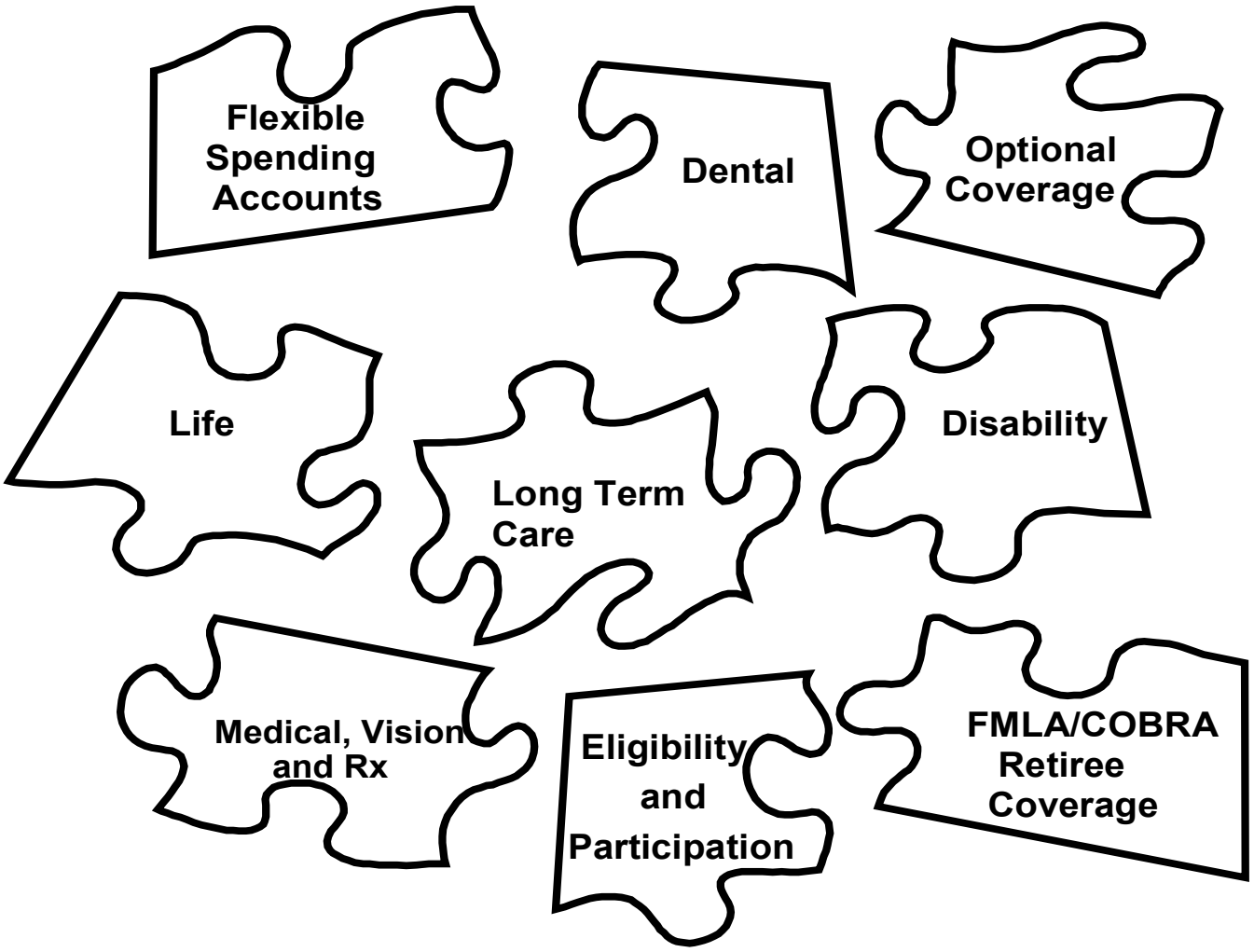
CLACKAMAS COUNTY

BENEFITS HANDBOOK

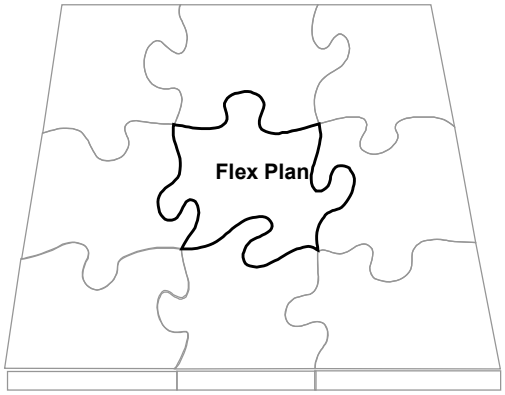


If you have any questions about your benefits or the information in this handbook, please contact the Benefits & Wellness Division at benefits@clackamas.us or (503) 655-8550.

Updated December 2021

TABLE OF CONTENTS

CLACKAMAS COUNTY
BENEFITS PROGRAM



- This handbook provides information on the Clackamas County Benefits Program. It has been prepared as a summary of the Benefits Plan Document and contracts with insurance providers.
- In the event of a discrepancy, the plan document or contract will govern.
- Every employee who is eligible to participate in the program has the opportunity to make enrollment changes each plan year as allowed by Section 125 of the Internal Revenue Code.

This booklet is available on the county internet/intranet Benefits site: Benefits Handbook

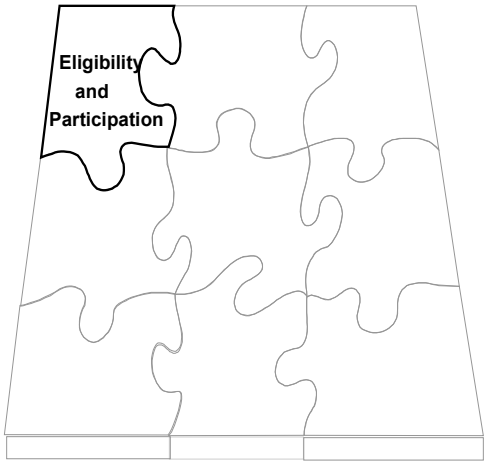
THE BENEFITS PROGRAM OFFERS:

- A Choice of Three Medical Plans with Vision and Prescription Drug Coverage
- Alternative Care Benefits
- A Choice of Four Dental Plans
- Wellness and Employee Assistance Program
- Group Term Life Insurance
- Long-Term Disability Insurance with Optional Salary Buy-Up Program
- A Choice of Full Benefits or Lesser Benefits with Flex Cash
- Health Care Flexible Spending Account (FSA)
- Dependent Care Flexible Spending Account (FSA)
- Optional Group Universal Life Insurance
- Optional Accidental Death & Dismemberment (AD&D) Insurance
- Optional Long Term Care Insurance
- Optional Voluntary Benefits through AFLAC and MetLife Legal

FOR HELP WITH YOUR BENEFITS

- Do not hesitate to call, fax or email information to the Benefits & Wellness Division
  - Customer Service..... (503) 655-8550
  - FAX Number ..... (503) 742-5468
  - Email Address..... Benefits@clackamas.us

ELIGIBILITY AND PARTICIPATION



ELIGIBLE EMPLOYEES

- Any regular employee who is classified by Clackamas County as an Elected Official, Non-Represented employee, or Represented employee in one of the following bargaining units: AFSCME (DTD, WES, or C-COM), FOPPO, Employees' Association, or Housing Authority Employees' Association.
- You must work 30 or more hours per week to be eligible for the full Benefits Program. Employees working in a position of 20-29 hours per week are eligible for the Benefits Program *except* for County-paid dental, group term life and disability coverage. Employees in job share positions must work at least 18.75 hours to be eligible for benefits.
- Your benefits become effective the first day of the month following the month in which employment commences.
- Employment commencement is when you begin working your regular work schedule.

ELIGIBLE FAMILY MEMBERS

- Your spouse or qualified domestic partner.
  - You and your domestic partner must complete a notarized Affidavit of Domestic Partnership to enroll your domestic partner as an eligible family member. We will accept a Certificate of Registered Domestic Partnership issued by any county in Oregon (or any other state with a similar law) in lieu of our Affidavit of Domestic Partnership.
- Your natural or legally adopted children, your spouse's or domestic partner's children, children residing in your home pending adoption, and/or children under court-appointed guardianship.
  - Children may be enrolled regardless of their student status, marital status, or tax dependent status until age 26.
- If your child is disabled, coverage may continue beyond age 26 provided you submit yearly certification of disability from your child's physician, starting with age 21. To qualify, your child must have either a physical handicap or a developmental disability that occurred prior to age 21 ***and*** is incapable of self-support. Coverage will continue as long as the child continues to be primarily supported by the employee or the employee's spouse. Contact your medical plan provider for the certification form at least one month prior to your child's 21st birthday.
- Eligibility is subject to change according to County policy and to comply with the Internal Revenue Code and Federal and/or State laws.

LEAVE OF ABSENCE

- If you had a qualified life event during a leave of absence, you may make enrollment changes.

CHANGING BETWEEN REPRESENTED AND NON-REPRESENTED EMPLOYEE GROUPS

- If you change from a Represented group to the Non-Represented group during the plan year, you are eligible for the benefits available under the Non-Represented Benefits Plan.
  - You may enroll in or make changes to your flexible spending account.
  - There are two levels of coverage under the Non-Represented group term life insurance – full coverage of $150,000 at no cost and $50,000 with flex cash back. You will be enrolled in the higher option ($150,000) unless you choose the lower option ($50,000) in ESS.
  - If you do not choose the $150,000 at this time, but want to increase your coverage at a later date, you will be required to provide an evidence of insurability (statement of health questionnaire). Any such increase will be subject to approval by Metropolitan Life.

- Your benefits under the Non-Represented group take effect the first of the month following the date of promotion or reclassification.
- If you change from a Non-Represented to Represented group during the plan year, you are eligible for the benefits under the bargaining group you are moving to.

RETURNING TO EMPLOYMENT AFTER TERMINATION

- **Reinstatement:** If you are reinstated ***within 6 months*** of your termination, re-enrollment is not required. You will be enrolled in the same Benefit plan options you had prior to your separation of service. Benefits would begin the first of the month following the date of reinstatement.
- **Rehire:** If you are rehired ***more than 6 months*** following a termination of employment, you may make new enrollments which will begin the 1st of the month following the month in which employment re-commences.
- **Return from Economic or Medical Layoff:** If you return within six (6) months or if you return within eighteen (18) months, *and* have continuously participated in COBRA continuation coverage, then you will be enrolled in the same Benefit plan options you had prior to layoff. Benefits would begin the first of the month following return from layoff.
- **Re-Enrollment Procedure:** You must complete enrollments in ESS for the plan year in which you are rehired.
  - If you had a qualified life event since the date of your termination or layoff, you may make enrollment changes.

DEFAULT PROVISION FOR NEW BENEFITS PROGRAM PARTICIPANTS

For new enrollments, your benefit selections in Employee Self Service (ESS) are due by the end of the month in which your benefits become effective. If you fail to make plan elections by your due date then you will be automatically enrolled in the Kaiser medical plan and the Delta Dental Preventive dental plan for single coverage only.

PARTICIPATION IN THE BENEFITS PROGRAM ENDS

- At the end of month in which your regular hours are reduced to less than 20 hours per week.
- Your employment with the County ends (resignation, layoff, retirement, dismissal, death).
- At the end of each plan year for Flexible Spending Accounts.

QUALIFIED LIFE EVENTS

Benefit plans are regulated by Section 125 of the Internal Revenue Code (IRC). This allows you to change your enrollment selections only during Open Enrollment and/or because of a qualified life event. Beneficiaries may be changed at any time during the plan year.

- All enrollment changes must be completed through the Benefits & Wellness Division, not through the insurance provider.
- To make changes, you must contact Benefits & Wellness at 503-655-8550 or at Benefits@clackamas.us **within 60 days of the qualifying event.** If you do not meet this 60-day deadline, you will not be able to make any changes until the next Open Enrollment.

BIRTH OF CHILD

- Contact Benefits & Wellness at 503-655-8550 or at Benefits@clackamas.us **within 60 days** from the date of birth.
- Provide a photocopy of the birth certificate from the birth facility or Department of Vital Statistics and Social Security Number as soon as you receive it.
- Enroll in all required coverage (Medical and/or Dental Insurance) in ESS. Changes to your Medical and/or Dental coverage are allowed.
- There are several optional changes you can make at this time:
  - You may add family life insurance coverage.
  - You may update your beneficiary designations for Life Insurance (including Group Universal Life (GUL) and AD&D), PERS/OPSRP and/or IAP by completing the necessary beneficiary form. If you have already selected the PERS/OPSRP Standard Designation, the child is automatically covered.

- You may begin participation in a Health Care and/or Dependent Care Flexible Spending Account (FSA), add the child to an existing FSA, or increase or decrease contributions to an existing FSA. You must enroll or update your FSA election in ESS to make any of these changes.
- You may add your newborn to your existing Group Universal Life and/or Accidental Death & Dismemberment insurance.
- Benefits are effective as of the date of birth.

ADOPTION AND LEGAL GUARDIANSHIP

- Contact Benefits & Wellness at 503-655-8550 or at Benefits@clackamas.us **within 60 days** from the date of placement, adoption or legal guardianship.
- Provide a photocopy of proof of placement from the adoption agency or legal guardianship court papers and Social Security Number.
- Enroll in all required coverage (Medical and/or Dental Insurance) in ESS. Changes to your Medical and/or Dental coverage are allowed.
- There are several optional changes you can make at this time:
  - You may add family life insurance coverage.
  - You may update your beneficiary designations for Life Insurance (including GUL and AD&D), PERS/OPSRP and/or IAP by completing the necessary beneficiary form. If you have already selected the PERS/OPSRP Standard Designation, an adopted child is automatically covered; a child under legal guardianship is not.
  - You may begin participation in a Health Care and/or Dependent Care Flexible Spending Account (FSA), add the child to an existing FSA, or increase or decrease contributions to an existing FSA. You must enroll or update your FSA election in ESS to make any of these changes.
  - You may add your child to existing Group Universal Life and/or AD&D insurance.

ADDING GRANDCHILDREN

- Children of qualified covered dependent children may be eligible for coverage under the County's medical, dental, vision and EAP plans. All plans require proof of legal guardianship by the employee or Spouse in order to enroll the child(ren).
- Children of non-covered dependent children may be eligible for coverage under the County's medical, dental, vision and EAP plans. All plans require proof of legal guardianship by the employee or Spouse in order to enroll the child(ren).
- Contact Benefits & Wellness at 503-655-8550 or at Benefits@clackamas.us **within 60 days** from the date of legal guardianship or date of legal custody as granted by the courts. Provide a photocopy of the birth certificate and Social Security number for each child you are adding onto coverage.
- Enroll in all required coverage (Medical and/or Dental insurance) in ESS. Changes to your Medical and/or Dental coverage are allowed.
- There are several optional changes you can make at this time:
  - You may add family life insurance coverage or enroll your grandchild in existing family life insurance, Group Universal Life and/or AD&D insurance.
  - You may update beneficiary designations for Life Insurance (including Group Universal Life and AD&D), PERS/OPSRP and/or IAP by completing the necessary beneficiary form.
  - You may begin participation in a Health Care and/or Dependent Care Flexible Spending Account (FSA), add the child to an existing FSA, or increase or decrease contributions to an existing FSA. You must enroll or update your FSA election in ESS to make any of these changes.

MARRIAGE

- To Enroll your new spouse and any eligible stepchildren you must contact Benefits & Wellness at 503-655-8550 or at Benefits@clackamas.us **within 60 days** from the date of marriage.
- Provide a photocopy of your marriage certificate and photocopies of birth certificates and Social Security Numbers for all new dependents.
- Enroll in all required coverage (Medical and/or Dental insurance) in ESS. Changes to your Medical and/or Dental coverage are allowed.

- There are several optional changes you can make at this time:
  - You may add family life insurance coverage.
  - You may update beneficiary designations on your Life Insurance (GUL and AD&D), PERS/OPSRP and/or IAP by completing the necessary beneficiary form. You will need to complete a new IAP Beneficiary form for a married member.
  - You may begin participation in a Health Care Flexible Spending Account (FSA), add your spouse and stepchildren to an existing FSA, or increase or decrease contributions to an existing FSA. You must enroll or update your FSA election in ESS to make any of these changes.
  - If your new spouse has qualifying children, you may begin participation in the Dependent Care Flexible Spending Account, add the dependents to an existing FSA, and/or increase or decrease your contributions to an existing FSA. You must enroll or update your FSA election in ESS to make any of these changes. If your new spouse already participates in a Dependent Care FSA, you may not be able to participate.
  - You may add your spouse and eligible dependent children to existing Group Universal Life and/or AD&D insurance.
  - Your spouse may apply for Long Term Care insurance.

DIVORCE OR LEGAL SEPARATION

- You **may** term coverage on your spouse (and stepchildren, if applicable) within 60 days from the date of your legal separation.
- You **must** remove your former spouse (and stepchildren, if applicable) **within 60 days** from the date the divorce is final. If you fail to term your former spouse **within the 60 days**, coverage will be termed retroactively ***and*** **you may be held responsible for claims paid for your former spouse or stepchildren which were incurred after your divorce was final**.
- You must provide a copy of your legal separation or divorce decree, with a minimum of the front page, page with the judge's signature and effective date of the separation or divorce, and the page with your former spouse's address and Social Security Number, if available. If there are any stipulations regarding the disposition of your Deferred Compensation or other benefits-related requirements, we also need copies of those pages.
- You must contact Benefits & Wellness at 503-655-8550 or at Benefits@clackamas.us .
- You must update all required coverage in ESS (Medical, Dental, and Life Insurance, if applicable).
- You may update beneficiary designations on your Life Insurance (including GUL and AD&D), PERS/OPSRP and/or IAP by completing the necessary beneficiary form. You will need to complete a new IAP Beneficiary form for a single member.
- If your former spouse was enrolled in a MetLife policy or Long Term Care coverage, they may not remain on the County's group plan. However, they may convert to an individual policy.
- You may begin participation in a Health Care Flexible Spending Account (FSA),, or increase or decrease contributions to an existing FSA. You must enroll or update your FSA election in ESS to make any of the changes.

ADDING DOMESTIC PARTNER COVERAGE

- You may add your domestic partner in the event they lose coverage or during the annual open enrollment.

  To qualify as a domestic partner, you ***both must meet*** the following requirements.
  - Be 18 years of age or older.
  - Share a close personal relationship and be responsible for each other's common welfare.
  - Be each other's sole domestic partner.
  - Not be legally married to anyone.
  - Not be related by blood closer than would bar marriage in the states of Oregon or Washington.
  - Be jointly financially responsible for "basic living expenses", defined as the cost of basic food, shelter, and medical expenses. (Note: Domestic partners need not contribute equally to the cost of these expenses as long as they agree that both are responsible for the cost).
  - Have been mentally competent to consent to the contract when the domestic partnership began.
- Enroll your partner during open enrollment or **within 60 days** from the date your domestic partner's coverage ends.

- Complete an Affidavit of Domestic Partnership form. Form must be signed in the presence of a Notary Public. We will accept a Certificate of Registered Domestic Partnership issued by any county in Oregon (or any other state with a similar law) in lieu of our Affidavit of Domestic Partnership.
- Contact Benefits & Wellness at 503-655-8550 or at Benefits@clackamas.us for enrollment in health plans including medical, dental and EAP. All new dependents must provide their Social Security Numbers. If adding children, you must provide photocopies of birth certificates.
  - Please note that in accordance with IRC rulings, the value of coverage for the domestic partner and their children may be considered taxable income to you, the employee, ***unless*** your domestic partner can qualify as your tax dependent (IRC section 152(a). Under Federal law, this includes all domestic partners. Under Oregon law, this includes only non-registered domestic partners.
  - **You may be required to pay Federal income taxes (and Oregon income taxes for non-registered domestic partners) on the value of the benefits provided to your domestic partner and their children. For information about whether your domestic partner qualifies as your tax dependent or the exact tax liability, you must contact your personal tax advisor**.
  - The value of the coverage is determined as outlined below.

• Domestic Partner	Medical, Dental, EAP	Domestic Partner Only
• Domestic Partner and His/Her/Their Child(ren)	Medical, Dental, EAP	Domestic Partner & Child(ren)

- There are several optional changes you can make at this time:
  - You may add family life insurance coverage.
  - You may update beneficiary designations on your Life Insurance (including GUL and AD&D), PERS/OPSRP and/or IAP.
  - You may add your domestic partner and eligible dependent children to existing Group Universal Life and/or AD&D insurance.
  - Your domestic partner may apply for Long Term Care insurance.
- Domestic partners and their children do not qualify for the Health Care or Dependent Care Flexible Spending Accounts per IRS regulations.

TERMING DOMESTIC PARTNER COVERAGE

- You must term coverage on your domestic partner and their children **within 60 days** from the date the domestic partnership ends. **If you fail to term coverage within the 60 days, coverage will be termed retroactively *and* you may be held responsible for claims paid for your former domestic partner or their children which were incurred after the end of the domestic partnership**.
- You must term coverage on your domestic partner and their children when your domestic partner dies. You must term coverage **within 60 days** from the date of death. **If you fail to term coverage within the 60 days, coverage will be termed retroactively *and* you may be held responsible for claims paid for your former domestic partner's children which were incurred after the death of the domestic partner.** (See DEATH OF A FAMILY MEMBER section.)
- You may voluntarily term coverage when your domestic partner obtains other insurance or when your personal circumstances change. (See CHANGE IN EMPLOYMENT – SPOUSE OR DOMESTIC PARTNER section.)
- If you and your domestic partner get married, you should change to spouse enrollment to avoid paying income taxes on the value of the insurance coverage. (See MARRIAGE section.)
  - The change in coverage will be effective the first of the month following the marriage.
- You must complete a Termination of Domestic Partner Benefits form.

