FIREFIGHTERS (IAFF)

ORIENTATION PACKET

NEW EMPLOYEE ORIENTATION – City of Astoria

NAME DEPT:	DOH:	
	Employee Initial	**HR Initial**
FORMS		
I-9 Employment Eligibility Verification *(Documents to I-9 Files)*		
W-4 *(Documents to Payroll File)*		
Direct Deposit Option *(Document to Payroll File)*		
Dues Form for General-Parks and Public Works *(Document to Payroll File)*		
PAF *(Documents to Personnel File)*		
Request for Draw		
APSA Employee Payroll Deduction Authorization *(Police Only)*		
BENEFITS / ENROLLMENT FORMS/BENEFICIARY INFORMATION ***File the following completed forms in Confidential or Benefits file***		
Medical Plan (BC/BS, Kaiser etc.)		
Vision Plan (BC/BS, Kaiser etc.)		
Dental Plan (BC/BS, MODA, Kaiser etc.)		
HSA/MSA/VEBA Enrollment and Beneficiary Forms		
Flexible Spending Forms (FSA) - Optional		
LTD/AD&D/ Life Forms		
Life/ Dependent Life/Supplemental Life Insurance - Option		
Dependent Life/ Supplemental Life Insurance - Option		
PERS Tier 1 & 2: PERS & IAP Beneficiary Form OPSRP: IAP Beneficiary		
Deferred Comp		
POLICIES / EMPLOYEE HANDBOOK		
*Employee Handbook Acknowledgment Receipt – *Personnel File*		
*Anti-harassment Acknowledgment Receipt – *Personnel File*		
*Public Employee Ethics and Reporting		
Credit card Policy and Agreement – optional – *Personnel File*		
Blood Borne Pathogens		
AFLAC – Optional		
Employee Assistance Program		
Safety		
Personnel Rules		

CITY OF ASTORIA
BENEFIT SUMMARY - 2017
IAFF - FIREFIGHTERS

Benefits are subject to change. This document is a guideline only.
Plan documents and collective bargaining agreements supersede this.

BENEFIT	ELIGIBILITY	EFFECTIVE	DESCRIPTION
Medical Plan - Regence BlueCross BlueShield of Oregon CIS – Copay Plan A $x4 with Alternative Care City pays 95%	Probationary & full time	1st month following 30 days continuous employment.	Employee Only 30.53 EMP + Child 57.01 EMP + Spouse 65.04 EMP + Children 75.95 EMP + Family 87.43
Vision Service Plan VSP-3 (24/24/24) City pays 95%	Probationary & full time	1st month following 30 days continuous employment.	Employee Only .42 EMP + Child .53 EMP + Spouse .60 EMP + Children .94 EMP + Family 1.08
Dental Plan -Delta Dental CIS – Dental II Plan City pays 95%	Probationary & full time	1st month following 30 days continuous employ.	Employee Only 2.60 EMP + Child 4.01 EMP + Spouse 4.56 EMP + Children 6.88 EMP + Family 7.91
Flexible Spending (Sect 125)	Probationary & Full time	1st month following 30 days continuous employ.	Employee may contribute to Pre-Tax Flexible Spending Account according to terms of Plan and IRS Section 125 rules
Alternate Coverage Benefit	Probationary & full time	1st month following 30 days continuous employment	After proof of adequate insurance coverage a $ 50/month payroll benefit is available, in lieu of City provided coverage.
Basic Life Insurance City pays 100%	Probationary & full time	1st month following 30 days continuous employment	Hartford Insurance $ 50,000 employee $ 10,000 spouse $ 10,000 qualified dependent
Flexible Spending (Sect 125)	Probationary & Full time	1st month following 30 days continuous employ.	Employee may contribute to Pre-Tax Flexible Spending Account according to terms of Plan and IRS Section 125 rules.
Accidental Death & Dismemberment (AD&D) City pays 100%	Probationary & full time	1st month following 30 days continuous employment	Hartford Insurance $ 50,000 employee
Long Term Disability City pays 100%	Probationary & full time	1st month following 30 days continuous employment	66 2/3% of salary, 90 day wait, $ 4,500 maximum benefit per month

