portion. The deductible does not apply to preventive care or certain other services.

Dental Basic Services

Services such as fillings, routine extractions, and some oral surgery procedures.

Dental Diagnostic & Preventive

Generally includes routine cleanings, oral exams, X-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to twice a year.

Dental Major Services

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

Eligible Expense

Also referred to as a covered service, this is a service or product for which your insurance plan will pay a portion of the allowed amount. Your plan will not cover any portion of the cost if the expense is not eligible, and the amount you pay will not count toward your deductible.

Embedded Deductible

A type of family deductible in which the plan covers eligible expenses for each person as soon as they reach their individual deductible.

Embedded Out-of-Pocket Max

A type of family out-of-pocket maximum in which the plan pays 100% of eligible expenses for a person as soon as they reach their individual out-of-pocket maximum.

Excluded Service

A service for which your insurance will not pay any portion of the cost. These services may also be referred to as "ineligible," "not covered," or "not allowed."

Glossary

Formulary

A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a preferred drug list.

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 the brand-name drug Lipitor.

Grandfathered

A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

In Network

Also known as participating providers, in-network providers have a contract with your insurance plan. They are usually the lowest-cost option because they have agreed not to charge you more than the allowed amount, and your insurance will cover a bigger portion of eligible expenses than with out-of-network providers.

Mail Order

A medical or prescription drug plan feature allowing a 90-day supply of medicines you take routinely to be delivered by mail.

Out of Network

Also known as nonparticipating providers, out-of-network providers do not have a contract with your insurance plan. They are typically a higher-cost option because they can charge you more than your plan's allowed amount, and your insurance will cover a smaller portion of eligible expenses than with in-network providers. Some plans do not cover out-of-network services at all.

Out-of-Pocket Costs

Healthcare expenses you are responsible for paying, whether from your bank account, credit card, or from a health savings account such as an HSA, FSA or HRA. These costs include any deductibles, copays, and coinsurance you pay for eligible expenses, along with the cost of any services your insurance does not cover.

Out-of-Pocket Maximum

The maximum amount of money you will have to spend on eligible expenses during a plan year. Once you spend this amount, your plan covers 100% of eligible expenses for the rest of the plan year.

Outpatient Care

Care from a hospital or clinic that doesn't require you to stay overnight.

Participating Pharmacy

Also known as an in-network pharmacy, a participating pharmacy has a contract with your medical or prescription drug plan. You will typically pay lower prescription costs at a participating pharmacy.

Plan Year

A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug

A list of prescription drugs your insurance will cover at the highest benefit level. The list, also known as a "formulary," is based on an evaluation of effectiveness and cost. Your coinsurance may be higher for drugs that are not on this list, or your insurance may not cover them at all.

Preventive Care

Routine healthcare services that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems.

Primary Care Provider (PCP)

Your main doctor. Some insurance plans require you to name a PCP, who will direct or approve all of your healthcare and referrals.

Provider

A doctor, dentist, physician's assistant, nurse, hospital, lab, or other healthcare professional or facility that provides healthcare services.

Telehealth/Telemedicine

A virtual visit with a provider using video chat on a computer, tablet or smartphone.

Usual, Customary, and Reasonable (UCR)

The cost of a medical service in a geographic area based on what providers in the area usually charge for the same or a similar medical service. Your plan may use the UCR amount as the allowed amount.

Urgent Care

Care for an illness, injury, or condition that needs attention right away but is not severe enough to require the emergency room. Treatment at an urgent care center generally costs less than an emergency room visit.

Vaccinations

Also known as "immunizations," vaccinations are biological preparations that help prevent or reduce the severity of specific diseases.

Voluntary Benefit

An optional benefit offered by your employer for which you pay the entire premium, usually through payroll deduction.

Important plan information

Health plan notices

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located on our benefits website.

- **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.
- **General Notice of COBRA Continuation Rights:** Describes when COBRA may become available to you and your family and what you need to do to protect your right to receive it.
- **Notice of Nondiscrimination:** Describes organization's compliance with Federal non-discrimination laws.
- **Medicare Secondary Payer (MSP) Notice:** Describes the situations where Medicare does not have primary payment responsibilities.

Annual Notices

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 Kaiser Permanente and HMA plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

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 Kaiser Permanente and HMA plan is 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](https://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 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](https://www.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:	10/01/2025
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 administrator (800) 722-1471.

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 (800) 722-1471.

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.

HIPAA Notice of Privacy Practices

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 Employee Benefits.

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 March 17, 2025. 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://hcpf.colorado.gov/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.flmedicaidtprecovery.com/flmedicaidtprecovery.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
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: (800) 403-0864 Member Services Phone: (800) 457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) 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/kihhip.aspx Phone: 1-855-459-6328 Email: KIHIP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov 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/health-care-coverage/ Phone: 1-800-657-3672
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: HSHIPPPProgram@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 HIP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
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 and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 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 Rlte 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
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
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 March 17, 2025, 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

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 receive 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 period¹ 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 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

Notice of Nondiscrimination

North Clackamas School District (NCSD) prohibits discrimination and harassment on any basis protected by law, including but not limited to an individual's perceived or actual race, color, religion, sex, sexual orientation, gender identity, national or ethnic origin, marital status, age, mental or physical disability, pregnancy, familial status, economic status, or veterans' status, or because of the perceived or actual race, color, religion, sex, sexual orientation, gender identity, national or ethnic origin, marital status, age, mental or physical disability, pregnancy, familial status, economic status, or veterans' status of any other persons with whom the individual associates. For inquiries regarding discrimination or the Americans with Disabilities Act (ADA), contact Title IX Coordinator Michelle Riddell at 503-353-6000. NCSD's Section 504 Program Manager is Tammy O'Neill at 503-353-6000. NCSD's Civil Rights Coordinator is Dr. Khaliyah Williams-Rodríguez at 503-353-6000.

Medicare Secondary Payer (MSP) Notice

Medicare Secondary Payer (MSP) regulations is a term used when Medicare does not have primary payment responsibilities. This term applies to all active district employees and their dependents currently enrolled in a district active medical plan in addition to being covered under Medicare. It does not apply to retirees enrolled in district Retiree coverage.

If you are an active employee or employee's dependent enrolled in a district plan as well as Medicare, please be advised that the district's coverage is primary. This simply means the district coverage must pay first and then Medicare will pick up any eligible balances. It is your responsibility to inform your providers that you are enrolled in both plans and the employee active plan is primary.

When you, your spouse, or your dependents receive health care services, be sure to tell our doctor or other providers about any changes in your insurance. If you elect Kaiser, please make sure you use the Kaiser Facilities and Providers as Kaiser requires. If you and/or your dependents seek services from providers outside of the Kaiser network, you will be held responsible for any and all charges that would have otherwise been processed by Kaiser on a primary basis.

Plan documents

Important documents for our health plan and retirement plan are available on our benefits website. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Benefits team.

Summary plan descriptions (SPD)

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 (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available on our benefits website and carrier websites.

Statement of Material Modifications

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

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This image shows a full page of white paper with horizontal grey ruling lines. The lines are evenly spaced and run across the width of the page, providing a template for handwriting practice or general writing. There are no margins, text, or other markings on the page.