EMPLOYMENT STATUS CHANGE (FULL-TIME TO PART-TIME STATUS)

- If your regular hours of work are reduced to less than 30 hours per week, enrollment in County-paid dental, life and disability coverage will end.
- Employees working 20–29 hours per week have the same medical choices as full-time employees and may purchase dental coverage. You may continue your participation in the Flexible Spending Accounts or increase or decrease your contributions. You may also continue your Group Universal Life, Accidental Death & Dismemberment, Long Term Care coverage and/or voluntary benefits.

EMPLOYMENT STATUS CHANGE (PART-TIME TO FULL-TIME STATUS)

- Your department must provide us with a *Personnel Action* form identifying the increase in your regular hours of work to 30 or more per week, making you eligible for the full benefits package.
- You are now eligible for County-paid dental coverage and you may select a dental plan (if not already purchasing coverage).
- You are now eligible for County-paid disability insurance, and depending on your salary level, you may be eligible for the Disability Buy-Up plan.
- You are now eligible for County-paid life insurance and you also may enroll in family life coverage.
- You may continue your participation in the Flexible Spending Accounts or increase or decrease your contributions. You may also continue your Group Universal Life, Accidental Death & Dismemberment, Long Term Care coverage and/or voluntary benefits.

EMPLOYMENT STATUS CHANGE (TO JOB SHARE – EMPLOYEES ASSOCIATION AND FOPPO)

- You and your Job Share partner must both work at least 18.75 hours per week to be eligible for benefits.
- Your department must provide us with a Personnel Action form identifying the change in your status and your regular hours of work.
- The amount of premium dollars for the Job Share position is divided equally between the Job Share partners. In most cases, this means that the County pays most or the entire single coverage medical and dental premium for both employees. However, there are employee-paid premiums for covering additional family members.
- Life insurance coverage for each of the job share partners is $25,000. You may also enroll, or continue enrollment, in family life coverage.
- Job share partners are eligible for County-paid disability coverage, and depending on your salary level, you may be eligible for the Disability Buy-Up plan.
- You may begin (or continue) your participation in the Flexible Spending Accounts or increase or decrease your contributions. You may also begin or continue your Group Universal Life, Accidental Death & Dismemberment, Long Term Care coverage and/or voluntary benefits.
- The Employees Assistance Program (EAP) premium is paid in full for both Job Share employees and their families.

CHANGE IN COVERAGE – SPOUSE OR DOMESTIC PARTNER

- You must contact Benefits & Wellness at 503-655-8550 or at Benefits@clackamas.us **within 60 days** of the date of coverage loss or coverage eligibility.
- Loss of Coverage:

  You must submit proof of loss of coverage, such as notification of cancellation from your spouse's or domestic partner's insurance company or notice of COBRA continuation rights from their employer. The Benefits & Wellness Division must approve the proof of loss.

  – If you chose to opt-out of group medical coverage and/or enroll in the 50% DELTA DENTAL dental plan, you may enroll into a medical plan and/or change your dental insurance option.

  – If your spouse loses pre-tax participation in an FSA, you may open a Health Care and/or Dependent Care FSA for the remainder of the plan year. However, if your spouse is available to provide dependent care (i.e., not working, attending school, or requiring care due to a handicap,) you may **not** participate in the Dependent Care FSA. (Domestic partners and their children are not eligible to participate in the FSA plans.)

  – If your spouse or domestic partner loses coverage on themselves and/or dependent children, you may add family coverage under the County's Group Term Life Insurance Program. No changes are allowed under the Group Universal Life or AD&D Insurance plans.

- Addition of Coverage:

  – You must submit proof of new coverage, such as enrollment forms or cards from your spouse's or domestic partner's insurance company or employer. The Benefits & Wellness Division must approve the proof of coverage.

- If your spouse or domestic partner has obtained new medical and/or dental coverage, you may term your comprehensive medical plan and choose to opt out of medical and/or dental coverage. Alternatively, you may change to any of the Medical and/or Dental plans available.
- If your spouse participates in a Flexible Spending Account, you may discontinue or decrease your contributions for the remainder of the plan year. If your spouse is no longer available to provide childcare, you may begin or increase contributions to a Dependent Care FSA. (Domestic partners and their children are not eligible to participate in the FSA plans.)
- If your spouse or domestic partner has obtained life insurance coverage on themselves and/or your dependent children, you may term your County Group Term Life Insurance family coverage.
- Under the Group Universal Life Insurance program, you may also decrease or term coverage on yourself, spouse or domestic partner and dependent children.

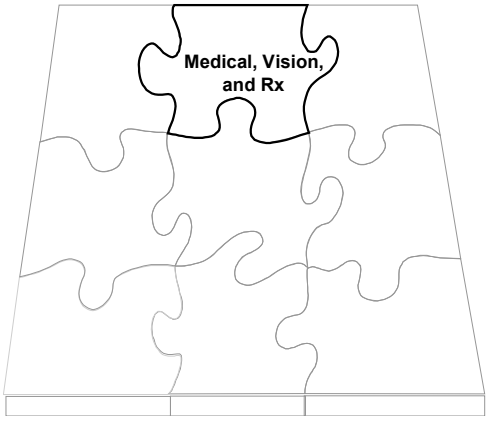
DEATH OF A FAMILY MEMBER

- You must contact Benefits & Wellness at 503-655-8550 or at Benefits@clackamas.us and provide us with a photocopy of the official Vital Records *death certificate*.
- You must remove the deceased family member from your existing medical, dental, FSA, County Group Term Life Insurance and Group Universal Life plan.
- You should also remove the deceased family member as a beneficiary on your life insurance(s), PERS/OPSRP and/or IAP by completing the necessary beneficiary form. Under PERS/OPSRP, if you currently have the Standard Designation, the deceased family member is already removed as a beneficiary. If the family member is your spouse, you will need to complete a new IAP Beneficiary form for a single member.
- If you lose coverage due to the death of a family member *and* are not enrolled in a comprehensive medical plan and/or dental plan, you may enroll in a medical plan and/or dental insurance option.
- You may increase or decrease contributions to your Health Care or Dependent Care Flexible Spending Account. Qualified expenses incurred by your deceased family member through the date of death will be reimbursed.
- If the deceased family member had coverage on any life insurance through the County, please contact the Benefits & Wellness Division for assistance in completing the death claim. *An official Vital Records death certificate is required.*

CHANGE OF RESIDENCE

- If you should change your residence to a location that is outside of your medical insurance service area, you may select from any other medical plan that will provide coverage in your new location.
- Contact Benefits & Wellness at 503-655-8550 or at Benefits@clackamas.us **within 60 days**.

MEDICAL PLAN OPTIONS



- Clackamas County's Benefits Program offers a choice of Health Maintenance Organization (HMO), Personal Option Plan (EPO), and Open Option Plan (OOP).
- Medical plans offered by Clackamas County do not contain pre-existing condition clauses which would delay coverage for the employee or eligible family members.
- We recommend that you call your carrier to verify current participation by your doctor, laboratory, facility, etc. in your plan before receiving treatment in order to avoid incurring unexpected charges. **A directory listing does not guarantee current eligibility.**

EMPLOYEE CONTRIBUTIONS FOR MEDICAL COVERAGE

- In the event an employee premium is required for any medical plan, that premium will be divided between the first two paychecks of each month. The first deduction will be taken on the payday immediately following the effective date of coverage. (Example: For a January 1st effective date the deduction is taken on the first pay check in January.)
- Your medical premium payments will be deducted on a pre-tax basis.

MEDICAL PLAN CHOICES

You have a choice among three different medical plans or the ability to opt out of medical coverage:

- Kaiser Permanente – HMO
  - includes vision, prescription drug, hearing aid, acupuncture, naturopath, chiropractic and massage
- Providence Health Plans – Personal Option Plan (EPO)
  - includes vision, prescription drug, hearing aid, acupuncture, naturopath, chiropractic and massage
- Providence Health Plans – Open Option Plan (OOP)
  - includes vision, prescription drug, hearing aid, acupuncture, naturopath, chiropractic and massage
- Opt out provision and receive additional monthly gross income

For specifics related to each plan, review the plan summaries carefully. Summaries may be obtained from the County internet/intranet.

CHOOSING A MEDICAL PLAN

Before selecting a medical plan, it is important to understand how the various plans work. It can make the difference between a year of satisfaction or aggravation.

While going through the process of selecting a plan, you may want to consider the following information:

- What will each plan cost me per month? (Look at the Benefit Plan Summary to review the monthly premium, if any, associated with each plan.)
- Will I have to pay a deductible and percent of the service charges or will I pay a co-pay?
- Can I go to any provider anytime, or must I use a Primary Care Physician (PCP)?
- What type of health coverage do I need based upon my current health status, or that of my family members? Will I need to change health care providers?

- How does my spouse's or domestic partner's coverage coordinate with the County's plans? (Examine the plans' limitations and exclusions carefully.)

COMMONLY USED TERMS

These terms are commonly used in benefit summaries and other communication about medical plans.

- **Coinsurance:** This is a method of sharing the cost of services between the insured person and the insurance company after the deductible is met. The amount shared is based upon a set ratio such as a 90% payment from the insurance company and 10% by the insured.
- **Co-payment:** A fixed dollar payment for health care services. For example, a $15.00 payment required for an office visit is called a $15.00 co-pay.
- **Deductible:** A deductible is the amount of out-of-pocket expenses that must be paid for health services by you before any services become payable by the carrier. Deductibles are required at the start of each plan year, and may only be offset by expenses incurred for services covered by the health plan. Typically, the plan limits the total amount of deductibles by a "total family deductible" limit.
- **Family Deductible:** A family deductible is the amount that is satisfied by the combined expenses of all covered family members. For example, a program with a $500 deductible may limit its application to a maximum of two (2) deductibles ($1000) for the family, regardless of the number of family members.
- **Primary Care Physician (PCP):** A PCP is a health care provider who is in Family Practice, General Practice, Internal Medicine, or Pediatrics. Some HMO's require that you select a PCP before you enroll in their plan and/or get a referral to see a specialist. You may choose a separate primary care physician for yourself and each of your covered family members. Your PCP is responsible for knowing your medical history and providing or coordinating all your health care needs.
- **Out-of-Pocket Maximum:** The maximum out-of-pocket expense for the insured is the most you would pay under the plan. Once you've made co-payments or paid co-insurance totaling your out-of-pocket maximum, any further allowable services are covered at 100% for the remainder of the year.

KAISER PERMANENTE HEALTH MAINTENANCE ORGANIZATION (HMO)

- Kaiser Permanente is a closed panel HMO and there are no out-of-plan benefits for this coverage. However, Kaiser works in cooperation with other non-Kaiser providers to provide a high level of specialized treatment throughout their service area with greater cost savings. You may not obtain covered services outside Kaiser facilities without a referral from a Kaiser health care provider.

IMPORTANT POINTS

- Kaiser has a $350 annual deductible, in-patient hospital services are subject to the deductible and 10% coinsurance. Most other services are either have a co-pay or are covered in full. The out-of-pocket maximum is $1,500 per indiviudal or $3,000 for a family.
- As with EPO's, Kaiser requires participants to use Kaiser service providers and facilities only unless referred by a Kaiser provider to a non-Kaiser provider or facility.
- Kaiser does not require you to select a Primary Care Physician, but you must have a referral from a PCP to see a specialist (except for emergencies, urgent care, vision, alternative care and women's annual exams).
- Hearing aids (18 and older) – balance after $1,500 credit is applied for each hearing aid per ear every three years.
- Hearing aids for enrollees under age 18 are provided by Kaiser at no cost per ear every 4 years.

OUT OF AREA DEPENDENT COVERAGE

Kaiser provides coverage for routine, continuing, and follow-up care in addition to medical emergency or urgent care services for dependents outside the service area. The benefit pays 80% of usual and customary charges (UCR) for covered services. The benefit is limited to $1,200 per calendar year. Amounts charged in excess of UCR are the responsibility of the member for services provided by a non-participating provider. Urgent or emergency care for out-of-area students will continue to be covered with applicable co-payments under the urgent and emergency care benefit. Kaiser must be notified within 48 hours after care has commenced. Preventive care is a covered expense if received within the service area. Preventive care received outside the service area is not a covered expense.

Prescription drugs for students will be covered at the co-pay if filled at a Kaiser Pharmacy or through Kaiser mail order. If the prescription is filled at a non-Kaiser Pharmacy, the plan will reimburse up to 80% of medically necessary prescriptions.

The Student Out-of-Area benefit will be limited to services provided within the United States.

PROVIDENCE HEALTH PLAN – PERSONAL OPTION PLAN (EPO)

An Exclusive Provider Organization (EPO) is a group of hospitals and physicians that contract with Providence Health Plan to provide comprehensive medical services. Providers' exchange discounted payment for services for increased patient volume. The participant's out-of-pocket costs are limited to $3,000 per individual or $6,000 for the whole family. This plan has an annual deductible of $1000 per individual or $2,000 for the family. Some services require a co-pay where the deductible is waived or a 20% co-insurance that is paid by the employee after the deductible has been met.

IMPORTANT POINTS

- Hearing aids for all participants are covered under the Durable Medical Equipment benefit at 20% co-insurance every 4 years.
- Doctors and specialists who are in-plan providers might use out-of-plan laboratories and/or facilities. Do not assume that all services will be covered in-plan. It is up to you to check with the service provider as to which laboratories and facilities will be used and whether any additional doctors or specialists will be rendering care. It may be possible to negotiate with the service provider to use only in-plan providers and facilities.
- All member payments for coinsurance, deductibles, office visit co-pays, and prescription co-pays will count toward satisfying the annual out-of-pocket maximum.

USING AN EXCLUSIVE PROVIDER

- Using services means you must choose an Exclusive Provider (doctor, specialist, laboratory or hospital) that contracts with Providence Health Plan in order to receive benefits. There are no out-of-plan benefits other than emergency services in this option.
- Provider directories list the contracting health care providers. You can view the provider directory by going online to http://phppd.providence.org/ to look at and/or print out a list of providers. The Benefits & Wellness Division recommends contacting Providence Health Plan to make sure the health care provider is still an Exclusive Provider before you obtain service.

OUT-OF-AREA DEPENDENT COVERAGE

Dependent children residing outside the Providence Health Plan regional service area are eligible to receive routine care and other covered benefits while in or out of the service area. Out-of-area dependents do not need to choose a Primary Care Provider or obtain referrals for services.

Regardless of where services are performed, the following services must be approved in advance:

- Non-emergency surgeries,
- Hospital stays,
- In-patient or Outpatient mental health/chemical dependency.

Out-of-area members are responsible for making sure their physician obtains prior authorization of these services from Providence Health Plan. Failure to pre-authorize will limit benefits to 50% of the Usual, Customary and Reasonable (UCR) charges.

If an emergency prevents obtaining prior authorization, Providence Health Plan must be notified within 48 hours or as soon as reasonably possible.

Contact Providence Customer Service at 503-574-7500 for information on covering your out-of-area dependent.

PROVIDENCE HEALTH PLAN - OPEN OPTION PLAN (OOP)

The Open Option Plan gives you the choice between in-plan and out-of-plan providers. In-plan providers are hospitals and physicians that contract with Providence Health Plan to provide comprehensive medical service. Out-of-plan providers do not have contracts with Providence and preventive services are not covered. This plan has an annual deductible of $750 per individual or $1,500 for the family. The out-of-pocket maximum is $2,500 per individual or $5,000 per family. The deductibles and out-of-pocket maximums are combined with in-plan services, which means regardless if your services are in or out-of-plan, you need only to satisfy one deductible and one out-of-pocket maximum.

USING AN IN-PLAN PROVIDER

- Using services means you must choose an in-plan provider (doctor, specialist, laboratory or hospital) that contracts with Providence Health Plan in order to receive benefits. Most services have a co-pay and other services have 10% co-insurance.
- Provider directories list the contracting health care providers. You can view the provider directory by going online to http://phppd.providence.org/ to look at and/or print out a list of providers. The Benefits & Wellness Division recommends contacting Providence Health Plan to make sure the health care provider is still an in-plan provider before you obtain service.

USING AN OUT-OF-PLAN PROVIDER

- If you choose a health care provider who is not an in-plan provider, you will be responsible for a larger portion of the cost for most service charges. The deductible is combined with the in-plan services, but the co-insurance is increased to 30% for most services.
- A greater expense for using out-of-plan providers is the plan's incentive to encourage you to use in-plan providers. When you use in-plan providers, you pay less out-of-pocket and the plan's claims costs are lower because of the discounted fees.

NATIONWIDE NETWORK OF PARTICIPATING PROVIDERS

- Providence Health Plan Open Option members may receive covered health care services at their In-Plan benefit from a provider belonging to Providence's nationwide network of Open option participating providers. The nationwide provider network supplements the provider network currently available in our Oregon and Southwest Washington service area.
- To chose a participating provider, go to the Providence Online Participating Provider Directory at http://phppd.providence.org/ and select as your plan type "Providence Signature Network." If you do not have access to the Providence Web site, please call the Providence Customer Service Team at 503-574-7500 or toll free at 800-878-4445 to request participating provider information.

IMPORTANT POINTS

- Providence does not require Primary Care Physicians. You may select any provider without a referral from a Primary Care Physician (PCP).
- No paperwork or process is required to change doctors or specialists.
- It is your responsibility to make sure services are in-plan in order to receive the maximum benefit.
- Doctors and specialists who are in-plan providers might use out-of-plan laboratories and/or facilities. Do not assume that all services will be covered in-plan. It is up to you to check with the service provider as to which laboratories and facilities will be used and whether any additional doctors or specialists will be rendering care. It may be possible to negotiate with the service provider to use only in-plan providers and facilities.
- Hearing aids for all participants are covered under the Durable Medical Equipment benefit at 10% co-insurance in-network and 30% co-insurance out-of-network every 4 years.
- All member payments for coinsurance, deductibles, office visit co-pays, and prescription co-pays will count toward satisfying the annual out-of-pocket maximum.

OUT-OF-AREA DEPENDENT COVERAGE

Dependent children residing outside the Providence Health Plan regional service area are eligible to receive routine care and other covered benefits while in or out of the service area. Out-of-area dependents do not need to choose a Primary Care Provider or obtain referrals for services. Coverage is considered out-of-plan and services are covered at the out-of-plan rate. Open Option member's dependent children may also receive covered health care services at the In-Plan benefit from a provider belonging to Providence's nationwide network of participating providers (see above).

VISION OPTIONS

- Vision benefits are available through Kaiser Permanente and Providence Health Plan.
- You ***must*** use the vision services provided by your medical carrier to receive maximum benefits.

KAISER PERMANENTE VISION PLAN

Kaiser's vision plan provides eye examinations and corrective lenses for members and their eligible family members. You must pay a $10 office visit co-pay for your routine eye examination. The plan has a $250 allowance for lenses and frames or contact lenses every calendar year.

EYE CARE SERVICES

- Eye examinations, glasses, and medically necessary contact lenses are covered.
- Two regular lenses and one frame from a specified selection of frames, or designated industrial safety glasses, or medically necessary contact lenses are provided with a prescription from a Kaiser optometrist or opthamologist every calendar year.
- If you choose to have contact lenses in lieu of glasses, Kaiser will apply the amount you would have received for glasses toward the total cost of the contacts.

VSP VISION PLAN FOR PROVIDENCE MEMBERS

Your Coverage with VSP Doctors and Affiliated Providers*			
Provider Choice and Eligible Expenses Your VSP ID# is your Employee ID# with enough zeros in front to make a 9-digit number	You may use any Vision Service Plan Choice Network provider or non-network provider. VSP chooses doctors carefully based on their professional licensing, work history, education, malpractice history, professional liability and ethics. Benefits for services performed by VSP network providers are covered at a higher rate and generally, you incur less out-of-pocket cost for services performed by network providers. You may obtain services from non-network providers. However, the plan only pays up to the specified dollar amounts listed below.		
Benefit	**Description**	**Co-pay**	**Frequency**
Well Vision Exam	• Focuses on your eyes and overall wellness	$10	Every calendar year
Prescription Glasses			
Frame	• $175 allowance for a wide selection of frames • $195 allowance for featured frame brands • $95 allowance for frame at Costco • 20% savings on the amount over your allowance	Included in Prescription Glasses	Every calendar year
Lenses	• Single vision, lined bifocal and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every calendar year
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$ 0 $30 $30	Every calendar year
Contacts (Instead of glasses)	• $175 allowance for contacts; co-pay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/special offers for details • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP doctor within 12 months of your last Well Vision Exam. **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Your Coverage with Other Providers
Visit vsp.com for details, if you plan to see a provider other than a VSP doctor. Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details
***Coverage with a retail chain affiliate may be different. Check with your affiliate to confirm they are a participating provider.** **Once your benefit is effective, visit vsp.com for details.** Coverage information is subject to change. In the event of a conflict between this information and your organizations's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

PRESCRIPTION DRUG PROGRAM

- Prescription Drug benefits are available through Kaiser Permanente and Providence Health Plan.
- You ***must*** use the pharmacies your medical carrier contracts with to receive maximum benefits.

KAISER PERMANENTE PRESCRIPTION DRUG PLAN

HOW THE PLAN WORKS

- The Kaiser prescription drug program provides a pre-paid benefit for which you have a co-pay of **$10 for generic drugs** or a **$20 co-pay for brand name drugs**. The co-pays are for a 30 day supply, or one pint for oral liquid drugs.
- To use the Kaiser plan, your prescription must be written by a Kaiser health care provider and you must purchase your prescriptions at a Kaiser pharmacy.
- For more specific information, please contact Kaiser Mail Order Pharmacy at 503-778-2678 or 800-548-9809 or call any Kaiser pharmacy.

BENEFITS

- You may purchase more than the standard monthly amount at a Kaiser pharmacy; however, you will have a co-pay for each 30-day supply.
- Internally implanted time-release drugs and injectable contraceptive drugs when prescribed by a Kaiser physician may be purchased at a charge determined by multiplying the charge for a 30-day supply of the drug by the expected number of months that the drug will be effective.
- **Mail order** prescriptions for maintenance drugs are available for **two co-pays for each 90-day supply**.
- Refills may also be made via the Internet at www.kaiserpermanente.org.

PROVIDENCE HEALTH PLAN PRESCRIPTION DRUG PLAN

PERSONAL OPTION PRESCRIPTION DRUG PLAN

- The prescription drug plan provides a pre-paid benefit where you pay a **$10 co-pay** for generic drugs or **50% coinsurance (max $200)** for brand name drugs for each 30-day supply filled by a participating retail pharmacy. To use this benefit, the prescription must be written by a participating Plan provider and purchased from a participating Plan pharmacy.

OPEN OPTION PRESCRIPTION DRUG PLAN

- The prescription drug plan provides a pre-paid benefit where you pay a **$15 co-pay** for generic drugs or a **$30 co-pay** for brand name drugs for each 30-day supply filled by a participating retail pharmacy.

HOW THESE PLANS WORK

- Prescriptions must be written by a participating Plan provider (does not apply to Open Option members) and purchased from a participating plan pharmacy. To obtain a list of provider pharmacies, you may contact Providence Customer Service or go online to Retail Pharmacies.
- Always present your current Providence Health Plan identification number listed on your identification card and submit the correct co-pay for each 30-day supply at the time of your purchase. The benefit allows you to purchase up to a 90-day supply for most maintenance drugs with 2 co-pays if you fill your prescription at one of the following pharmacies 90 day Prescription Preferred Pharmacies.

- All drugs must be FDA approved, medically necessary and require a prescription by law to dispense the medication.
- Insulin is covered by the Plan. Once you've received insulin for the first time with a prescription, you will not need another prescription to obtain insulin thereafter.
- For refills, call your pharmacy before you run out of your medication. Be sure to identify yourself as a Providence Health Plan Member, give your Plan identification number listed on your identification card and the required information regarding your prescription, including your prescription number.

EMERGENCIES

- Medications required as a result of an emergency illness or injury when temporarily outside the service area are covered. Please submit an itemized pharmacy receipt along with a Prescription Drug Reimbursement Request form to the Plan.
- You will be reimbursed for the cost of the prescription less the applicable co-payment if the Plan approves the urgent or emergency care claim. You may obtain a Prescription Drug Reimbursement Request form by going online to Providence RX reimbursement or by calling the Customer Service Department at (503) 574-7500 or toll free at (800) 878-4445.

ORDERING PRESCRIPTIONS BY MAIL

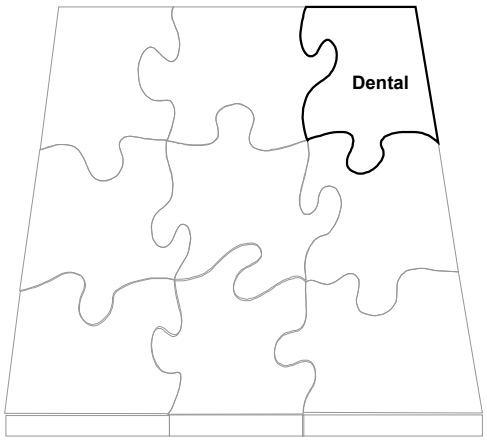
- Providence provides two mail order prescription programs to members.

Costco Home Delivery
802 134th St. SW, Ste 140
Everett, WA 98204-7314
1- 800-607-6861
Costco Home Delivery 90-day Prescriptions

Postal Prescription Services
P. O. Box 2718
Portland, OR 97208
1-800-552-6694
(also for refills by touch tone phone) Postal Prescription Services 90-day Prescriptions

- To order prescriptions by mail through Costco Home Delivery, you can go online to Costco Home Delivery 90-day Prescriptions and download the order forms, or call the customer service number at 1-800-607-6861.
- To order prescriptions by mail through Postal Prescription Services, you may go online to Postal Prescription Services 90-day Prescriptions and download the order form, or call customer service at 1-800-552-6694.
  - Once you have completed the form and enclosed the appropriate co-payment, you may submit it to the pharmacy for processing. It generally takes about two weeks for the prescription to be processed and delivered, so be sure to plan ahead.
  - For refills, all you need to do is contact the pharmacy to request a refill. You will then need to send the appropriate co-payment to the pharmacy and once they receive the payment, they will ship the prescription to you.
  - There may be a small charge for shipping and handling. Please verify with the pharmacy if there will be a charge.
- The cost for mail order prescriptions is **two co-pays for each 90-day supply** of prescription drugs. For your co-pay amounts refer to your plan choice.
- Please call ahead whenever possible to allow time for the pharmacy to verify your coverage or contact your physician.
- You may also receive a 90-day supply from certain retail pharmacies that have contracted with Providence to provide these services at their various locations. Follow this link to locate the pharmacy near you: 90 day Prescription Preferred Pharmacies.

DENTAL PLAN OPTIONS



- The Benefits Program allows you to select your dental plan based on level of coverage you desire and the dental carrier you prefer.
- You have a choice of four dental plans: the Kaiser Permanente plan, Delta Dental Incentive plan, the Delta Dental Preventive plan, and the Delta Dental Constant/50% plan.
- Your selection of ***dental coverage is independent*** of your medical plan.
- Your dental care program covers services performed by a licensed dentist when determined to be necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury.

HOW THE KAISER DENTAL PLAN WORKS

- Kaiser's Dental Care Program offers you and your family members access to comprehensive dental care with a unique emphasis on prevention. There is no yearly deductible or lifetime benefit maximum.
- There are no claim forms to fill out for treatment within the service area.
- You are covered for all office visits from the first day you become eligible.
- As a member you agree to receive care at one of their dental offices unless you need urgent or emergency dental care outside the serivce area.

KAISER DENTAL PLAN ANNUAL MAXIMUMS

- There is no annual maximum for regular dental services, including office visits, restorative services, simple extractions, prosthetic devices, periodontics, endodontics, oral surgery, and emergency treatment.
- You and your family members must use a Kaiser dentist located at any of their dental clinics throughout the service area. For specifics on clinic locations, call Membership Services at (503) 813-2000 or (800) 813-2000, go online to http://www.kaiserpermanente.org/ or consult the dental provider directory.

KAISER DENTAL PLAN ORTHODONTIA COVERAGE

- Orthodontic benefits under the Kaiser Dental Plan will be provided with ***no*** age limit for you and your enrolled family members. Under this plan Kaiser Permanente covers 50% of orthodontic services up to a lifetime maximum of $2000.
- You and your family members must use an authorized Kaiser orthodontist.

KAISER CLAIMS AND APPEALS

If you have questions or claim problems, you may contact Membership Services. It is recommended that you first consult Kaiser with your questions and claim problems. If matters are not resolved, then contact the Benefits & Wellness Division.

From Portland ..... (503) 813-2000 **From All Other Locations ..... (800) 813-2000**

DELTA DENTAL PLANS – COVERED SERVICES

- You and your family members may choose any dentist under the Delta Dental plans. However, charges by non-participating dentists will be paid at an amount not to exceed the usual and customary rate (UCR) set for Delta Dental participating dentists for similar services. This means that you may be responsible for the difference between what Delta Dental will pay and what your dentist charges.
- Benefits are based on an "eligibility year" which is the 12-month period starting January 1 and ending December 31. For employees hired after January, their first year is computed from the date their benefits become effective to December 31 of that calendar year.
- Dental Implants – Covered under Class III Prosthodontics: Implant placement and removal covered once per lifetime per tooth space.
- The Delta Dental Incentive plan, the Delta Dental Preventive plan, and the Delta Dental Constant/50% plan cover the same services, but at different levels:

DELTA DENTAL PREVENTIVE DENTAL PLAN

- Preventive services (exams and cleanings) - 100%, $0 deductible
- Basic Restoration (fillings) - 80%, $50 individual/$100 family deductible.
- Crowns – 70%, $50 individual/$100 family deductible.
- Major Resstorative (dentures) - 70%, $50 individual/$100 family deductible.
- Annual maximum for the above services is $2000. (Preventive First Program – Preventive services will not count towards the annual $2000 maximum.)
- Orthodontia – 50%, $3000 maximum (adults and children). Orthodontia services for adults do not need to be medically necessary.

HOW THE DELTA DENTAL INCENTIVE PLAN WORKS

- The program provides 70% toward covered Class 1, 2, and 3 services (Diagnostic, Preventive and Restorative) during the first year that the individual is eligible. The level of coverage increases by 10% each successive eligibility year.
  - To qualify for this 10% increase, individuals must visit their dentist for an examination at least once during the eligibility year. Failure to do so will cause a 10% reduction in coverage for the next eligibility year, although payment never goes below 70% for Class 1, 2, and 3 services.
  - At the end of three years of eligibility, assuming at least one dental exam in each of these eligibility years, the individual will reach 100% payment for Class 1, 2, and 3 services. To continue the 100% coverage level, individuals must continue to visit the dentist for an exam at least once each year.
- Class 4 services (Prosthodontic) are always covered at 50%.

DELTA DENTAL INCENTIVE PLAN ANNUAL MAXIMUMS

- You and each of your eligible family members have an individual annual maximum amount of $2,000 payable for all services each plan year (January 1 to December 31). For employees hired after January, the plan year maximum applies from the date their benefits become effective to December 31 of that calendar year. (Preventive First Program – Preventive services will not count towards the annual $2000 maximum.)

DELTA DENTAL INCENTIVE PLAN ORTHODONTIA COVERAGE

- Orthodontic benefits under the Delta Dental Incentive Plan are available to eligible dependent children, provided treatment is started before their 17th birthday.
- Under this plan, Delta Dental covers 50% of orthodontic services up to a lifetime maximum of $2,000.

HOW THE DELTA DENTAL CONSTANT/50% PLAN WORKS

- All covered services are paid at 50%. No change in coinsurance level will take place, regardless of whether you visit the dentist or not.
- You might consider this plan option if you have other dental coverage.

DELTA DENTAL CONSTANT/50% ANNUAL MAXIMUMS

- You and each of your eligible family members have an individual annual maximum amount of $2,000 payable for all services each plan year (January 1 to December 31). For employees hired after January, the plan year maximum applies from the date their benefits become effective to December 31 of that calendar year. (Preventive First Program – Preventive services will not count towards the annual $2000 maximum.)

DELTA DENTAL CONSTANT/50% DENTAL PLAN ORTHODONTIA COVERAGE

- There is no orthodontia coverage available with this plan.

NON-PARTICIPATING DENTISTS

- The program requires that amounts payable for services of a non-participating dentist be limited to the applicable percentages toward the prevailing fees charged by other dentists for corresponding services.
- Prevailing fees are defined as fees which satisfy and are charged by the majority of dentists in Oregon, as determined by Delta Dental on the basis of confidential fee listings from participating dentists.

OFFICE VISIT PROCEDURE

- During your first appointment tell your dentist that you have dental insurance through Delta Dental. Confirm that they are a Delta Dental provider. Give <u>your</u> Delta Dental Member ID Number and Delta Dental group number (found on your member ID card).
- Your dentist will perform an examination and may submit a treatment planning form to Delta Dental to determine what part of the dentist's bill you will have to pay.

PRE-TREATMENT ESTIMATE

- Before any treatment is started, be sure you discuss the total amount of the fee with your dentist (and any portion you will be required to pay).
- Your dentist submits a treatment planning form to Delta Dental. You might be asked by the dentist's office to help complete the part identifying the patient. Sign the form to indicate that you are in agreement with the treatment your dentist has decided upon.
- All incoming treatment plans are reviewed to assure that actual charges made by the dentist do not exceed their usual fees on file with Delta Dental.

COORDINATION OF BENEFITS

- If you or an eligible family member are entitled to other dental benefits through another prepaid program, benefits under this program are coordinated with such a program. The purpose of this provision is to avoid duplication of payment.
- Amounts paid will be computed in accordance with rules used by nearly all prepayment programs. This means that payments will be shared with your other programs so that total payments will not be greater than the actual cost of covered services.

DELTA DENTAL CLAIMS AND APPEAL PROCEDURE

- Your dental program has a unique relationship with participating dentists. All forms are submitted by the dental office and all benefits are paid directly to the dentist.

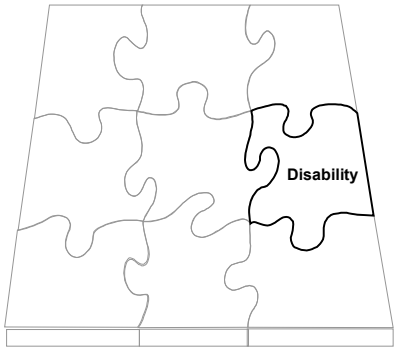
- When a claim has been processed by Delta Dental, you will receive a notice of payment. If you have questions concerning the payment, we recommend that you contact your dentist. They are the best person to explain to you any services which may be limited or excluded. After that, if you still have questions or disagree with the payment, you have the right to request a review. Such a review must be requested in writing within 90 days following receipt of the notice of payment or denial.

- You may request a review by writing to the DELTA DENTAL HEALTH PLAN DENTAL SUBSCRIBER SERVICE DEPARTMENT, 601 SW SECOND AVE, PORTLAND OR 97204. https://www.modahealth.com/index.shtml

- Your request must state the reason you are requesting reevaluation of the denial. You should include the employee's group number (including sub-group number) and the employee's Delta Dental member ID number with any correspondence. ***Remember: Claims concerning your family members must be submitted with the employee's group number, sub-group number and Delta Dental ID Number.***

- If the dispute involves dental questions, a panel of dentists will review the matter and make a final decision. That decision is final and binding on all parties. Other kinds of questions may be subject to arbitration statutes of the State of Oregon.

DISABILITY INSURANCE



- Clackamas County provides disability insurance for all eligible regular employees working in a position of at least 30 hours per week. It provides partial protection from loss of salary in the event that you become unable to perform your job because of an illness, accident or pregnancy.
- Your benefit from the disability plan provides 60% of your base monthly earnings (including longevity pay) up to your insured salary level.
- Disability benefits are subject to Federal withholding and six months of FICA (Social Security) withholding.

EMPLOYER PAID COVERAGE

- The maximum insured salary level is $3,333. The maximum monthly benefit is $1,999.80.
- The insured salary level is your base salary, plus longevity pay. It does not include overtime pay, incentive pay or other adds to pay.
- If you earn less than $3,333 per month, take your insured salary amount for one month and multiply it by 60%. The resulting amount will be your maximum monthly benefit.

EMPLOYEE PAID COVERAGE – OPTIONAL

- In addition to the County-paid disability coverage, you may choose to purchase on a before-tax basis optional disability coverage if your base salary (plus longevity) exceeds the monthly insured salary level of $3,333.
- The benefit level will be 60% of your covered salary over $3,333, up to a total maximum insured salary level of $8,333 per month. The maximum benefit for the employee-paid coverage will be $3,000 per month, for a maximum total benefit of $4,999.80 per month (60% of $8,333).
- If you enroll within 31 days of being eligible for the optional disability coverage (when benefits are first effective or when your base salary plus longevity exceeds $3,333 per month), you will not need to complete a statement of health form. Delaying enrollment in the optional program until the County's annual open enrollment period will require a completed statement of health form.

BENEFIT WAITING PERIOD

- Benefit payments begin after a waiting period of 30 calendar days of disability; or
- After your accrued sick leave is exhausted, whichever is longer.

PREEXISTING CONDITION CLAUSES

- COUNTY PAID COVERAGE: A preexisting condition is defined as a mental or physical condition for which you have consulted a physician, received medical treatment or services, or taken prescribed drugs or medications at any time during the 90-day period just before the effective date of your insurance.
- EMPLOYEE PAID COVERAGE: A preexisting condition is defined as a mental or physical condition for which you have consulted a physician, received medical treatment or services, or taken prescribed drugs or medications at any time during the 6-month period prior to the effective date of your insurance .
- Under both of the disability programs, you are not covered for a disability contributed to or caused by a preexisting condition or medical or surgical treatment of a preexisting condition unless you meet BOTH of the following requirements on the date you become disabled:
  - You have been continuously insured by the County's disability plan for at least 12 months; and
  - You have been actively at work for at least one full day after the 12 months of continuous insurance.

TO APPLY FOR DISABILITY BENEFITS

- To apply for your disability benefits, contact the Clackamas County Leave Administration Team at (503) 655-8550 or at LeaveAdmin@clackamas.us. A representative of the Leave Administration Team will meet with you to review the program information and forms that must be completed.
- If an emergency situation arises and you are unable to meet with a representative prior to your leave, contact the Leave Administration Team as soon as reasonably possible to discuss the program and apply for disability benefits.

DURATION OF BENEFITS

- Benefits will continue up to 24 months, as long as you are disabled from your *own* occupation.
- For benefits to continue beyond the 24 months, you must be disabled from *all* occupations. Benefits will then continue until your 65th birthday as long as you continue to be disabled.
- If you become disabled at age 62 or older, your benefits may continue past age 65 on a limited basis.

RETURNING TO WORK

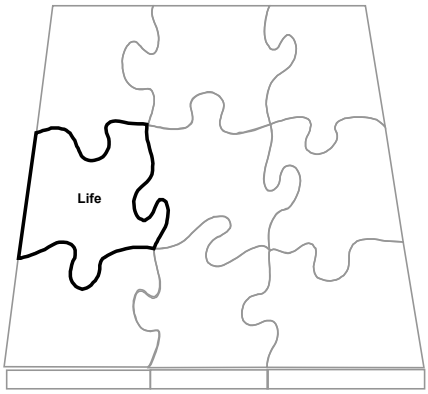
- When you return to work, you must provide your supervisor with a **Release to Return to Work** form completed and signed by your attending physician.
- The form must indicate whether you are being released without any limitations or whether you will be released on a limited basis. If there are any limitations, they must be described in detail.
- Upon full release, a new Release to Return to Work form must be given to your supervisor. A copy must also be sent to the Leave Administration Team.

MATERNITY LEAVE

For employees on maternity leave, there is one important reminder: **You must enroll your new child(ren) in your health plans within 60 days from the date of birth.** You need to submit a copy of either the certificate of birth issued by the hospital or official Certificate of Live Birth **within 60 days** of your child's birth.

- Contact Benefits & Wellness at 503-655-8550 or at Benefits@clackamas.us within 60 days of the birth. If you decide to participate in either the Health Care or Dependent Care Flexible Spending Accounts, you will also need to enroll or update your FSA election in ESS.
- For additional information, see the QUALIFIED LIFE EVENT section.

LIFE INSURANCE



- Clackamas County provides group term life insurance for all eligible employees working in a position of at least 30 hours per week.
- Nonrepresented employees can choose the maximum level of coverage or choose less coverage and receive cash back.
- Represented employees are provided one level of coverage.
- Both groups can purchase $5,000 of life insurance for eligible family members at a cost of $2.38 per month.

NON-REPRESENTED EMPLOYEES	COVERAGE	FLEX CASH	EMPLOYEE PREMIUM
Elected Officials & Nonrepresented Employees	$150,000	$0	$0
General County / Housing Authority	$50,000	$16.00	$0

- If you choose $50,000 in coverage and later wish to change to the $150,000 coverage at Open Enrollment or due to a qualified life event change, you will be required to submit evidence of your good health to Metropolitan Life Insurance Company for their approval.
- In the event your evidence of good health is ruled to be unsatisfactory, your existing level of coverage will remain in effect.

REPRESENTED EMPLOYEES	COVERAGE	EMPLOYEE PREMIUM
AFSCME-DTD (Department of Transportation & Development)	$50,000	$0
AFSCME-WES (Water Environment Services)	$50,000	$0
AFSCME-C-COM (Communications)	$50,000	$0
Employees' Association - General County / Housing Authority	$50,000	$0
FOPPO (Probation and Parole Officers)	$75,000	$0

FAMILY COVERAGE	COVERAGE	EMPLOYEE PREMIUM
All Employee Groups – Coverage for Eligible Family Members	$5,000	$2.38

- Life insurance for eligible family members is optional and can be purchased at $2.38 per month. The $2.38 premium covers all family members, regardless of the number.
- The coverage provides $5,000 of life insurance for your eligible spouse or domestic partner and children to age 26. Infants are covered at $500 from the age of 14 days to six months.
- No eligible individual may be covered more than once under this plan. If you are covered as an employee, you cannot be covered as a spouse, domestic partner or child of another employee. If you and your spouse or domestic partner are both employed by Clackamas County, any eligible child may be insured by only one of you.

CONTINUED LIFE INSURANCE PROVISIONS

LEAVE OF ABSENCE

- If your leave is due to medical reasons, your group term life insurance will be continued by the County for up to 180 days.
- If your leave of absence is **not** medically related, your life insurance coverage will be continued up to 90 days.
- If you have coverage on your family members, it will end unless you choose to continue it by making payments to the Benefits & Wellness Division. Otherwise, your family members will be given the opportunity to convert the life insurance into an individual policy.

WAIVER OF PREMIUM (IF YOU BECOME DISABLED)

- In the event of a permanent and total disability prior to age 60, you may be eligible for continuation of the life insurance coverage you had at the time you left employment with the County. This provision has a six-month waiting period. During this waiting period, the County will continue to provide your group term life insurance coverage at no cost.
- Should you qualify, your County-paid life insurance coverage will continue as long as:
  - You continue to be totally disabled; and
  - You provide an annual update as to your medical condition. Once each year, a review of the status of each Waiver of Premium participant is completed. Failure to comply with the Met Life's request will automatically terminate your coverage.
- If it is determined that your disability does not meet the definition of totally disabled as described by the contract, you will be notified of the cancellation of your coverage and the conversion privilege available.

CONVERSION OF LIFE INSURANCE

- You and your family members may convert your life insurance to individual plans if you should lose coverage due to termination of employment or loss of eligibility.

ACCELERATED LIFE BENEFITS

- The County's group life insurance policy provides for the payment of "accelerated" life benefits if you are diagnosed as terminally ill and are expected to die within the very near future (i.e. six months or confined to a nursing home with a life expectancy of less than two years). This option can provide financial assistance and flexibility in a crisis.
- The amount of the accelerated benefit is up to 50% of your coverage in effect at the time of your request.
- This provision will pay benefits if you are less than 63 years old when the application is made and coverage is in effect at the time of your request.
- The accelerated benefits are payable only once and will reduce your life insurance coverage and the amount available for you to convert to a personal life insurance policy in the event the policy is terminated.
- Proof of eligibility is required. The County's group term life insurance company may require specific information in a specified format. It is also possible for the insurance carrier to request an additional medical determination by a physician of their choice.
- Accelerated benefits will not be payable if the County has been notified that all or a portion of your life insurance is to be paid to your former spouse as part of a divorce agreement or that you do not meet the requirements as a result of attempted suicide or injuring yourself intentionally.
- Since accelerated life benefits may be taxable or may affect your eligibility for benefits under state and federal law, you should seek the advice of counsel before you make any decisions concerning the accelerated benefit option.

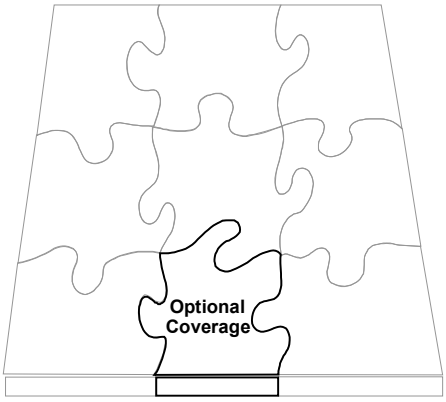
BENEFICIARY DESIGNATIONS

- A beneficiary designation is the person or persons you list on your County Life Insurance application to receive benefits in the event of your death. If you do not name a beneficiary, death benefits will be paid in equal shares to your survivors who are related to you and who survive you in the following order:
  - Your spouse.
  - Your children.
  - Your parents.
  - Your siblings.
- If there is no surviving relative in any class, the face amount of your coverage will be payable to your estate.
- You are the beneficiary for the life insurance on your eligible family members. If you also die, the benefit for a dependent child will be paid to your spouse.
- You may change your beneficiary designations at any time. Be sure to keep them up-to-date so that benefit payments go to the correct person(s). To make a change, contact the Benefits & Wellness Division.

ADDITIONAL INFORMATION

- For additional details about this employer-provided group life coverage, please refer to the Group Life Plan Booklet. The booklet can be accessed online at Group Life Plan Booklet .

AD&D & OPTIONAL LIFE COVERAGE



- Have you considered the need for additional life and accident insurance protection to provide income that your family could depend on in the event of your death or serious injury?
- The County provides the opportunity to purchase additional life and accident insurance for you and your eligible family members.
- The County's Optional Insurance Program offers two types of coverage:
  - Accidental Death & Dismemberment (AD&D)
  - Group Universal Life Insurance

ACCIDENTAL DEATH & DISMEMBERMENT	COVERAGE	EMPLOYEE PREMIUM
Employee Only Coverage (Nonrepresented and Represented)	$10,000 - $500,000	$0.04 per $1,000
Family Coverage (includes Employee and Eligible Family Members)	$10,000 - $500,000	$0.06 per $1,000

- Accidental Death & Dismemberment (AD&D) benefits are paid if a covered person dies or incurs certain serious injuries as a result of a covered accident. AD&D benefits are paid in addition to any benefits that are payable under the Life Insurance plans.

COVERED LOSSES DUE TO AN ACCIDENT	BENEFIT AMOUNT
Life	100% of Full Amount
Any two of the following: a hand, a foot, sight of an eye	100% of Full Amount
Any one of the following: a hand, a foot, sight of an eye	50% of the Full Amount
Thumb & index finger of same hand	25% of the Full Amount
Both speech and hearing in both ears	100% of Full Amount
Either speech or hearing in both ears	50% of the Full Amount
Quadriplegia (total paralysis of both upper and lower limbs)	100% of Full Amount
Paraplegia (total paralysis of both lower limbs)	50% of the Full Amount
Hemiplegia (total paralysis of upper and lower limbs on one side)	50% of the Full Amount

- AD&D coverage may be purchased in increments of $10,000 to $500,000*, but no more than 10 times your base annual salary*.
- You may purchase AD&D coverage for yourself only or for yourself and your eligible family members.
- The family plan provides coverage for yourself, your eligible spouse or domestic partner, and children from the age of 14 days to age 26.
  - All family members are covered for a single premium.
  - You may purchase AD&D coverage for your family members even if you do not cover them on your life insurance.
  - Coverage for your spouse or domestic partner and children is a percentage of your coverage level.
- No eligible individual may be covered more than once under this plan. If you are covered as an employee, you cannot be covered as a spouse, domestic partner or child of another employee. If you and your spouse or domestic partner are both employed by Clackamas County, any eligible children may be insured by only one of you.
- There is no conversion benefit with AD&D coverage. Once you leave employment, your AD&D coverage will end and you cannot convert it to an individual policy.

GROUP UNIVERSAL LIFE INSURANCE

- Group Universal life gives you the same insurance protection as term insurance ***plus*** optional tax-deferred savings. Not only do you protect your family with insurance, but the savings can help purchase a home, pay for college tuition, or a wedding. When you retire, you can use your savings to choose one of many retirement options.
- You have the option to make contributions to an accumulation fund through monthly payroll deductions or lump sum deposits. The savings contribution is deposited into your personal cash accumulation fund, and earns a competitive rate of interest.
- The money in your cash accumulation fund earns interest on a tax-deferred basis. This means your savings are not taxed until you withdraw more money than you have contributed. In addition, your beneficiaries will receive the death benefit income tax free.
- The death benefit is comprised of the face amount of your coverage plus the amount of money in your accumulation fund less any loan amount and loan interest. As your savings grow, your death benefit also grows.
- The money in your accumulation fund is yours. You have access to your savings through loans and withdrawals. Even if you borrow or withdraw money from your accumulation fund, you are still guaranteed coverage of at least the amount of life insurance you selected.
- Access to your Group Universal Life savings fund is hassle-free. You may take one loan and one withdrawal per year ***after*** you have had Group Universal Life coverage for one year.
- The minimum loan or withdrawal amount is $250. When you take a loan or withdrawal, you must leave a modest amount in your accumulation fund to ensure that your coverage does not inadvertently lapse.
- There are no expenses associated with a withdrawal.
  - If you take a loan, there is no time limit on repayment.
  - Before your loan check is sent to you, the amount of interest you will be charged for the year will be deducted. However, borrowed funds will continue to be credited with interest, at a rate that is somewhat lower than the interest rate you were charged for the loan.
- Group Universal life insurance is portable. If you leave employment with the County, you will have the opportunity to take the coverage with you.

COVERAGE AMOUNTS FOR GROUP UNIVERSAL LIFE INSURANCE

- You may purchase coverage for yourself, your spouse or domestic partner and dependent children.
- You may purchase coverage for yourself in increments of $10,000 up to $300,000. For newly eligible employees you may apply for coverage to a maximum of $50,000 without completing an extensive medical questionnaire. For new enrollments or increases in coverage over $50,000, you must satisfy evidence of good health.
- You may purchase coverage for your spouse or domestic partner in increments of $10,000 up to $300,000. For newly eligible spouses or domestic partners, you may apply for coverage to a maximum of $20,000 without completing an extensive medical questionnaire. For new enrollments or increases in coverage over $20,000, your spouse or domestic partner must satisfy evidence of good health.
- You may purchase coverage for your children in increments of $2,000 up to $10,000. You will pay one premium for all of your children, regardless of how many children you have. Children may be covered from 14 days of age up to the end of the month in which they reach age 26.

COST

- Your monthly premiums for the Group Universal Insurance option is determined by your age as of December 31, whether or not you use tobacco and the amount of coverage you choose. (These criteria apply to spouses and domestic partners also.)
  - To qualify for a non-smoker rate, you must have been tobacco-free for 12 months or more.
- To determine your monthly premium, find your age in the age brackets in the first column. If you are a non-smoker use the rate in the second column. If you use tobacco (smoke or chew), use the rate in the third column. Then multiply the rate times the number of 1000's in coverage.
  - For example: If you are 42, a non-smoker and want $100,000 in coverage, you would multiply 0.096 x 100 = $9.60 per month.

AGE	NON-SMOKER RATE	SMOKER RATE
15-29	.044	.066
30-34	.049	.074
35-39	.062	.102
40-44	.096	.149
45-49	.164	.223
50-54	.270	.330
55-59	.424	.518
60-64	.641	.797
65-69	1.186	1.269
70-74*	1.986	1.986

*For rates over age 74, please call MetLife toll-free at **1-800-438-6388**

CHILD RATES

Coverage Amount	$2,000	$4,000	$6,000	$8,000	$10,000
Monthly Rate	$0.118	$0.236	$0.354	$0.472	$0.59

PREMIUM ADJUSTMENTS

- Your premium can change even though you maintain the same level of coverage.
  - At the beginning of the calendar year in which you or your covered spouse or domestic partner reach the lowest age in the next higher 5-year age bracket, your premium will increase.
  - If your or your spouse's smoking status changes, your premium may change.
  - Metropolitan Life may increase or decrease the age-graded rates when the contract renews each January 1st.

CHANGING YOUR COVERAGE

Changing coverage is often dictated by changes in life circumstances. The plan provides flexibility to accommodate these changes. Changes may be made at Open Enrollment or due to a qualifying life event.

- You may change your coverage amount or monthly contributions to the optional cash accumulation fund. Any request for an increase in coverage must be accompanied by a completed Statement of Health form.
- You may add or term coverage on family members.
- You may term coverage at any time by providing *written* notice to the Benefits & Wellness Division.

IF YOU BECOME DISABLED

- If you become disabled before you reach age 60 and after you have been in the plan for one year, MetLife will waive the premiums and administrative fees for your coverage (and any coverage on your family members) until the earliest of your recovery, death, or reaching age 65.
- The cash in your accumulation fund will continue to earn interest at the declared rate.
  - No additional cash will be added to your fund, however, except by direct payment from you.
- There is a 9-month waiting period before waiver benefits begin, and disabilities during the first year of coverage are excluded.

ACCELERATED LIFE BENEFITS

- MetLife understands that terminal illnesses can be emotionally and financially draining for both the individual and loved ones. To help relieve some of the financial burden, you may be eligible to receive an early payment of up to 50% of the face amount of your insurance.

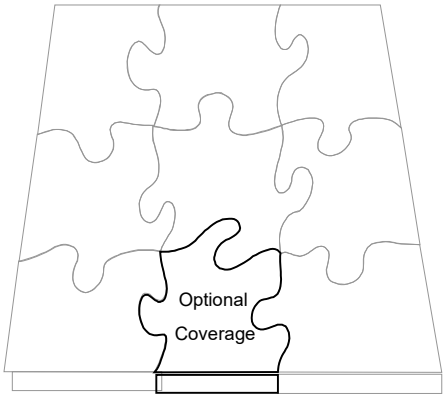
LEAVING EMPLOYMENT WITH CLACKAMAS COUNTY

- Group Universal Life is portable. If you should leave Clackamas County, you will have the opportunity to take your coverage with you and still take advantage of group rates.
  - You will still be eligible for the privileges associated with Group Universal Life coverage.
  - Rates may change, based on MetLife's experience with other employees from MetLife Group Universal Life plans who have also taken their coverage with them.
  - You may continue your coverage at full-face amount until you reach age 70. At that time, you will be able to maintain Group Universal Life coverage at an amount that is not less than $10,000 and does not exceed 5 times the amount in your accumulation fund.
- If you choose the Group Universal Life Option, you will have the opportunity to choose between a variety of options in order to best meet your needs.
  - You may cash in your accumulation fund.
  - You may use the money in your accumulation fund to elect paid-up coverage.
  - You may also choose to continue your Group Universal Life coverage at full-face amount until the later of your actual retirement date or your employer's normal retirement date or the 10th anniversary of your Group Universal Life coverage.
  - At that time, you will be able to maintain Group Universal Life coverage at an amount that is not less than $10,000 and does not exceed 5 times the amount in your accumulation fund.

ENROLLMENT PROCESS

- To enroll in the Group Universal Life or Accidental Death & Dismemberment Insurance plans, download the enrollment applications from the intranet/internet at Group Universal Life Packet or Voluntary Accidental Death & Dismemberment Packet .
- For application after your initial eligibility period or for coverage exceeding the initial application amounts on yourself and/or your spouse or domestic partner, each person requesting a higher level of coverage must complete the enrollment application, including the health questionnaire. You must also designate a beneficiary.
- You are eligible for this plan as long as you are actively at work on the effective date of coverage.

LONG TERM CARE INSURANCE



- Long-term care insurance provides coverage when someone needs assistance – either at home or in a facility – with the activities of daily living due to an accident, illness or advancing age.
- There's a 1 in 3 chance that an individual will spend 2.5 years of their life in a nursing home.
- National nursing home care costs average between $25,000 and $75,000 per year, depending on location and type and frequency of care.
- The County provides the opportunity to purchase long term care insurance from UNUM-Provident at group rates for you and your eligible family members, including parents, grandparents, siblings, and adult children.

ELIGIBILITY

Long-term care insurance is available to all employees regularly working 20 hours per week or more (18.75 hours for Job Share employees) and to their eligible family members. It is also available to retirees and their eligible family members. Eligible family members include your spouse or domestic partner, your adult siblings, and the parents, grandparents, and adult children of you, your spouse or domestic partner.

BENEFITS

Benefits become payable when a physician certifies that you are disabled – when you are unable to perform (without substantial assistance from another individual) at least two Activities of Daily Living (ADL's) or you require substantial supervision by another individual to protect you from threats to safety and health due to severe cognitive impairment. ADL's include:

- Bathing – washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower with or without equipment or adaptive devices.
- Dressing – putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- Toileting – getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring – moving into or out of a bed, chair, or wheelchair with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other supportive devices.
- Continence – the ability to maintain control of bowel or bladder function, or, when unable to maintain control of bowel or bladder functions, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- Eating – feeding oneself by getting food into the body from a receptacle (such as plate, cup, or table) or by a feeding tube or intravenously.

PLAN OPTIONS

You have several options for coverage.

- Monthly Facility Benefit of $1,000 to $6,000 per month (in $1,000 increments).
  - Adult Foster Care benefit is 60% of Monthly Facility Benefit
  - Professional Home Care benefit is 50% of Monthly Facility Benefit
- Choice of Facility Benefit Duration of 3 Years, 6 Years or Unlimited
- Option to purchase Total Home Care
  - Total Home Care benefit is 50% of Monthly Facility Benefit
- Option to purchase Inflation Protection

LEVEL OF CARE & COVERAGE

Nursing Home or Long Term Care Facility: An institution or distinctly separate part of a hospital that provides skilled, intermediate or custodial care under state licensing and certification laws.

Adult Foster Care: An assisted living facility licensed to provide ongoing care and services to a minimum of 10 inpatients in one location.

Professional Home Care: Visits to your home by a licensed Home Health Care Provider during which skilled nursing care, physical, respiratory, occupational, dietary or speech therapy, or homemaker services are provided.

Total Home Care: Professional home care services, as well as care received from any care provider of your choosing, including relatives and friends who provide care in your home.

Inflation Protection: 5% annual simple inflation capped at 200% of original Monthly Facility Benefit Amount.

GUARANTEED ISSUE

Coverage is guaranteed and no medical questionnaire is required for employees during their initial enrollment period, unless you choose to purchase Unlimited Facility Duration or a Monthly Facility Benefit Amount in excess of $4,000. After the initial enrollment period, employees can elect Long Term Care Insurance at open enrollment where the Long Term Care Insurance Application and Evidence of Insurability (medical questionnaire) will need to be completed. All retirees and family members must complete UNUM's Group Long Term Care Insurance Application and Evidence of Insurability (medical questionnaire).

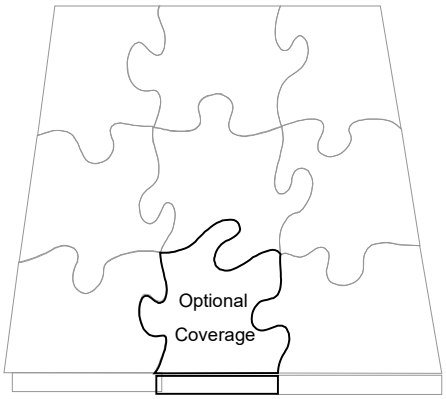
COST

Cost varies by your age at the time you enroll and the level of coverage you select. Here are some representative costs for a basic plan with a $1,000 Monthly-Facility Benefit, 50% Professional Home Care and a 3-Year Benefit Duration:

Age	Monthly Premium
35	$ 5.80
40	$ 6.90
45	$ 8.60
50	$ 10.80
55	$ 14.80
60	$21.20
70	$58.50

As you can see, the younger you are when you purchase the insurance, the lower the cost. Rates will not go up because you grow older. (However, rates for everyone may occasionally be increased or decreased by UNUM.)

VOLUNTARY BENEFITS



- Clackamas County offers a variety of optional programs designed to meet the needs of employees and their families.
- All plans are employee paid – some through convenient payroll deduction.
- Some programs are paid directly by the employee to the provider while still enjoying reduced group rates.
- Programs are provided by AFLAC (critical illness and accident) and Met Life (legal insurance).

ELIGIBILITY

Plans are available to all employees regularly working 20 hours per week or more (18.75 hours for Job Share employees). Some plans provide coverage for the employee's eligible family members.

PLANS AVAILABLE

AFLAC

Employees can choose from a variety of plans to enhance their current insurance coverage. Options include coverage for accidents, disability and critical illness plus dental, life and vision benefits. Most premiums are set up on a pretax payroll deduction basis.

How to enroll: New employees must enroll in AFLAC during their initial enrollment period or, like any eligible employee, they can choose to enroll during a future Open Enrollment period. You may contact the AFLAC representative at 503-409-7425 to review your options. The representative can enroll you in your chosen coverage immediately.

Leaving employment with Clackamas County: AFLAC coverage is portable even into retirement. You can continue coverage, but you will lose the pre-tax savings unless you transfer coverage to a new employer with the same program.

HRA/VEBA ACCOUNT

The HRA/VEBA plan is a health reimbursement arrangement (HRA). The County makes tax-free contributions to HRA/VEBA on your behalf. The funds are held in a non-profit, tax-exempt voluntary employees' beneficiary association (VEBA) trust authorized under Internal Revenue Code (IRC) § 501(c)(9). You can use these tax-free funds to reimburse eligible out-of-pocket healthcare costs and premiums for yourself, your spouse, and your qualified children and dependents. The HRA/VEBA plan is available to public employees in the Northwest.

Eligibility: The Unions who have agreed to participate are AFSCME-CCOM, AFSCME-DTD, AFSCME-WES and Employees' Association. Non-represented employees (elected officials, directors, managers, supervisors and confidential employees) are also eligible. For details on contributions and enrollment, visit the HRA/VEBA page.

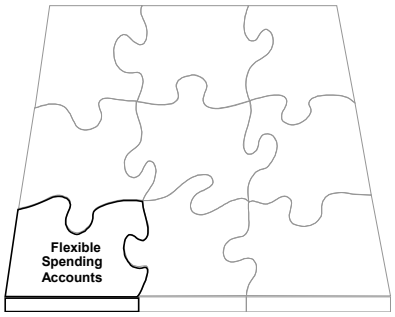
METLIFE LEGAL PLANS

MetLife provides employees with telephone and office consultations for an unlimited number of matters. Services include estate planning documents (wills, trusts, etc.), real estate matters, family law, financial matters, document preparation and defense of civil lawsuits. You pay a set monthly fee of $17.30, which covers you, your spouse and your eligible dependents. There are no deductibles, no co-payments, no claim forms and no limit on usage. If you stay within the network of providers, covered legal services are provided with no additional attorney fees. Of course, you also have the flexibility to use a non-Plan Attorney and be reimbursed for covered services according to a set fee schedule (you will be responsible to pay the difference, if any).

How to enroll: New employees may enroll in MetLife Legal coverage during their initial enrollment period by completing the enrollment form or, like any eligible employee, can choose to enroll during a future Open Enrollment period. Once enrolled, you must remain in the Plan for the entire Plan year. You can contact MetLife Legal at 1-800-821-6400 or visit their web site at www.legalplans.com and enter the passcode 1500317.

Leaving employment with Clackamas County: You can continue coverage for 24 months after separation of service. However, you must make a lump sum premium payment of $415.20 for the entire period.

FLEXIBLE SPENDING ACCOUNTS



- Flexible Spending Accounts (FSA) allow you to withhold pre-tax dollars from your paycheck to reimburse yourself for certain health care expenses and/or work-related dependent care expenses.
- Your contributions are made before Federal and State income taxes and Social Security (FICA) taxes are withheld.
- This is a permanent tax break, not just a deferral. You will not owe taxes on this money. However, you will lose any funds remaining in the account if you do not submit eligible expenses incurred by the cutoff date as explained below.
- **You must re-enroll each year to continue participation in the Flexible Spending Accounts.**

ADVANTAGES

+ Flexible spending accounts are an excellent way to pay for medical, dental and vision care expenses not covered by your health plans or for care of your dependents while you work *with before-tax dollars.*
+ Accounts are funded with payroll deductions withheld *before* Federal, State, and FICA taxes are calculated.
+ Reimbursements also are not subject to Federal, State and FICA withholding, thereby increasing your spendable income.
+ Contributions to either account may be as little as $130 per calendar year.
+ Both accounts provide a debit card for your convenience. It allows you to pay for eligible expenses directly wherever it is accepted. This negates the need to submit claim forms and wait for reimbursement.
+ The accounts are administered with complete confidentiality by Navia Benefit Solutions.

DISADVANTAGES

− "USE IT OR LOSE IT" – Any funds left in your Health Care FSA account over $550 at the end of the claims run out period will be forfeited. Funds under $550 will be rolled over to the next year if you re-enroll for the next year. All funds left in the Dependent Care FSA account after the claims run out period will be forfeited. There is no roll over provision for the Dependent Care FSA account.

− You cannot move money from one account to the other. Money set aside for the Health Care Account cannot be used to pay for Dependent Care expenses, or vice versa.

− Benefits based upon wages (such as Social Security) may be reduced because of salary reduction. This program does not affect PERS/OPSRP contributions.

− Once the plan year starts, you can only make changes in the Flexible Spending Accounts if there is a qualified life event.

ELIGIBILITY

- To participate, you must enroll online via ESS at the time you are first eligible for benefits or during the annual open enrollment period.
- **You must re-enroll each year to continue participation in the Flexible Spending Accounts.** You may re-enroll each year during Open Enrollment by enrolling online via ESS.
- Changes in enrollment made during Open Enrollment become effective on the first day of the new plan year, January 1. However, you may make changes at other times if they are related to changes in employment or a qualified life event. See the section on Qualified Life Events for more information.
- Domestic partners and their children are <u>not</u> dependents under IRS guidelines and are not eligible to be enrolled in your FSA's unless you claim them as dependents on your Federal tax return in compliance with IRC Section 152.

WHEN DOES PARTICIPATION END

- Your participation in the Flexible Spending Accounts will terminate on the earliest of the following dates:
  - The date you retire or terminate employment.
  - The last day of the plan year.
  - The date of a qualified life event (at your request and consistent with the life event).
- Any amount that has been withheld from your salary as of the date your participation ends will be available for your use, but only for qualified expenses incurred while you were an active participant.
- If your participation ends for any reason, you may choose to continue making payments into your Health Care Flexible Spending Account **on an after-tax basis** for the remainder of the plan year. This option may be to your benefit if you have been paying into your account for medical services or supplies that won't be incurred until after you leave employment.

FUNDING YOUR FLEXIBLE SPENDING ACCOUNTS

- You must make a separate election to fund each account independently. The two accounts are entirely separate.
- You may choose to fund one or both accounts. However, money from your health care account ***cannot*** be used to pay for dependent care expenses and vice versa.

CONTRIBUTIONS

- The Health Care FSA requires a minimum contribution of $130 and a maximum of $2,500 annually.
- The Dependent Care FSA requires a minimum of $130 and a maximum of $5,000 annually.
  - If you are married and file separate tax returns, you may only contribute up to $2,500 annually.
  - A lower limit will also apply if your spouse is a full-time student or earns less than $5,000 annually.
- Contributions to either or both accounts are made using pre-tax salary deductions. Pre-tax salary deductions are taken on a pay-period basis for the month in which they apply and submitted to Navia Benefit Solutions.
- When you enroll, you will need to estimate what your eligible reimburseable expenses will be for the plan year. You should contribute that amount or less to your Flexible Spending Account.
  - For example, if you incur dependent care expenses only during the summer, you will have to fund your account over the entire plan year, not just during the summer.

CARRYOVER PROVISION

- The County provides a carryover provision for the Health Care FSA account that allows you to carryover up to $550 of unused funds from the previous plan year if you re-enroll during open enrollment for the following plan year. These funds will be available for access for expenses incurred in the new plan year after the claims runout period for the previous year has ended.

USE IT OR LOSE IT

- Funds remaining in your Health Care FSA account over $550 at the end of the claims run out period will be forfeited. All funds under $550 will be rolled over to the next year if you re-enroll for the next year. Funds remaining in the Dependent Care FSA account after the claims run out period will be forfeited. There is no roll over provision for the Dependent Care FSA account.

CLAIMS RUNOUT PERIOD

- Our plan provides a 90-day claims runout period at the end of the plan year (March 30th of the following year) to submit claims for payment for expenses incurred in the prior plan year. Claims received on or after the 91st day will not be reimbursed.

UNIFORM COVERAGE PROVISION

- **This provision applies *only* to the Health Care FSA**.
- There is no minimum reimbursement amount. You may submit claims for any amount, no matter how small, to receive payment.
  - You may also submit a claim whose amount is larger than your balance, but no larger than your annual maximum contribution. You will receive immediate payment as long as the entire reimbursement pool is adequately funded by all plan participants.
  - The "pool" is the total contributions paid in for all participants.

- A delay in payment would only happen if there was not enough money to cover all claim requests from all participants that month. In that case, payment for the balance would be issued the following month.

ACCOUNT STATEMENTS

- If any of your Debit Card charges require substantiation, you will receive a monthly summary of your card activity for those charges. This form is e-mailed to you at the beginning of each month from Navia Benefit Solutions.

TAX CONSIDERATIONS

- You must submit claims for all the money in your Flexible Spending Accounts. Otherwise, you may forfeit any unclaimed funds.
- Also, when you use tax-free dollars to reimburse yourself for eligible expenses, you cannot claim an income tax deduction or tax credit for the same expenses.

HOW TO REQUEST A REIMBURSEMENT

- When you enroll in the Health Care Flexible Spending Account you will be sent two Debit Cards to use for eligible expenses. When you receive the card it will be loaded with the full amount that you elected for that plan year. This will allow you to pay your provider directly for qualified health care expenses. If you require additional cards, or if your cards are lost or stolen, there is a $10 reissue fee, which is deducted from your account balance. You will need to keep itemized receipts and documentation for the eligible services and products purchased with the Navia Benefits Debit Card.
- Debit Card Valid Merchants: The card is accepted at any Inventory Information Approval System (IIAS) participating merchants and medical care merchants using the MasterCard system. This includes: Doctor Offices, Dental/Vision Clinics, Hospitals, Mail Order Rx Programs, Pharmacies and grocery stores.
- Eligible members: yourself and your eligible family members.
- You may submit a claim whose amount is larger than your balance, but no larger than your annual maximum contribution. You will receive immediate payment as long as the entire reimbursement pool is adequately funded
- If you have eligible expense items from a merchant that does not accept the Debit Card, you can use the Navia Online Claim Submission Tool.
- You must include supporting documentation in order for the claim to be reimbursed:
  - **Health Care**: The expenses are for what type of service, the dates the expenses were incurred during the plan year (regardless of when you are billed or pay for the expenses), and the amount.
    - Eligible expenses should be submitted only after all other sources covering the expenses have provided payment. Your itemized receipts should show the amount that was or was not covered by any group health plan, or you may submit a copy of the Explanation of Benefits (EOB) in addition to the itemized receipt. Eligible expenses can be found at: Eligible Expenses.
- **Dependent Care FSA;** pay the bill with your Dependent Care Flexible Spending Account debit card or another form of payment. If you use another form of payment then use the Navia Online Claim Submission Tool. You may submit claims for any amount, no matter how small.
  - **Dependent Care**: To be reimbursed for eligible dependent day care expenses, you will need to submit an itemized bill showing dates of service and for whom services were rendered.
    - The itemized bill should have the name of the provider pre-printed and, if possible, be signed by the provider. Your provider must have a Tax Identification Number or Social Security Number listed on the bill.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

Since Health Care FSA expenses are subject to the Uniform Coverage Provision, you may submit a claim for more than the amount accumulated in your account and receive full payment, provided the amount does not exceed your total year's contribution.

- Funds in your account may not be available until two days following the pay period in which the contribution is withheld.
- Payments are mailed directly to your home or can be auto deposited.
- As long as you incur expenses by the last day of the plan year you have a 90-day runout period afterward to submit a claim for expenses incurred during the plan year.
- Money left in either account at the end of the runout period must be forfeited in accordance with IRS guidelines except for up to $550 in the Health Care FSA. Re-enrollment in the Health Care FSA account in order to be eligible for a roll over.
- Expenses must be incurred between the first and last day of the plan year. If you begin participating after the plan year has begun, your expenses must be incurred after you join the plan, but not later than the last day of that plan year if your account has funds available.
- Expenses are not covered, paid for or reimbursed under any group health plan under which you or your eligible family members are covered and meet the criteria for deductible medical expenses under the Internal Revenue Code.
- You cannot claim the expenses as deductions on your Federal or state income tax return in any tax year.

FRAUDULENT USE OF PLAN

- If the Plan Administrator finds that you have made fraudulent use of the plan, your participation in the plan will end, and you will forfeit your unused funds.

ESTIMATING YOUR HEALTH CARE REIMBURSABLE EXPENSES

- To assist you in determining the amount to fund your Health Care FSA, complete the worksheet below. Be conservative when estimating reimburseable expenses, because you will lose the money in your account over $550 if you do not use it.

HEALTH CARE FSA WORK SHEET

1.	Medical Plan Deductibles	$ _____
2.	Medical Plan Co-payments/Coinsurance	$ _____
3.	Uninsured Medical Expenses	$ _____
4.	Dental Plan Deductibles	$ _____
5.	Uninsured Dental Expenses	$ _____
6.	Uninsured Eye Exams, Lenses, Frames	$ _____
7.	Estimated Expenses For Any Eligible Dependent Who Does Not Have Health Care Coverage (i.e. dependent parents)[1]	$ _____
	Total Estimated Annual Expense[2]	$ _____
	Divide by the number of pay periods remaining in the plan year to determine your payroll deduction amount (26 in a calendar year).	$ _____

[1]Dependents must be eligible in accordance with the Internal Revenue Code Section 152.

[2]This amount cannot exceed the annual limit of $2,500 established by the County due to the Uniform Coverage requirement. See the section on Uniform Coverage.

EXAMPLES OF ELIGIBLE EXPENSES FOR YOUR HEALTH CARE FSA

Acupuncture

Ambulance Fees

Bandages/Gauze

Braces

Breast Pump

Chiropractic Services

Coinsurance/Co-payments

Contacts & Solutions

Contraceptives

CPAP Machine

Crutches

Deductibles

Dental Services

Diabetic Supplies

Drug Addiction Treatment

Eye Drops

Eye Examinations

Fertility Treatments

Flu Shots

Hearing Aids and Supplies

Hospital Fees

Immunizations

Laboratory Fees

Lamaze

Laser Eye Surgery

Nasal Strips

Naturopathic Visits

Orthodontia

Orthotics

Oxygen & Equipment

Pregnancy Test

Prenatal Vitamins

Prescription Drugs

Prescription or Reading Glasses

Saline Nasal Spray

Smoking Cessation Programs

Speech Therapy

Sterilization Procedures

Thermometer

Walker

Well Baby and Well Child Care

Wheelchair

X-rays

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

- You may use the Dependent Care FSA to reimburse yourself for care of any dependent qualified under IRS regulations.
- You will only be reimbursed to the extent that your account total can cover requests each month. Any amounts not paid at the time of the request will be paid as soon as your account can fund it.

IRS DEFINITION OF DEPENDENT

- A child who is 12 years of age or younger and who is considered your dependent or your spouse's dependent for purposes of claiming an exemption on your Federal income tax return.
- Your relative or household member who is physically or mentally incapable of self-care and who is considered your dependent or your spouse's dependent for purposes of claiming an exemption on your Federal income tax return.
- Your spouse who is physically or mentally incapable of self-care.

SERVICES THAT QUALIFY (ACCORDING TO THE IRS)

- You must be allowed to work while your dependent is receiving care.
- If you are married, your spouse must be either employed, a full-time student, or disabled.
- You must pay a "qualified person" to care for your eligible dependent(s). A "qualified person" does not include any of your children under age 19 or any other person you claim as a dependent.

EXAMPLES OF ELIGIBLE DEPENDENT CARE EXPENSES

- Programs for children 12 years of age or younger while schools are not in session.
- Preschools and day care centers.
- Individuals who care for young children in or outside your home.
- Special care for your mentally or physically handicapped spouse or other eligible dependents.
- Home care, non-medical nursing or nurse's aid services for a dependent who lives with you. (Medical care falls under Health Care expenses.)

EXAMPLES OF INELIGIBLE DEPENDENT CARE EXPENSES

- Cost of food, education, or transportation between your home and the dependent care facility.
- Payments to a dependent relative (such as older siblings).
- Baby-sitting during non-work hours.

W-2 REPORTING

- Employers are required to report the amount incurred for dependent care assistance.
- If you participate in this program in any plan year, the amount contributed over a tax year (calendar year) will be reported on your W-2 form.

INCOME TAX REPORTING

- The taxpayer claiming a dependent care credit or excluding a dependent care reimbursement from income must provide the name, address, and taxpayer identification number or Social Security Number of the dependent care provider.

DEPENDENT CARE FSA AND THE FEDERAL CHILD AND DEPENDENT TAX CREDIT

- Before deciding to participate in the Dependent Care FSA, you should determine whether you would save more tax dollars by claiming a tax credit for all or some of your dependent care expenses on your tax return.
- The maximum annual tax credit is $3,000 for one dependent and $6,000 for two or more dependents. The maximum annual Dependent Care FSA contribution is $5,000 for any number of dependents.
- The amount which you may take as a tax credit on your tax return will be reduced, dollar for dollar, by the amount excluded from your income and contributed to your Dependent Care FSA.
- For example: If you have one child and $6,000 in dependent care expenses and you contribute the annual maximum of $5,000 to the Dependent Care FSA, the tax credit limit of $3,000 is reduced by $5,000. Since the $5,000 exceeds the amount of the expenses eligible for the credit ($3,000), the credit limit is reduced to zero.

- You may exclude the $5,000 under IRC Section 129, but may not take a credit on the remaining $1,000. The $1,000 is not eligible for a tax credit because the $5,000 provided a greater benefit than the $3,000 limit provided under the credit.

Total Day Care Expenses	$6,000
Maximum Dependent Care Contribution	5,000
Balance	$1,000

CONTRIBUTION ADJUSTMENTS FOR HIGHLY COMPENSATED EMPLOYEES

- The IRC may limit or deny the tax benefits of a Dependent Care Flexible Spending Account for "highly compensated" employees in certain circumstances.
  - The County may adjust or eliminate contributions to the Dependent Care FSA made by highly compensated employees, if necessary, to comply with IRS requirements. Any highly compensated employee affected by such an adjustment will be notified by the Benefits & Wellness Division.
- If you have questions regarding W-2 reporting, income tax reporting or coordination of credit and exclusions, contact your independent tax consultant.

ESTIMATING YOUR DEPENDENT DAY CARE REIMBURSABLE EXPENSES

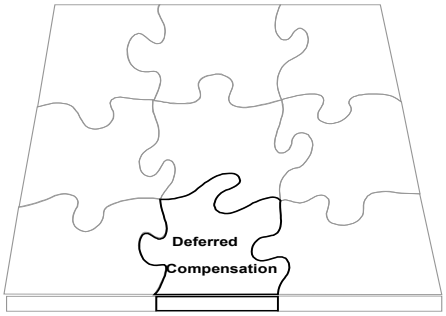
- To assist you in determining whether the Dependent Care FSA or Federal Child and Dependent Care Tax Credit is the most advantageous for you, please contact a tax specialist.
- If you decide to utilize the Dependent Care FSA, the worksheet below may help you determine the monthly contribution.

DEPENDENT DAY CARE FSA WORK SHEET

1.	Preschool or Day Care Expense	$ _____
2.	Baby-sitting In or Outside Your Home (only while you are at work)	$ _____
3.	Other Non-Educational Program To Care For Children When School Is Out (i.e., summer camp, etc.)	$ _____
4.	Non-Medical Home Care or Nursing For a Dependent Parent or Handicapped Spouse or Child	$ _____
	Total Estimated Annual Expense	$ _____
	Divide by the number of pay periods remaining in the plan year to determine your payroll deduction amount.	$ _____

- The total annual reimbursement cannot exceed the lesser of:
  - Your income;
  - Your spouse's income; or
  - $5,000 ($2,500 if married and filing separate tax returns).
- Generally, you cannot receive reimbursement from the Dependent Care FSA if your spouse is unemployed.
  - The exception is if your spouse is either a full-time student or is incapable of self-care. If this is the case, your spouse will be assumed to have an income of $200 per month when you have one eligible dependent and $400 if you have more than one eligible dependent.

DEFERRED COMPENSATION



- You may defer additional salary up to 100% of your includable compensation each year, or an annual maximum of $20,500 whichever is less and may increase in future years.
- You can receive a payout of Deferred Compensation funds at termination, retirement or total disability.
- Deferred compensation is a supplemental retirement program, not a savings account.

WHAT IS DEFERRED COMPENSATION?

Clackamas County's Deferred Compensation Program is provided under Internal Revenue Code Section 457. It is a program for public employees enabling them to defer taxes on wages and investment earnings in order to establish savings for supplemental retirement income.

The Deferred Compensation Program provides an opportunity for employees to invest a portion of their salary with one or more deferred compensation funds. With a deferred compensation plan, accumulating savings for the future is easier to manage because contributions are not subject to federal and state income taxes at the time of deferral;

- taxes are not paid on the deferred income and accumulated earnings until they are actually paid out;
- contributions are made through automatic payroll deduction;
- you have the opportunity to invest contributions in various types of investment options;
- you have a variety of payment options at retirement; and
- guaranteed benefits may be paid to your beneficiary at your death.

WHO IS ELIGIBLE TO PARTICIPATE?

Any regular, probationary, elected, or contract employee of Clackamas County or the Housing Authority of Clackamas County in a regular or job share position of at least 18.75 hours per week is eligible to participate.

WHY YOU SHOULD PARTICIPATE

This program provides a convenient way for you to accumulate money to meet long-term retirement objectives such as:

- increasing financial independence in the future;
- supplementing retirement income;
- accumulating more money than may be possible using after-tax savings methods; or
- reduce your current tax liability.

WHY YOU SHOULD NOT PARTICIPATE

You should *not* defer compensation if you:

- do not have accumulated savings for emergencies, vacations, large purchases, college, or other family expenses;
- cannot afford to save money over a long period of time for future use; or
- expect to have substantially more taxable income after retirement than you presently have.

A deferred compensation account is not a savings account. The money you defer and any earnings will generally ***not be available to you*** until you leave employment with Clackamas County.

Deferred compensation is only one aspect of personal financial management. It may not be the best option for you. You should consult your financial planner and consider all of your options before deciding to participate in the Deferred Compensation Program.

TAX ADVANTAGES OF DEFERRED COMPENSATION

This type of plan offers you two important tax advantages:

1. The Ability To Make Before-Tax Contributions To Your Retirement Plan Account

For example, if your income is $32,000 and you defer $4,000 to your deferred compensation account, your income would be taxed as if you earned only $28,000. The chart below illustrates how this program provides tax savings on contributions to a deferred compensation account.

RETIREMENT PLAN CONTRIBUTIONS

	WITHOUT A DEFERRED COMPENSATION PLAN[2]	WITH A DEFERRED COMPENSATION PLAN
BEFORE-TAX AMOUNT	$4,000	$4,000
Federal Income Taxes Paid[1]	$1,120	$ 0
State Income Taxes Paid[1]	$ 360	$ 0
Available for Savings/Investment	$2,520	$4,000

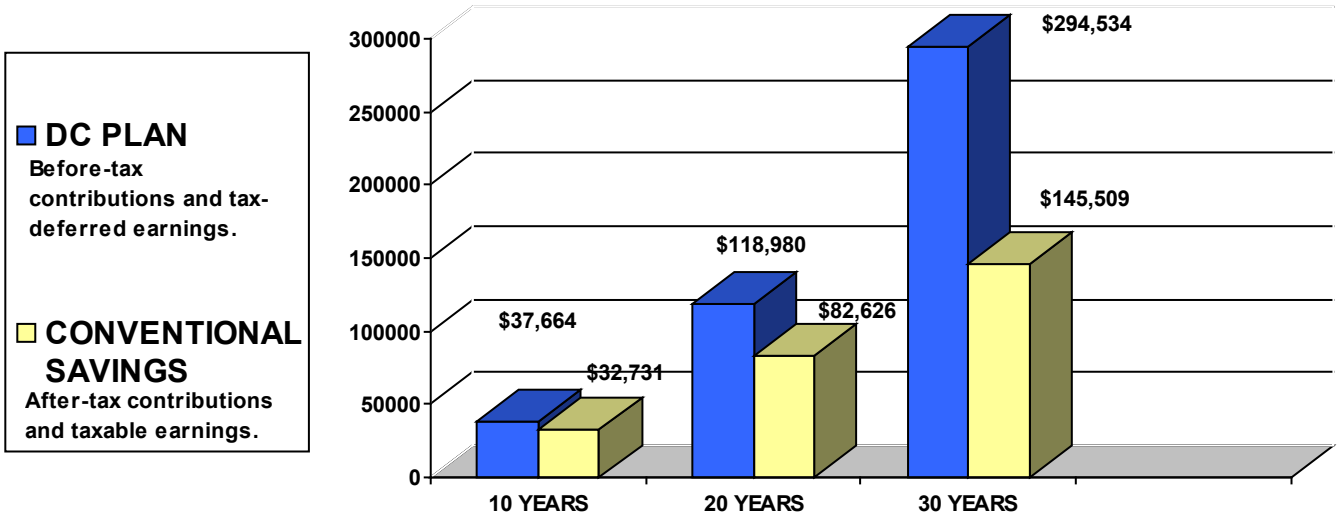
[1]*Assuming a federal tax of 28% and an Oregon tax rate of 9%.* [2] *All deferred compensation contributions are subject to FICA tax.*

You do not pay income taxes on your deferred compensation until you receive payments from your account. Moreover, because you usually withdraw money at retirement when you might be in a lower tax bracket, you could pay lower taxes on these earnings.

2. The Ability To Build Your Account Faster Through Tax-Deferred Accumulation

You also defer paying current income tax on the interest and dividends that may be earned on your contributions. This means that the money you would have paid in taxes can remain in your account where it can continue to generate additional income. The advantage of pre-tax savings is shown below. As you can see, the growth of your deferred compensation account quickly outdistances that of the conventional taxable savings plan due to tax-deferred accumulation.

THE POWER OF TAX-DEFERRED GROWTH



This chart compares the difference in accumulated savings between an individual participating in a deferred compensation plan and one who is saving after tax, assuming a 28% federal tax bracket, a 9% state tax and an 8% annual return for both. The individual participating in the deferred compensation program contributes $100 per pay period, paying no federal or state income tax. The individual with an after tax savings/investment program has only $63 to save/invest after federal and state tax withholding ($100 - $28 federal tax - $9 state tax = $63). This chart is for illustrative purposes only and is not intended as a guarantee of a specific rate of return.

FINANCIAL SECURITY AT RETIREMENT

A deferred compensation plan offers you an opportunity to enjoy additional financial security during your retirement years. The potential growth of your deferred compensation account is shown below, showing pay period contributions of $25, $50, $100, or $150, with an estimated annual earnings rate of 8%.

ACCUMULATION POTENTIAL OF A DEFERRED COMPENSATION PLAN*

Years	$25/Pay Period $650 Per Year	$ 50/Pay Period $1,300 Per Year	$100/Pay Period $2,600 Per Year	$150/Pay Period $3,900 Per Year
10 YEARS	**$9,939**	**$19,876**	**$39,742**	**$59,611**
20 YEARS	**32,153**	**64,302**	**128,573**	**192,864**
30 YEARS	**81,675**	**163,357**	**326,636**	**489,955**

**This table is for illustrative purposes only and is not intended as a guarantee of a specific rate of return.*

AMOUNTS DEFERRED

Minimum Amount:

You must defer at least $13.00 or 1% of base pay per pay period. Remember Clackamas County has 26 pay periods each calendar year.

Maximum Amount:

Section 457 allows you to defer up to 100% of your "*includable compensation*" to a maximum of $20,500 per year. (The $20,500 maximum is indexed to inflation and may increase in future years.)

Additional Contributions for Participants Age 50 and Over:

Those employees who have reached or will reach the age of fifty (50) during any plan year – and are not participating in the Catch-up Provision described below – may contribute an additional amount over the annual maximum for the plan year. The additional amount is equal to $6,500 and then may be indexed in $500 increments by the IRS. This additional contribution cannot be used in the years a participant utilizes the Catch-up provision.

If you are not sure how much you can defer, contact the Benefits & Wellness Division at 503-655-8550 or at Benefits@clackamas.us.

Catch-up Provision:

During the last three years before the year you are eligible for normal retirement through PERS/OPSRP, you may be eligible to defer up to 2 times the annual maximum per year (for 2022 the maximum amount available is $41,000). The actual amount you may defer will be based on your individual eligibility and prior contribution levels.

Normal retirement for General Service Tier 1 members is age 58, age 60 for Tier 2 members and age 65 for OPSRP members. OPSRP members may also receive normal retirement benefits beginning at age 58 with 30 years of service. Police and Fire members may retire at age 55, or for OPSRP members at age 60, or at 50-55 with 25 or more years of credible service. A Tier 1 or 2 member may retire at any age with 30 or more years of credible service.

Contact the Benefits & Wellness Division at 503-655-8550 or at Benefits@clackamas.us for more details.

IMPACT ON YOUR SPENDABLE INCOME

Deductions from your pay for deferred compensation reduce your taxable income and have a direct effect on the amount of spendable income you receive each pay period. Your deferral, however, does not change the Social Security (FICA) taxes withheld from your pay, which are based on your unadjusted gross earnings.

Based on current tax tables, the following are examples of how deductions for deferred compensation can affect your take-home pay:

Bi-weekly salary of $1,150, married with two exemptions	**Without Deferred Compensation**	**With Deferred Compensation**
Federal Tax	$36.15	$32.40
State Tax	54.00	51.00
FICA	71.30	71.30
Amount Deferred	0.00	37.50
Medicare	16.68	16.68
WC	.88	.88
Trans	1.15	1.11
Net Pay	$969.84	$939.13
After Tax Savings Account	37.50	0.00
Spendable Income	**$932.34**	**$939.13**

Bi-weekly salary of $716, single, with one exemption	**Without Deferred Compensation**	**With Deferred Compensation**
Federal Tax	$40.94	$37.95
State Tax	42.00	40.00
FICA	44.39	44.39
Amount Deferred	0.00	25.00
Medicare	10.38	10.38
WC	.88	.88
Trans	.72	.69
Net Pay	$576.69	$556.71
After Tax Savings Account	25.00	0.00
Spendable Income	**$551.69**	**$556.71**

Bi-weekly salary of $1700, married, with 3 exemptions	**Without Deferred Compensation**	**With Deferred Compensation**
Federal Tax	$74.62	$67.12
State Tax	91.00	85.00
FICA	105.40	105.40
Amount Deferred	0.00	75.00
Medicare	24.65	24.65
WC	.88	.88
Trans	1.70	1.63
Net Pay	$1401.75	$1340.32
After Tax Savings Account	75.00	0.00
Spendable Income	**$1,326.75**	**$1,340.32**

ENROLLMENT PROCESS

To begin participating in the Deferred Compensation Program, you must complete the required forms:

- VOYA Deferred Compensation Plan E-Z enrollment form

You may also meet with the investment representative to setup your account and complete the forms specifying how you want your money invested. Please refer to the investment provider listed in the notice in the back of this section or contact the Benefits & Wellness Division at 503-655-8550 for more information.

- For employees enrolled through auto enrollment or a County-paid contribution the E-Z enrollment form is not needed for account setup.

EFFECTIVE DATES

Participation is effective on the first day of the month following completion of the VOYA enrollment forms. Deferrals effective on the first day of the month will be deducted from your first paycheck of the month. If forms are received after the due date, your participation will not be effective until the following month. See examples in the following chart:

All Required Forms Received	Effective Date	Paycheck Affected
February 21 - March 20	**April 1**	**First Paycheck**
March 21 – April 20	**May 1**	**First Paycheck**

PARTICIPATION CHANGES

Once you are enrolled in the Deferred Compensation Program, you may:

Increase your contributions	Up to the last day of a month	1st of the following month
Restart after stopping	Up to the last day of a month	1st of the following month
Decrease or stop contributions	Up to the last day of a month	1st of the following month
Transfer balances between options within the provider	Any time	Any time
Change your beneficiary	Any time	Any time

All changes must be made on the VOYA website or by calling VOYA Customer Service at 800-584-6001.

WHEN PARTICIPATION ENDS

You will no longer be able to contribute to the County's Deferred Compensation program when you have severed your employment, or no longer meet the eligibility requirements.

PAYOUT FROM YOUR DEFERRED COMPENSATION ACCOUNT

Payments from your Deferred Compensation Account may be made in the event of:

- your severance of employment;
- your retirement;
- your total and continuing disability;
- your death (paid to your beneficiary or beneficiaries);
- an unforeseen emergency (see *Hardship Withdrawals* section); or,
- inactive accounts with a balance of less than $5,000 (see *In-Service Withdrawals* section);
- In-service withdrawals starting at age 59 ½.
- Qualified Birth or Adoption

When you make your decision regarding the date your payout is to begin, you must contact VOYA Customer Service at 800-584-6001 to request payout paperwork. There are no Federal tax penalties for early withdrawal.

Income taxes are due for the tax year(s) in which you receive the money. Rollovers from your 457 account into a 401(k), 403(b) or IRA will be allowed (refer to page 11-7). However, the amounts rolled over may be subject to a tax penalty if a withdrawal is elected prior to age 59 ½. Consult your financial or tax advisor for specific details.

PAYOUT DATES AND OPTIONS

When you leave employment with the County, you may begin payout immediately or you may decide to wait to receive your benefits. However, payments must begin no later than April 1 after the year in which you reach age 72. There are no tax penalties for early withdrawal of 457 Deferred Compensation plan funds.

The amount of your payments will vary depending on several factors, including the amount of compensation you deferred, the investment options you selected, how well your investment(s) "performed"; and the payout option you select. You can make your payout decision anytime after you have separated from service. Regulations allow changes to your method and amount of payout even after you have begun receiving your money.

However, if you do not select a payout option by March 1 of the year after you reach age 72, payments will be over a period not to exceed your life expectancy.

Payout options may change periodically. Some of the options may include:

- partial surrenders;
- life annuity option (with or without payment certain option);
- joint and last survivor income;
- payments for a designated period (equal monthly, quarterly, semi-annual or annual payments);
- lump sum;
- systematic withdrawal option;
- estate conservation option.

For the most up-to-date options, contact your VOYA representative (listed on the back page of this section.)

DEATH BENEFITS

If you die *after* you begin receiving payments, your account will be transferred to your beneficiary and they will be able to elect a payout at any time, a partial surrender or stop payments if you had chosen a Systematic Withdrawal Option.

If you die *before* you begin receiving payments, your account will be transferred to your beneficiary and they will be able to elect a payout at any time or a partial withdrawal or full withdrawal.

If there are no surviving beneficiaries, the current value of any remaining payments will be paid to your estate in a lump sum.

HARDSHIP WITHDRAWALS

Generally, you will not have access to your Deferred Compensation account until you have severed your employment or retired. However, Section 457 of the Internal Revenue Code allows for Hardship Withdrawals in the event of an "unforeseeable emergency." An unforeseeable emergency is defined as a severe financial hardship of the participant or beneficiary resulting from an illness or accident of the participant or beneficiary, the participant's or beneficiary's spouse or the participant's or beneficiary's dependent (as defined in section 152(a); loss of the participant's or beneficiary's property due to casualty, or other similar extraordinary and unforeseeable circumstance arising as a result of events beyond the control of the participant or the beneficiary. Section 457 specifically states that the purchase of a home or the payment of college tuition are not unforeseeable emergencies.

Evidence of the unforeseen emergency and financial hardship is required. It must be a situation you could not have anticipated or otherwise budgeted for. The expenses must not be relieved through reimbursement or compensation from insurance; by liquidation of your assets, to the extent the liquidation of such assets would not itself cause severe financial hardship; or by cessation of deferrals under the plan for the situation to be considered an emergency. **If approved**, the withdrawal must be limited to the amount reasonably necessary to satisfy the emergency need (which may include any amounts necessary to pay any federal, state or local income taxes or penalties reasonably anticipated to result from the distribution). Money received will be considered as income for that year and will be taxable.

IF YOU NEED TO APPLY FOR A HARDSHIP WITHDRAWAL, CONTACT VOYA CUSTOMER SERVICE AT 800-584-6001 TO REQUEST AN APPLICATION.

IN-SERVICE WITHDRAWALS

Section 457 also allows for withdrawals for inactive accounts with low balances and starting at age 59 ½. You may make a ***one-time*** lump sum withdrawal of your entire account balance while still employed by the County, if the following conditions are met:

- your account balance is $5000 or less; and,
- no contributions have been made for at least two years; and
- you have not made any previous in-service withdrawals while employed (other than a hardship withdrawal);or
- you are age 59 ½.

If you are receiving County-paid deferred compensation, your account is considered active and you do not qualify for an in-service withdrawal prior to age 59 ½.

Contact VOYA Customer Service at 800-584-6001 to request the required forms for an In-Service Withdrawal.

QUALIFIED BIRTH OR ADOPTION DISTRIBUTIONS

Plan participants may take up to a $5,000 distribution from their account for a qualifying birth or adoption by meeting certain criteria provided in the plan document.

Contact VOYA Customer Service at 800-584-6001 to request the required forms for a Qualified Birth or Adoption Distribution.

QUALIFIED DOMESTIC RELATIONS ORDER (QDRO)

If you are involved in a divorce, annulment or marital separation, the court may make a judgment to award part of your deferred compensation account to your spouse or another dependent (alternate payee). If this happens, you or your attorney should contact your deferred compensation provider immediately for specific information regarding the division of assets between you and the alternate payee.

In accordance with a divorce decree, order, or settlement, the alternate payee may request any payout date and option. The alternate payee's payments may begin when the appropriate paperwork is received by VOYA in good working order.

The investment provider will withhold federal and state income taxes from the alternate payee's payments based on the alternate payee's withholding liability. Should the alternate payee die while receiving a distribution, the remaining funds will be paid out to the alternate payee's beneficiary.

ROLLOVERS

From another Plan: The Clackamas County Deferred Compensation Plan will accept a direct rollover (plan to plan) or an indirect rollover (by participant within 60 days of receipt of distribution) from other retirement plans such as 401(k), 403(b), 401(a) and Individual Retirement Accounts (IRAs). Only pre-tax contributions made to these other plans may be rolled over into our plan. The monies from these accounts will be kept separate from your 457 account. Rollovers from other governmental 457 plans will be deposited with your Clackamas County deferred compensation account. All rollovers into the Deferred Compensation plan are subject to approval by Clackamas County.

To another Plan: At severance of employment you will be able to transfer your account to another type of deferred compensation account – 401(a), 401(k), 403(b), IRA – not just another governmental 457 plan. However, amounts transferred into a plan will generally take on the characteristics of the receiving plan. For example, a 457 account that is rolled into a qualified plan or IRA will be subject to a tax penalty if a withdrawal is elected prior to age 59 ½ .

NONASSIGNABILITY CLAUSE

Your deferral of compensation to the Plan is expressly declared unassignable and nontransferable. Neither you nor any other person can use your account balance as collateral for the purchase of a house or for a personal loan. Your account balance is not subject to garnishment, bankruptcy judgments, alimony, or payment of any debts.

DEFERRED COMPENSATION COMMITTEE

The Deferred Compensation Committee is comprised of County employees who have been appointed by their Appointing Authority. Committee membership consists of:

- Benefits Manager as Committee Chair;
- County Treasurer as Committee Co-Chair; and,
- Represented and Non-Represented County employees.

The role of the committee is to review the operation of the plan and make recommendations for changes in the areas of investment options and administration. The plan employs 3rd party consultant NW Capital Management to assist the committee in its fiduciary duties to the plan.

ANSWERS TO THE MOST COMMONLY ASKED QUESTIONS…

ABOUT THE PROGRAM

1. ***Who owns the deferred compensation funds?***

   The County determines plan investment providers and makes decisions about the administration of the plan, but all assets in our Deferred Compensation plan must be held in a qualified trust, custodial account or annuity contract for the exclusive benefit of participants and their beneficiaries. These assets are not subject to the claims of the creditors of the County nor can the County use them for any purpose other than the payment of benefits to plan participants or their beneficiaries.

ABOUT THE ENROLLMENT PROCESS

2. ***What is the minimum amount I must contribute each pay period to participate in the program?***

   $13.00 or 1% of base pay per pay period is the minimum allowable contribution.

3. ***What is the maximum amount I may defer?***

   You can defer 100% of your includable gross income up to a maximum of $20,500 per calendar year. (The $20,500 maximum is indexed to inflation and may increase in the future.) This maximum includes all eligible deferred compensation plans in which you are participating. (See "Amounts Deferred" on page 11-3.)

4. ***Can I enroll in, and make deposits to, more than one fund at the same time?***

   Yes, subject to the indicated minimum and maximum contribution levels.

5. ***What if I have additional questions before I can make my decision about enrolling?***

   For general information, call the Benefits & Wellness Division at 503-655-8550 or at Benefits@clackamas.us.

   For technical information on the options available from the investment provider, contact the representative listed in the back of this booklet. If this notice is missing, please contact the Benefits & Wellness Division at 503-655-8550 or at Benefits@clackamas.us for current information on the representative.

6. ***When will deductions begin for my requested contributions?***

   Participation is effective on the first day of the month following receipt of all required forms by the due date. If forms are received after the due date, your participation will not be effective until the following month. (See "Enrollment Process and "Effective Dates" on page 11-5.)

ABOUT CHANGES DURING THE YEAR

7. ***How do I increase, decrease, or stop my contributions?***

   Contribution changes can be made on the VOYA website or by calling VOYA Customer Service at 800-584-6001. (See "Participation Changes" on Page 11-5.)

8. ***If I stop contributions to a fund, must I transfer the money to another fund?***

   No. While employed at Clackamas County you may leave those funds on deposit indefinitely even if you are no longer making regular contributions. Funds in your account will continue to be invested in the options you chose, and you will continue to receive account statements from the provider.

9. ***May I transfer accumulated balances between a provider's investment options?***

   Yes. There are no restrictions to the transfer of variable accounts but other restrictions may apply. Contact your investment provider representative for details.

10. ***What happens to my deferred compensation during an unpaid leave of absence?***

    When you stop receiving a paycheck, contributions will be suspended until you return to active status and have sufficient earnings to cover the deferral amount. Funds in your account will continue to be invested in the options you chose, and you will continue to receive account statements from the provider.

11. When can I change my beneficiary?

You may change your beneficiary at any time. You can go online to the VOYA website to change your beneficiary or you can call VOYA Customer Service at 800-584-6001 to request your beneficiary change over the phone.

12. If I change my name and/or my address, is it necessary to notify the investment provider(s) in which I participate?

Yes, in order to ensure that accounts are maintained in the correct name and that you will receive account statements and other information from the providers. Log in to the VOYA website or call VOYA Customer Service at 800-584-6001 to update your personal information.

ABOUT PAYOUT OR DISTRIBUTION OF FUNDS

13. When do I become eligible to receive the funds in my deferred compensation account?

You are eligible to receive payments from your account when you sever your employment with the County for any reason, in the event of a financial emergency, when you have an inactive account with less than $5000, or at age 59 ½. Your beneficiary will be eligible to receive payments at your death.

14. Will I have to wait until I am age 65 to receive the money?

No. Once you are eligible for payout, you may choose to receive payments immediately or you may delay receipt until a future date. All payouts, however, must begin by April 1 in the year after you reach age 72, or when you sever your employment with the County if you work beyond that date. There are no Federal tax penalties for early withdrawal of deferred compensation funds.

15. What do I need to do to receive a payout of the funds in my deferred compensation account?

Contact VOYA Customer Service at 800-584-6001 to request payout paperwork. If no payout date is selected, payments may be scheduled to begin no later than April 1 of the calendar year following the calendar year in which you or your beneficiary reach age 72.

16. What kinds of options for payout are offered?

The investment provider has different payout options available, and they may change periodically. (See "Payout Options" on page 11-6.)

17. What if I change my mind about payout after I am receiving funds from my account?

You will be able to change your payout amount and method of payment after payout begins. You will be able to make a change once a quarter or 4 times a year.

18. If I die before or after payout has begun, can my beneficiary file new Payout Request and W-4 forms and select a different method of payout of the funds in my account?

Yes. If you die before or after payout has begun, your beneficiary should contact VOYA Customer Service at 800-584-6001 within 60 days of the date of your death to obtain information about any restrictions or limitations on the method, amount or beginning date of payout.

19. If I think I need a payout from my deferred compensation account to meet a financial hardship, how do I apply?

In the case of financial hardship, obtain an application for hardship withdrawal from the investment provider. On the application, you must document the exact nature of the hardship, that you have depleted all other assets, and indicate the exact amount of money that will be needed to meet the emergency. You will also need to provide documentation of your emergency need. All applications are kept in strict confidence and are reviewed by the investment provider to determine if the circumstances fall within the guidelines allowed by the Internal Revenue Service for hardship withdrawals. If approved, the investment provider will process your withdrawal request.

ABOUT HOW DEFERRED COMPENSATION AFFECTS TAXES AND OTHER RETIREMENT INCOME

20. ***While I'm still employed, will my W-2 reflect deferred compensation deductions?***

Your W-2 will list the deferred amount in Box 12b. It will also show your adjusted gross wages that were subject to taxes, and your total earnings before any deductions were made for deferred compensation, flexible spending accounts and health insurance premiums. Amounts in deferred compensation accounts are not reported as taxable income until payments are actually received by you or your beneficiary.

21. If I participate in the deferred compensation program, will it affect current contributions to Social Security or PERS/OPSRP?

Under current regulations, deferred compensation will not affect the level of Social Security taxes or PERS/OPSRP contributions. These are calculated on your gross earnings before any deferral of income. The only two items affected by deferring income are the withholdings for state and federal income taxes.

22. Are there any financial penalties applied to payouts?

There are no IRS penalties other than ordinary income taxes due at the time of payout.

23. When I start receiving the money, how do I report it to the Internal Revenue Service?

Each year, the provider will report the amount paid out to you and amount withheld for taxes to the IRS and to you on a 1099R form. The amount of taxes withheld by the provider may not be your actual tax liability for the year. That liability will depend on your total gross income from all sources. It is your responsibility to complete the state and federal income tax forms as required.

24. Do I need to report payout income from my deferred compensation fund(s) to Social Security? Will that income have an effect on the amount of Social Security benefits I receive?

No. At the time you were contributing to deferred compensation, Social Security taxes were deducted from your gross earnings. You report deferred compensation as income for state and federal tax purposes only. At this time, deferred compensation payments are not subject to Social Security taxes and are not considered earnings in applying the Social Security earnings limitation.

25. After retirement, will deferred compensation income affect my normal PERS/OPSRP retirement benefits?

No. PERS/OPSRP retirement benefits are not affected by income from deferred compensation programs.

26. If I am receiving payout over a period of time, may I file a revised W-4 if I want to change my tax withholding?

Yes. With changing circumstances, you may need to increase or decrease your withholding for state and federal taxes. The change would be effective with the first check issued after the investment provider receives and processes your revised W-4.

ABOUT OTHER IMPORTANT DEFERRED COMPENSATION PROGRAM INFORMATION

27. Since the County holds my deferred compensation funds in a trust, do I really have any control as to where the money is invested?

Your contributions are limited to the investment provider offered through the County's program. Should Clackamas County determine the investment provider is not fulfilling its contractual responsibilities or is no longer providing adequate services or protection of participant accounts, the County will notify you promptly and will provide other investment options.

28. If I acquire a sum of money, can I deposit it in my deferred compensation account(s)?

No. Only contributions withheld from your Clackamas County earnings can be deposited to your deferred compensation account.

29. Other than my pay period contributions, are there any administrative costs to me?

The investment providers do not charge any maintenance fees, but may collect an asset fee equivalent to a percentage of your account balance. Contact the providers for more information. An Administrative Fee is collected from all participants to pay for the Recordkeeping expense and other plan-related expenses incurred by the County. The Deferred Compensation Committee monitors these fees to keep them low.

30. If I already have an Individual Retirement Account (IRA), can I also participate in the Deferred Compensation Programs?

Yes, you can participate subject to the regulations concerning IRA's and the minimum and maximum contribution requirements of the Deferred Compensation Program. Contact your financial or tax advisor for more information. When you retire or end employment with Clackamas County, your deferred compensation funds may be rolled over into an IRA or you may leave your funds in your account.

31. Are my deferred compensation funds protected? Are earnings on my deferred compensation guaranteed?

The variable accounts are subject to the gains and losses of the market. Neither Clackamas County nor the investment provider can guarantee that your investment choices will show a gain. The approved investment funds have been carefully selected, but you should consider your choices. The actual gains or losses of the investments you choose will be reflected in your account balance.

For more information, contact the representative listed on the provider list. If this notice is missing or out of date, please contact the Benefits & Wellness Division at 503-655-8550 or at Benefits@clackamas.us for current information.

DEFERRED COMPENSATION PROVIDER INFORMATION

VOYA FINANCIAL SERVICES

Contact Wendy Stefani at 503-937-0351

Cell Number: 503-704-8697

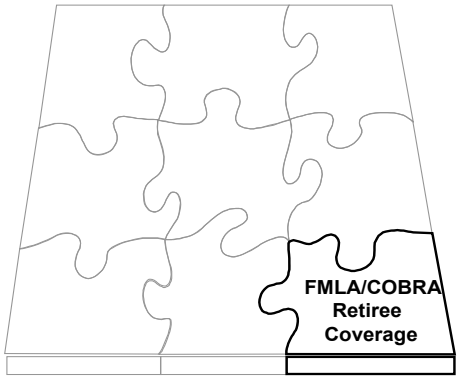
Email: wendy@lewis-stefani.com

Web address: https://voyaretirement.voyaplans.com/eportal/welcome.do

Toll free Customer Service: (800) 584-6001

- Plan oversight by a third party consultant.
- 35 Best-in-class investment options currently offered (including 13 Target-Date Portfolios).
- Self-Directed Brokerage Account Option
- Auto Escalation
- Lower fees
- If you wish to participate without choosing an investment option, you will be enrolled in the Target Date Portfolio that is based on your date of birth.

CONTINUATION OF HEALTH BENEFITS



- The Family and Medical Leave Act (FMLA) provides for the continuation of County-paid group health coverage, for up to twelve (12) weeks while you are on an approved family and medical leave of absence.
- The Oregon Family Leave Act (OFLA) provides additional leave time for parental leave and sick child care.
- COBRA and Retiree coverage provides you and your qualifying dependents the opportunity to continue group health coverage at your own expense if you should lose that coverage, such as termination of employment, an extended leave of absence, reduction in hours or loss of eligibility.

FAMILY AND MEDICAL LEAVE – EPP # 10

ELIGIBILITY

For purposes of this policy, employees include probationary, regular status, seasonal and/or temporary employees. Employees who are absent from work due to service in the National Guard or the Reserves shall have their time spent in military service count toward the eligibility requirements for FML.

- To be eligible under **FMLA**, an employee must have worked for a total of at least **12 months** (not necessarily consecutive) and worked for at least **1250 hours** during the 12 month period immediately preceding the leave.
- To be eligible under **OFLA**, an employee must have worked for a period of **180 calendar days** immediately preceding the date leave begins and worked an average of **25 hours per week** during the 180-day period. However, these criteria do not apply if the leave is to care for a newborn child or newly placed adoptive or foster child.

QUALIFYING EVENTS

- County policy currently combines the Federal and State family leave laws to provide the most generous benefit to employees. Under County policy, these events qualify for family and medical leave:
  - **Serious health condition** of the employee, employee's spouse or domestic partner, parent, parent-in-law or domestic partner's parent, child, stepchild or domestic partner's child, or an individual with whom the employee has an *"in loco parentis"* relationship (a parent-child type of relationship in the absence of biological or adoptive parents).
  - **Parental leave** for the birth of a child, or placement of a child with the employee for adoption or foster care (must be taken within one year of birth or placement).
  - **Sick child leave** to care for a child suffering from a non-serious illness or injury that requires home care.

DURATION OF THE LEAVE

- Under the federal Family & Medical Leave Act (FMLA), you are permitted to take a total of 12 weeks in any 12-month period for any qualifying event.
- Under the Oregon Family Leave Act (OFLA), you are permitted to take up to 12 weeks of family leave in any 12-month period for serious health condition leave and/or parental leave and/or sick child leave. (FMLA and OFLA leave for a serious health condition or parental leave run concurrently.) OFLA provides additional leave as follows:
  - A woman who takes leave because of a pregnancy-related disability may take an additional 12 weeks for any other OFLA qualifying event; and
  - An employee who takes 12 weeks of parental leave may also take an additional 12 weeks of sick child leave. If an employee does not take a full 12 weeks of parental leave, they are only entitled to take sick child leave up to their basic 12 week entitlement.

- Family leave can be taken intermittently or consecutively. The amount of leave available is determined on a "rolling 12-month" basis, in which the 12-month period is measured backward from the date the leave is effective. Even if you have more than one qualifying event in any 12-month period, you are not entitled to any additional leave.

CERTIFICATION OF SERIOUS HEALTH CONDITION

- The County will require certification from the attending health care provider(s) for leave to care for a family member with a serious health condition or for your own serious health condition, including disability for pregnancy and following childbirth.
  - This information must accompany the request for family medical leave.
- If the serious illness is related to a family member, the attending health care provider must indicate on the certification form that you are needed to provide care (which may include psychological comfort).
- A serious health condition means an illness, injury, impairment or physical or mental condition that involves:
  - Inpatient care in a hospital, hospice, or residential medical care facility or subsequent treatment resulting from such impatient care; or
  - A period of incapacity of more than 3 consecutive calendar days, and any subsequent treatment (two or more treatments or once with a regimen of continued treatment); or
  - Any period of incapacity for pregnancy or prenatal care; or
  - Any period of incapacity or treatment of such incapacity due to a chronic serious health condition (asthma, diabetes); or
  - Permanent or long-term incapacity due to a condition for which treatment may not be effective (Alzheimer's, severe stroke, etc.); or
  - Any period of absence to receive multiple treatments either for restorative surgery after an accident or injury or that would likely result in a period of incapacity of more than 3 days if untreated; or
  - An illness, disease or condition that poses an imminent danger of death, is terminal in prognosis, or requires constant care.

  Examples include but are not limited to: heart attacks and conditions requiring surgery (e.g., bypass or valve operations); back conditions requiring extensive therapy or surgery; strokes; severe nervous disorders (mental/emotional/stress); severe respiratory conditions; pregnancy, severe morning sickness, prenatal care, childbirth and recovery from childbirth; appendicitis; pneumonia; severe arthritis; treatment for substance abuse (not absence because of use of substance).

  Health conditions not considered serious (unless complications arise) include, but are not limited to: short term illnesses (common cold, flu, ear aches, upset stomach, ulcers, headaches other than migraines), routine dental or orthodontia problems, cosmetic treatment, or routine physical exams.
- All of the following Health Care Providers must be authorized to provide health care by the State in which they practice:
  - Doctors of medicine or osteopathy; podiatrists; dentists; clinical psychologists; optometrists; chiropractors; nurse practitioners; clinical social workers; and any health care provider recognized by the County's group health plans, and
  - Nurse midwives/Direct entry midwives; and Naturopathic physicians (OFLA only).

  Other types of providers covered under Family and Medical Leave include:
  - Christian Science practitioners listed with the First Church of Christ Scientist in Boston, MA;
  - A health care provider as defined above who practices and is licensed in a country other than the United States.

HEALTH BENEFIT CONTINUATION

- You are entitled to continued benefit coverage while on an approved **Federal FMLA** leave for up to 12 weeks in any 12-month period of time. (Oregon OFLA does not have any provision for benefit continuation.) The benefits required to be continued include medical, prescription drug, vision, dental, Employee Assistance Program, and Health Care Flexible Spending Account (FSA). Contributions to a dependent care flexible spending account may be suspended during a continuous FML.
- During the leave, you will be responsible for paying any employee contribution toward your health insurance premium and Health Care FSA, just as when you are an active employee.
  - If you remain in a paid status during your leave, premiums will be collected from your paycheck on a pre-tax basis.

- If you are in an unpaid status, you must pay the premium by check, money order or cash. These premiums will be on an after-tax basis. Alternatively, you may choose to have the premiums taken as a payroll deduction immediately upon return from leave.

- The County will also continue your County-paid life and disability insurance. You have the option of continuing employee-paid coverage such as dependent life, universal life, supplemental disability, accidental death and dismemberment and long term care insurance. If you will be in an unpaid status, you must pay the premiums to the County by check, money order or cash.

FAILURE TO RETURN FROM LEAVE

- In the event you voluntarily terminate your employment with the County during an approved leave or fail to return to work at the end of the leave, you will be required to repay the County for the health insurance premiums paid by the County during any unpaid FML period.

- In the event the failure to return to work is beyond your control, such as severe deterioration of the health status of yourself or your family member, or you elect retirement, this requirement will be waived. If failure to return is due to continuation, recurrence or onset of a serious health condition, medical certification will be required within 30 days from the date the County requests the information.

PAID LEAVE

- If you are taking family medical leave for your own serious health condition or to care for a family member with a serious health condition, you must use your accrued sick leave.
  - You may use your accrued vacation when all of your sick leave is exhausted. If you choose not to use vacation or compensatory time, you will be put into a leave without pay status.
  - Use of sick leave for family members must comply with the applicable collective bargaining contract or County policy.

- For other uses of the family medical leave, such as parental leave for birth, adoption or foster care of a child, you have the choice of using any or all accrued sick or vacation leave, at your discretion.
  - If you choose to retain some or all of your accrued paid leave, you will be placed in a leave without pay status for the remainder of your family leave. You may not go back and forth between leave with pay and leave without pay.

- If you are taking family medical leave to care for a family member who then dies, your family leave will end. However, you will be entitled to the use of bereavement leave as stated in your collective bargaining agreement or the Personnel Ordinance.

- When an employee is not eligible to receive overtime under Federal or State law, County policy or a collective bargaining agreement (i.e., managers) and is on intermittent leave, they are not required to use sick or vacation when the FML leave is 4 hours or less in a day. However, the time taken is charged against the employee's FML entitlement.

SERVICE ACCRUAL AND OTHER BENEFITS

- Seniority continues to accrue during all authorized leaves, paid or unpaid.

- Longevity, time towards salary increases, sick leave and vacation will accrue during a family medical leave according to the 11-day rule.
  - The 11-day rule states that an employee must be working, half-time or greater, or in a paid status for 11 working days in a calendar month in order to gain service accruals for that month. For employees who work a part-time or compressed work week (i.e., four 10-hour days), the 11-day rule will be prorated.

- PERS/OPSRP requires employees to be in a paid status for 50 hours per month to receive creditable service for that month. Service credit is not granted for months in which an employee is on a leave without pay. Time spent on leave without pay also is not included in the service time used to determine eligibility for unreduced early retirement benefits. (Refer to PERS/OPSRP handbook or contact PERS/OPSRP for more information.)

ADDITIONAL LEAVE AT THE END OF FML

- Once an employee's FML entitlement is exhausted, they may request an additional leave of absence with or without pay, subject to approval by the employee's department. Unless otherwise specified in the applicable collective bargaining

agreement, a department director may approve a leave of absence with or without pay for a limited period not to exceed 90 days.

- If an employee goes into a leave without pay status during an approved FML, this unpaid time counts toward the 90-day period that may be approved by the department. The Board of County Commissioners must approve leaves of absence in excess of 90 days. (See EPP #11 – Leaves of Absence for more information.)
- If all or part of the FML was leave without pay, the employee may request leave with pay if they have accrued leave time. Once a post-FML leave without pay has been granted, an employee may not request leave with pay. Under no circumstances will an employee be allowed to go back and forth between paid and unpaid leave for the purpose of extending eligibility for County-paid benefits or earning service accruals.

REINSTATEMENT

- Upon conclusion of a family medical leave, you shall be restored to your former position (or to an equivalent position if your original position no longer exists) without loss of seniority or previously accrued benefits or rights, except for paid leave you used during the leave of absence.
- If you have been on leave due to your own serious health condition, you must provide your supervisor with a doctor's release prior to your return to work.
- However, the County retains the right to deny restoration in the following situations:
  - The employee would have lost the job due to layoff if they had not been on leave.
  - The employee fraudulently obtains a family and medical leave.
  - The employee violates the County's policy governing outside employment during the leave.
  - The employee fails to provide a release to return to work upon return.
- You may cancel your family leave and notify your supervisor of your request to return to work if the condition of the family member or yourself improves and no longer requires constant care.
  - Under these circumstances, you will be reinstated within two (2) working days.
  - If there is less than a week of the anticipated leave remaining at the time you provide notification, you may be reinstated at the end of the leave as originally scheduled.

REQUEST PROCEDURES

- Upon request, Leave Administration will send FML packets to employees who may be eligible for FML leave. The request may be made by the employee or by the supervisor or a family member on behalf of the employee.
- You must submit a family medical leave/parental leave request form to your supervisor at least **30 calendar days** in advance of the start of the leave for situations where the leave is anticipated.
  - In situations where an emergency arises and the need for the leave is not anticipated, you must notify your supervisor as soon as practical and complete a FML request form.
  - Since actual dates of leave often cannot be determined in advance, you should estimate the dates as closely as possible at the time of the request.
  - If the date(s) are different from those originally submitted, your supervisor must use the Family Medical/Parental Leave Action Notice to amend the dates and return the form to Leave Administration.
  - Leave Administration will amend the start and end dates of FML upon receipt of this information. You will receive a copy of this form mailed to your home or mailing address.
- When a leave is requested for your own illness or that of a family member, the request form must be accompanied by the health care provider's certification documenting the need for the leave.
  - If a medical certification is unavailable due to emergency or unanticipated leave, the employee must provide such certification within **15 calendar days** after submitting the request form. Leave Administration may extend this deadline to accommodate special circumstances when the employee has been unable to obtain the certification within 15 days.

- In the event an employee fails to provide medical certification, Leave Administration will investigate and determine whether to count the leave toward FML and allow the use of paid leave time or to place the employee on unauthorized leave without pay.
- A copy of the Health Care Provider Certification Form may be obtained from your supervisor, the Employment Policies and Practices Handbook, or by contacting the Leave Administration at (503) 655-8550 or at LeaveAdmin@clackamas.us.

- Contact Leave Administration, ask your supervisor or refer to Employment Policy and Practice #10 for more information on Family and Medical Leave.

RETIREE AND COBRA COVERAGE

Oregon law (ORS 243.303) requires public employers to provide PERS/OPSRP retirees the opportunity to continue group health insurance in effect at the time of retirement up to age 65 (or Medicare eligibility, whichever comes first). Oregon law also requires that employers provide surviving spouses over age 55 the opportunity to continue group health coverage up to age 65 (or Medicare eligibility). If you choose to continue coverage as a retiree or surviving spouse, you must pay the full cost each month.

The Federal law, COBRA, provides employees and their enrolled family members with the right to continue health insurance upon loss of coverage under the County's group plan. Individuals eligible for COBRA continuation coverage are designated as "Qualified Beneficiaries" which includes you, your spouse, your children and your spouse's children. Domestic partners and their children do not have rights under COBRA, but may be enrolled in continuation coverage as dependents of an employee, former employee or retiree. If you choose to continue coverage under COBRA, you must pay the full cost each month and a 2% COBRA administration fee (discussed on page 4 under *Premium Cost)*.

Clackamas County currently allows Medicare retirees (generally over age 65) to continue health care coverage under the Kaiser and Providence Health Plans. However, the coverage under those plans may not be identical to the coverage for active employees and non-Medicare retirees (generally, those under the age of 65).

Retirees have the option of choosing retiree coverage or COBRA coverage at the time of retirement. *The County is required to offer you COBRA coverage, even if you qualify for Retiree coverage.* For non-Medicare retirees, there is no difference in the plan benefits – the coverage you receive as a retiree or COBRA participant is the same. The premiums for retiree coverage do not include the 2% COBRA administration fee, and COBRA coverage is generally for a shorter period, but there may be reasons why you might choose COBRA coverage rather than Retiree coverage.

If you become eligible for Medicare *after* you enroll in COBRA coverage, your COBRA coverage will end. If you choose COBRA coverage, you *cannot* convert to Retiree coverage at the end of your COBRA continuation period. However, if your separation from service is due to medical reasons and you become eligible for PERS/OPSRP disability retirement within six (6) months of separation, you may convert your COBRA coverage to Retiree coverage.

If you need assistance in deciding which option is best for you, please contact the Benefits & Wellness Division at (503) 655-8550 or at Benefits@clackamas.us.

AVAILABLE COVERAGE

Health care coverage defined under COBRA includes medical and dental coverage, Employee Assistance Program (EAP), and the Health Care Flexible Spending Account (FSA). Retiree coverage has the same options as COBRA coverage, with the exception that dental coverage is only available up to age 65.

You may continue medical (which includes vision), dental, EAP or Health Care FSA coverage through Retiree or COBRA options. ***If you do not select medical, dental, EAP or FSA coverage at your initial Retiree or COBRA enrollment, you cannot add them later.*** In addition, if the coverage provided under the County's group health plans changes due to collective bargaining, revisions made by the County or our providers, or due to Federal or State law, your coverage will also change accordingly.

END OF ELIGIBILITY FOR COUNTY-PAID BENEFITS

If you are an **employee**, your County-paid benefits will end on the last day of the month in which you were an active employee. However, disability coverage ends on the actual last day of your employment with the County.

If you are an enrolled **family member of an employee**, your County-paid benefits will end on the last day of the month in which you lose eligibility (i.e., final date of divorce, date domestic partnership terminates, child turning age 26, etc.).

MEDICAL AND DENTAL COVERAGE

You may only continue the coverage you were enrolled in at the time you became eligible for COBRA coverage with two exceptions:

- If you will be living outside the service area of your current medical coverage, you may be able to select another plan that is available through the County (depending on carrier requirements).
- You may enroll in a lower-cost, high deductible medical plan through Providence or Kaiser.

Retirees may select any plan available to their retiree group at the time they become eligible for retiree coverage.

Once you are enrolled in Retiree/COBRA coverage, you may change your medical and dental coverage, or add or delete dependents, only at Open Enrollment or when you have a qualifying Qualified Life Event (see page 6 for details).

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Employee Assistance Program provided by Cascade Centers Incorporated provides services that provide support, guidance, and resources that can help you resolve personal issues and meet life's challenges. If you are currently receiving EAP services and/or wish to continue this benefit, you must enroll for Retiree/COBRA continuation. If you do not continue coverage through the retiree program or COBRA, you will be responsible for payment for any service you receive after your County-paid benefits end.

Contact the Cascade Centers EAP Services at (800) 433-2320 or www.cascadecenters.com for questions or to access services.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

If you were participating in the Health Care FSA, you may continue coverage by paying the amount you selected at the start of the Flexible Benefit Program plan year. You may then submit expenses for reimbursement that occur during your COBRA period. If you do not continue your Health Care FSA through COBRA, you will only be reimbursed for expenses incurred prior to the end of the pay period at the time of your termination. However, you may submit claims up to 90 days following the end of that calendar year.

Contributions made to a Health Care FSA through COBRA coverage are made on an **after-tax** basis. If you have been setting aside funds in your Health Care FSA account for expenses which you will not incur until after you leave employment, it might make sense to continue the FSA. If you are setting aside funds in your account for ongoing expenses, there is no longer a tax advantage for using the Health Care FSA.

18-MONTH COBRA COVERAGE

At retirement or termination of employment, an employee may purchase up to 18 months of COBRA coverage for themselves and/or enrolled family members (spouse and/or children). Domestic partners and their children do not have rights under COBRA, but may be enrolled in continuation coverage as dependents of an employee, former employee or retiree.

24-MONTH COBRA COVERAGE

An employee who was absent from employment for uniformed service had the right under USERRA to elect to continue health plan coverage (including coverage for any dependents) for up to 18 months. The new law extends the maximum period for USERRA continuation coverage 24 months.

29-MONTH COBRA COVERAGE (SOCIAL SECURITY DISABILITY)

The 18-month COBRA coverage may be extended for an additional 11 months (total 29 months) if:

- During the original 18-month period, the Social Security Administration or PERS determines that a Qualified Beneficiary is disabled; and,
- The Qualified Beneficiary provides a copy of the PERS or Social Security Administration determination and a written request for benefit extension within 60 days of the date of determination and before the end of the original 18-month period.

If the Social Security Administration or PERS later determines that the individual is no longer disabled, the Qualified Beneficiary must notify the Benefits and Wellness Division within thirty (30) days after receiving this determination. Loss of disability status will result in termination of COBRA coverage for the extended period for all covered individuals.

36-MONTH COBRA COVERAGE

During the original 18-month continuation period, qualified family members (spouse and/or children) may become eligible for a total of 36 months of coverage in the event of:

- divorce of the employee/retiree and spouse;
- loss of dependent eligibility as defined by the group health plan;
- death of employee/retiree; or
- employee/retiree becomes entitled to Medicare.

The maximum period of COBRA coverage for multiple qualifying events is 36 months from the date of the INITIAL qualifying event. (For example, if you are an employee and resign or retire, you and your family members will be eligible for 18 months of COBRA coverage. If you and your spouse divorce during the 18-month period, your ex-spouse may continue coverage for up to the 36-month maximum.)

SURVIVOR COVERAGE

If a retiree with retiree coverage dies,

- their enrolled spouse may continue coverage under the County's plan indefinitely if they are on Medicare at the time the retiree passes away. An enrolled spouse over age 55 may continue coverage under the County's plan until age 65 or Medicare eligibility.
- their enrolled dependent children may continue coverage under the County's plan for 36 months following the death of the retiree.
- their enrolled domestic partners and the domestic partner's children may continue coverage under the County's plan for one month following the death of the retiree.

LOSS OF RETIREE/COBRA RIGHTS

Your Retiree or COBRA coverage may terminate if:

- the required premium is not paid on time; or
- you become covered, after the date of your COBRA election, under another group health plan or government plan that does not contain any exclusion or limitation for any of your pre-existing conditions (see below); or
- you become eligible for Medicare coverage, after the date of your COBRA election.

In addition, your COBRA rights will end for any group plan that Clackamas County terminates for all employees.

ELECTION PERIOD

When an employee announces their intention to retire, the employee's department will complete a Personnel Action Form, which will notify the Benefits, and Wellness Division who will then send an enrollment packet to the employee. If you do not receive your enrollment packet, please contact the Benefits and Wellness Division immediately (contact information on cover of packet and on "Provider Contact Information" page at end). If you wish to enroll with Retiree or COBRA coverage, you (or a third party acting on your behalf) must enroll ***in writing*** for Retiree or COBRA coverage within sixty (60) days from the later of:

- the date of the County's letter notifying you of your right to continue coverage, or
- the date the County-provided health coverage ends.

If the due date falls on a weekend or holiday, then the due date will be extended to the next regular working day.

When continuing coverage with the County under one of the Medicare advantage plans, you must complete and return the Medicare plan application before the first day of the month in which your Medicare advantage plan becomes effective. Medicare applications must also be signed within 30 days of its effective date. Medicare applications signed too early will be rejected, and Medicare applications will be made effective the 1st of the following month after which it is received.

Verbal notice by you is not binding. The Benefits and Wellness Division must receive written confirmation from you by completing the relevant election form. Please see the contact information on the cover page or the Provider Contact Information sheet at the end of the booklet.

PREMIUM COST

The cost of COBRA coverage is based on single, two-party, single with children, or family rates in effect at the time. The County adds a 2% fee to COBRA premiums for plan administration as allowed by COBRA regulations. Premiums are subject to change at any time with advance written notification but generally will not change during a plan year.

Clackamas County's benefit plans renew annually during Open Enrollment (see page 4) which may involve changes in your coverage and/or premium rates. The Benefits and Wellness Division will notify you in writing of any such changes prior to implementation.

PREMIUM PAYMENT

New Enrollees:

- The first premium payment must be paid within 45 days from the date the election form is signed. The first payment must include the amount due from when premium begins through the month in which the completed election form is received by HR.
- If full payment is not received within 45 days, coverage will be canceled retroactively to the retiree/COBRA insurance eligibility date.

  Note: All future eligibility for coverage is lost unless the participant returns to active employment at Clackamas County in a benefits-eligible position.
- Participants are given the option of auto-pay enrollment. If they submit their auto-pay enrollment form after the 15th of the month prior to their first month's premium, the first month's payment must be made through money order, cash, or check.
- Although you have the right to wait the 45 days to remit payment, any delay may cause a break in service with the insurance carriers. When payment is received and forwarded to the insurance carrier, any unpaid claims for that time can be re-submitted for payment.

Retirees/COBRA Participants:

- Premiums are due the 1st of the month in which the premium covers.
- Grace notices are sent fifteen dates after the due date if payment has not been received for the current month.
- Once a premium is 30 days overdue, a letter is sent notifying the participant that payment must be received within fifteen days. Otherwise, the policy will be canceled.
- Once a premium is 45 days overdue, coverage will be canceled retroactively to the original due date. Participants are responsible for any claims incurred after the original due date.
- Once coverage is cancelled for non-payment, participants lose eligibility for future coverage through Clackamas County, unless they return to active employment in a benefits-eligible position.

AUTOMATIC PAYMENT PROGRAM

You have the option of paying your Retiree/COBRA premiums through an automatic withdrawal from either a checking or savings account. Your total premium amount will be deducted from the bank account each month, usually around the 10th of the month for that month's coverage. This program provides freedom from having to write monthly checks (especially convenient for frequent travelers) and ensures that your premiums are paid on time and you don't suffer from loss of coverage.

To enroll, complete the Authorization Form included in your enrollment packet, attach a voided check (for checking accounts) or deposit slip (for savings accounts) and return both the form and the voided check or deposit slip to the Benefits and Wellness Division. You will receive written confirmation of the effective date of the automatic payment. It takes about one month to set up the automatic payment, so any premium due in the interim will have to be paid directly to the Benefits and Wellness Division. If you change banks or account numbers, you must complete a new Authorization form with a new voided check or deposit slip.

Premium increases or decreases will be processed automatically though the Automatic Payment Program. (You will be notified in advance of any premium changes.)

You may cancel your participation in the Automatic Payment Program at any time by notifying the Benefits and Wellness Division **in writing** no later than the 15th of the month prior to the month of cancellation. This must be done in time to give the County and your bank reasonable time to act upon your request. No refunds will be allowed for late requests or any other reason except for error on the part of the County. If a refund is necessary, the County will reimburse you by check.

OPEN ENROLLMENT

During the Retiree/COBRA continuation period, you will be able to change your medical (which includes vision) and/or dental plan during the County's annual Open Enrollment. However, you will not be allowed to add any coverage that you did not choose at the beginning of your Retiree/COBRA continuation period.

During Open Enrollment, you may add dependents that meet the eligibility criteria. If adding dependents changes your coverage to two-party, single with children or family, your premiums will increase. Dependents include:

- Your spouse or domestic partner.
  - A copy of your marriage certificate is required to include your spouse as an eligible dependent on your plans.
  - To add a domestic partner to your coverage, you must provide a copy of your registry with the State of Oregon or a notarized Affidavit of Domestic Partnership.
- Your children up to age 26. A copy of the child's birth certificate or adoption/guardianship court order is required to include the child as an eligible dependent on your plans.

Children include:

- Your natural or adopted children.
- Your spouse's or your domestic partner's natural or adopted children.
- Children residing in your home pending adoption and/or children under court-appointed guardianship.
- If your child is disabled, coverage may continue after age 26 provided you submit an annual certification of disability from your child's physician. To qualify, your child must have either a physical or a mental disability, which occurred prior to age 21, be incapable of self-support and primarily supported by you, your spouse or domestic partner.

If you, your spouse or domestic partner give birth, legally adopt a child or become a child's legal guardian while you are on Retiree/COBRA continuation coverage, you may enroll your new child for coverage. Enrollment must be done within 60 days from the date of birth, placement for adoption or appointment as guardian. The newborn or legally adopted child of a qualified beneficiary will also have "Qualified Beneficiary" status (see page 1) and will have additional multiple qualifying event rights. Other dependents (such as a new spouse or domestic partner) may be added to your Retiree/COBRA coverage after the initial qualifying event, but will not become Qualified Beneficiaries under COBRA. They will not be eligible for continued COBRA coverage if you become ineligible or your COBRA period ends.

QUALIFIED LIFE EVENTS

Generally, you can make changes in your Retiree/COBRA coverage only during Open Enrollment. However, you may also make changes due to a Qualified Life Event such as:

- marriage, divorce or legal separation;
- qualification or termination of a domestic partnership relationship;
- birth, adoption or guardianship;
- loss of other coverage by a spouse or domestic partner;
- loss of eligibility, such as dependent child reaching maximum age; or
- death of a spouse, domestic partner or child.
- move outside the service area.

When a family member loses eligibility for coverage, it is the employee/retiree's responsibility to notify the Benefits and Wellness Division within 60 days of the qualifying event. If you fail to notify the Benefits and Wellness Division when a family member loses eligibility for coverage under the plans provided through the County, you may be held liable for any health claims or costs incurred by that person after the date of the qualifying event. **To make any changes, new enrollment forms must be submitted within 60 days of the date of the Qualified Life Event.**

END OF RETIREE/COBRA COVERAGE

You may be entitled to purchase individual medical coverage at the end of your Retiree/COBRA continuation period through the insurance carrier**.** Retirees also have health coverage options through PERS and several individual Medicare Advantage or Medicare Supplement policies. **Contact PERS or your insurance carrier for more details before your Retiree/COBRA coverage terminates (see Provider Contact Information at end of booklet).** *Once you choose not to elect coverage available to retirees through the County for you and/or your dependents, you cannot come back on to coverage at any time in the future.*

There is no conversion to an individual policy for the Health Care FSA or Employee Assistance Program.

BENEFITS NOT AVAILABLE UNDER COBRA

DISABILITY COVERAGE

While still working, you received disability coverage. Upon retirement, you are no longer eligible through the County. If you are an employee covered by the County's Disability Program, your long-term disability benefits end on the last day of employment. Dependents are not covered by disability insurance. There is no continuation or conversion privilege available for disability insurance. If you are currently receiving disability income benefits due to a disability that occurred while you were an active employee, the payments will continue until you are no longer disabled or until you reach the maximum benefit limit described in the disability certificate.

LIFE INSURANCE

There is no Retiree/COBRA continuation privilege available for life insurance. If you are covered by the County's Group Term Life Insurance Program as an employee or family member, you may apply for a conversion of the group life insurance benefit. Contact Metropolitan Life Insurance Company for details.

If you become totally and permanently disabled while covered by life insurance, the County will continue to pay the life insurance premiums on your behalf, if:

- you were an active employee at the time you were disabled; and
- you were under age 60; and
- you are certified by the disability insurance carrier as totally and permanently disabled.

Your life insurance will remain in effect and the County will continue to pay the premiums for as long as you remain totally and permanently disabled. However, you will be required to provide proof of continuing disability through an annual certification process.

GROUP UNIVERSAL LIFE

If you are an employee participating in the Metropolitan Group Universal Life Insurance Program, you may continue the coverage for yourself and your eligible family members. We will notify Metropolitan Life Insurance of your separation from County service and Metropolitan will notify you in writing of the options available to you. If you decide to continue the policy, you must pay the premiums directly to Metropolitan. If you do not hear from Metropolitan Life, we again recommend you contact them using the contact information provided at the end of this booklet.

LONG TERM CARE

If you are an employee purchasing Long Term Care Insurance (LTC) through UNUM, you may continue the coverage for yourself and your eligible dependents.

A form will be included in your Retiree/COBRA packet which you must complete and return to UNUM within 31 days of your group coverage termination.

If you decide to continue the policy, you must pay the premiums directly to UNUM. You may contact them at 1-800-227-4165.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

If you participate in the Dependent Care FSA, your coverage will end the last day of the pay period in which the County employs you. If funds still remain in your account, you may only submit expenses that were incurred through the end of the pay period in which your employment ended. You may submit claims up to 90 days after the end of the plan year.

DEFERRED COMPENSATION

- If you have been contributing to a Deferred Compensation account and would like to discuss your options, please contact your plan representative. See page 11-12 for provider information.
- If you would like to receive your funds you may choose from a number of different payout options.
- You may choose to leave your account with your Deferred Comp carrier, or roll it over to an IRA or 401(k) without being subject to tax liability. However, the regulations for most types of retirement accounts do require that you begin payout no later than your 72nd birthday.

PUBLIC EMPLOYES RETIREMENT SYSTEM (PERS) OR OREGON PUBLIC SERVICE RETIREMENT PLAN (OPSRP)

- If you are not vested in PERS/OPSRP (less than 5 years as a contributing member) you may wish to contact PERS/OPSRP regarding the options available to you for the funds in your employee-owned account (the 6% County-paid benefit).
- If you have been a contributing member for 5 years and are fully vested, you need to contact PERS/OPSRP to discuss the options available. The phone number for Customer Service is (503) 598-7377.

AFLAC – ACCIDENT AND CRITICAL ILLNESS COVERAGE

- Coverage is 100% portable even into retirement. You can continue coverage but you will lose the pre-tax savings unless you transfer coverage to a new employer with the same program.

MET LIFE – LEGAL INSURANCE

- You can continue coverage for 24 months after separation of service. However, you must make a lump sum premium payment for the entire period. You can convert coverage to an individual policy.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT WHILE ON AN APPROVED LEAVE

- If you are off work on an approved Leave Without Pay or Worker's Compensation Leave and participate in the Health Care FSA, you may choose to continue or discontinue your participation.
- If you choose to continue participating in the Health Care FSA, you and your family will be covered by the contributions to the account. Individual family members cannot elect to participate separately.
  - The monthly premium will be your current contribution plus a 2% administration fee (i.e., if contributing $50.00 prior to leave, the contribution during your leave would be $51.00 per month and would be on an ***after-tax*** basis).
  - Eligible expenses incurred prior to the leave of absence as well as during the leave of absence will be covered for both you and your eligible family members.
  - When you return to work, your contributions will be deducted on a pre-tax basis the pay period following your return. (For example: If you return to active status on January 10th, your pre-tax contributions will begin January 31st covering the period of January 16th through January 31st.)
- If you choose not to continue participating during your approved leave, your payroll deductions will end on the pay period immediately following the beginning of your leave without pay**.**
  - Expenses incurred during your Leave without Pay will ***not*** be eligible for reimbursement. Only expenses submitted that were incurred prior to your Leave without Pay effective date will be covered.
  - Upon your return to active status, you may re-enroll by contacting Benefits & Wellness at 503-655-8550 or at Benefits@clackamas.us within 15 days from the date of your return.
  - Re-enrollment does not allow for reimbursement of expenses incurred during your leave if you did not contribute during your leave, nor does it allow you to defer an amount that would exceed the total plan year maximum of $2,500. (Example: If you had contributed $200 prior to your leave, you could only contribute up to $2,300 upon your return, for a total plan year maximum contribution of $2,500).
  - If you re-enroll upon your return to active status, your contributions will be deducted on a pre-tax basis the pay period immediately following your return. (For example: If you return to active status on January 10th, your pre-tax contributions will begin January 31st covering the period of January 16th through January 31st.)
  - If you do not re-enroll upon your return to active status, your participation ends.

- Re-enrollment in the FSA does not allow you to make changes in your medical, dental, or life coverage. Those benefits will be reinstated automatically at the level you were enrolled in prior to your leave of absence.

PLAN ADMINISTRATOR

Clackamas County
Department of Human Resources
Benefits & Wellness Division
Public Services Bldg.
2051 Kaen Road, Suite 310
Oregon City, OR 97045
Benefits@clackamas.us
(503) 655-8550

PROVIDER CONTACT INFORMATION

AFLAC
PO Box 727
Corvallis, OR 97339
Bill Meditz-Agent
☎(503)409-7425
http://www.aflac.com/

CLACKAMAS COUNTY
HR: Benefits and Wellness Division
Public Services Building, 3rd floor
2051 Kaen Rd
Oregon City, OR 97045
Ph: (503) 655-8550
Fax: (503) 655-5468
www.clackamas.us/des

NAVIA BENEFIT SOLUTIONS
Flexible Spending Account
600 Naches Ave SW
Renton, WA 98057
☎(425) 452-3500
☎(800) 669-FLEX(3539)
customerservice@naviabenefits.com

VOYA FINANCIAL ADVISERS, LLC.
Deferred Compensation
5331 South Macadam Ave Ste 207
Portland, OR 97239
☎(503) 937-0351
http://www.ingretirementplans.com/

KAISER PERMANENTE
Medical and Dental
500 NE Multnomah Street, Suite 100
Portland, OR 97232-2099
☎Member Service: (503) 813-2000
☎Outside Portland 1-800-813-2000
http://www.kp.org/

UNUM PROVIDENT CORPORATION
(LTC)
222 SW Columbia, Suite 990
Portland, OR 97201
☎ (503) 221-8686 Fax: (503) 221-2072
Toll Free: (800) 228-9587
http://unumprovident.com/

Gallagher, Inc.
HRA VEBA
☎(888) 659-8828
www.hraveba.org

METLIFE
Life Insurance
https://www.metlife.com/
Ph: (800) 638-5000
Or, contact a representative for assistance at:
Mass Mutual Financial Group
5885 Meadows Rd. Suite #850
Lake Oswego, OR 97035
Kevin Kirkpatrick, Financial Planner
Ph: (503) 542-9432
kevinkirkpatrick@financialguide.com

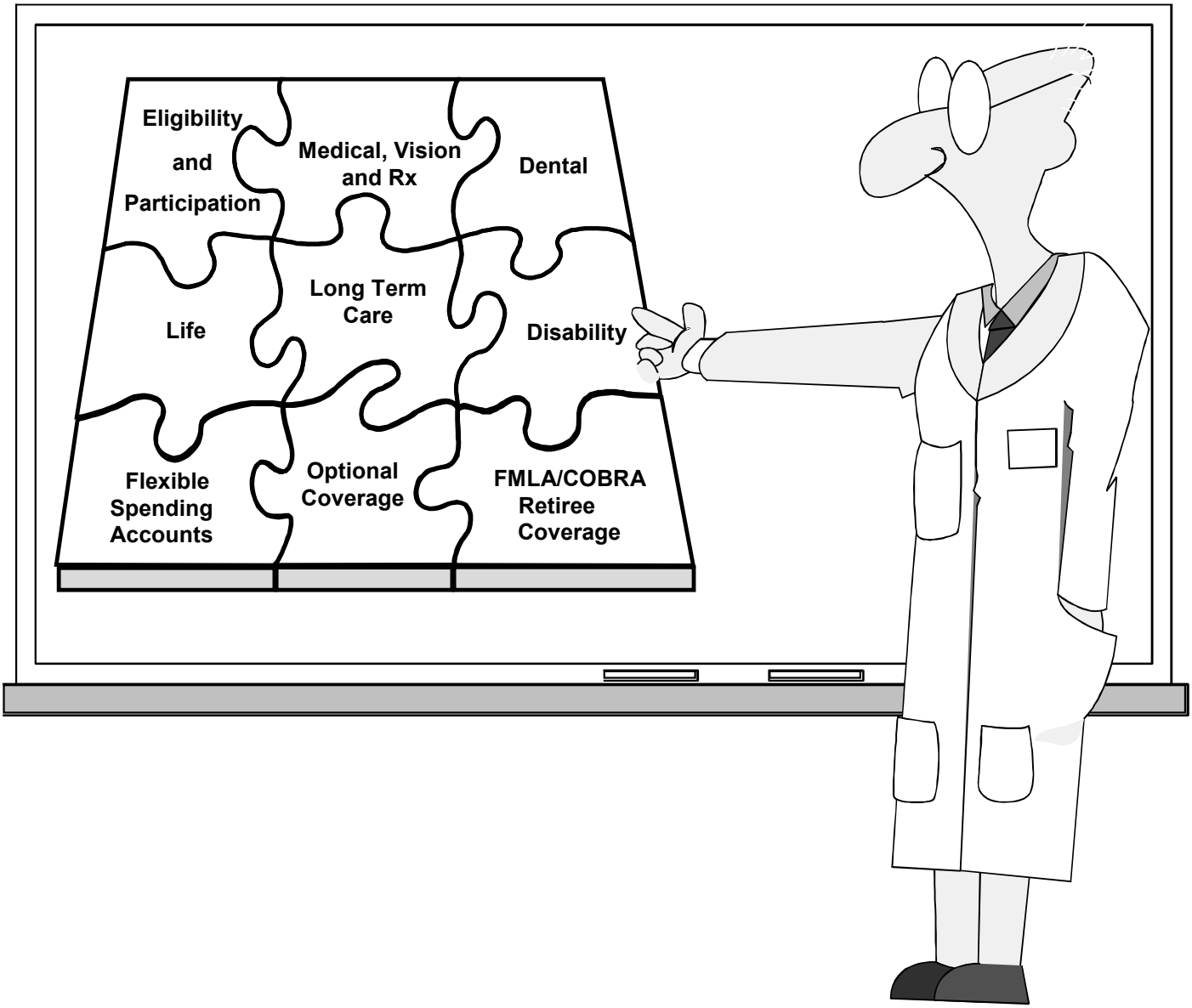
DELTA DENTAL PLAN
Dental
601 SW Second Avenue
Portland, OR 97204-3154
☎(800) 452-1058 (Dental Customer Service)
http://www.deltadental.com/

PROVIDENCE HEALTH PLAN
Medical
1235 NE 47th, Suite 220
Portland, OR 97213-2196
☎Customer Service: (503) 574-7500
☎Outside Portland 1-800-878-4445
http://www.providence.org/

OREGON PERS
PUBLIC SERVICES RETIREMENT PLAN
Mailing Address: P. O. Box 23700
Tigard, OR 97281-3700
☎(503) 598-PERS (7377)
http://www.pers.state.or/

EMPLOYEE ASSISTANCE PROGRAM (EAP)
Available 24/7
1-800-433-2320
www.cascadecenters.com

METLIFE – LEGAL PLANS
☎(800) 821-6400
www.legalplans.com
Passcode: 1500317


Eligibility and Participation
Medical, Vision and Rx
Dental
Life
Long Term Care
Disability
Flexible Spending Accounts
Optional Coverage
FMLA/COBRA Retiree Coverage

THE END