BENEFIT	ELIGIBILITY	EFFECTIVE	DESCRIPTION
Short Term Disability Employee pays 100%	Probationary & full time	1st month following 30 days continuous employment	Hartford Insurance Various benefit levels available/rates dependent upon age and level of benefit
Retirement (PERS)	As defined by PERS	6 months from date of employment.	Defined benefit plan. Employer contributes rate set by PERS Employee pays 6%.
Stability Pay	Full time	Based on length of service – Calculated on Range Step A	5 – 10 years = 2.0% 10 – 15 years = 3.5% 15 – 20 years = 4.5% > 20 years = 6.0%
Sick Leave at Retirement	Full time	After 10 years of service	Hired prior to August 29, 2003 will have all unused sick leave, up to 2080 hours, reported to PERS. Not available to those hired later
Holidays	Probationary & full time	Immediately	10.5 holidays per year
Floating Holiday	Probationary & full time	Immediately	24 Hour to be used at one time in Fiscal Year
Vacation	Probationary & full time	Accrues immediately; can use after 90 days continuous employment	0- 5 years 12 hrs/mo 6-10 years 14 hrs/mo 11-15 years 18 hrs/mo 16-20 years 20 hrs/mo 21-24 years 22 hrs/mo > 25 years 24 hrs/mo Maximum accrual is 360 hours
Vacation Cash Out	Used 72 hours during year and remaining balance > 40 hours	Annual election made in writing between 8/1 and 8/20 – paid with Sept paycheck	May cash up to 48 hrs within specific criteria
Personal Leave	Probationary & full time	Immediately	10 hours per fiscal year, for specified personal, business reasons – unaccrued
Sick Leave	Probationary & full time	Begin accruing sick leave after 30 days employment. Entitled to use sick leave during the first year of employment.	Provided for non-occupational disability. Employees working a 56-hour a week shift will accrue sick leave at the rate of 16 hours per month. May be used for immediate family illness Accumulated unused sick leave limited to 2464 hours
Deferred Compensation	Regular employees	1st of month following six months of service	Employee option to reduce tax-able wages by contributing to a tax deferred retirement plan. Three 457 deferred plans are available.
Utility Credit	Regular employees who live in Astoria city limits	One year from date of hire	$10.00 per month towards utility bill; renter not paying utilities receives cash as wages

CITY OF ASTORIA

Regular Employee Orientation

Employee		Employee No.		Job Title	
Address		Effective Date		Date of Hire	Department
Phone		Date Stability Pay		Time Sheet	W-4 Exemptions
Social Security No.		Birth Date		Former Employee	Water Credit
M/S/R*	Ret. W/H	Range/Step	Month	Year	Hour
Job Code	Occupational Code	Budget Code	Bargain Unit	WC Code	Status

In case of emergency, please notify: _____

Relationship _____ Phone _____

---

*RACE

- ☐ Non-Hispanic Origin
- ☐ Hispanic
- ☐ Asian or Pacific Islander
- ☐ White
- ☐ Black
- ☐ American Indian or Alaskan Native
- ☐ Other

UNION DUES

- ☐ Union Dues $_____ Date to begin deduction: _____
- ☐ Initiation Fee $_____ Deducted over _____ pay periods.
- ☐ Date to begin deduction: _____

MEDICAL

- ☐ Insurance Insurance Effective date: _____
  - o Employee
  - o Employee Spouse
  - o Employee Child
  - o Employee Children
  - o Employee Family

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶ **START HERE:** **Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization

List A

Document Title
Issuing Authority
Document Number
Expiration Date *(if any)(mm/dd/yyyy)*

Document Title
Issuing Authority
Document Number
Expiration Date *(if any)(mm/dd/yyyy)*

Document Title
Issuing Authority
Document Number
Expiration Date *(if any)(mm/dd/yyyy)*

List B

Document Title
Issuing Authority
Document Number
Expiration Date *(if any)(mm/dd/yyyy)*

List C

Document Title
Issuing Authority
Document Number
Expiration Date *(if any)(mm/dd/yyyy)*

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** Native American tribal document
		6. Military dependent's ID card		**6.** U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		**8.** Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**For persons under age 18 who are unable to present a document listed above:** **10.** School record or report card **11.** Clinic, doctor, or hospital record **12.** Day-care or nursery school record		

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Form W-4 (2016)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A ____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B ____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C ____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D ____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E ____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F ____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child	G ____
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ▶	H ____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4** — Department of the Treasury, Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2016

1	Your first name and middle initial	Last name	2 **Your social security number**
	Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	
5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5	
6	Additional amount, if any, you want withheld from each paycheck	6 $	
7	I claim exemption from withholding for 2016, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7	

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) ▶ **Date** ▶

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1 Enter an estimate of your 2016 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1952) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over $311,300 and you are married filing jointly or are a qualifying widow(er); $285,350 if you are head of household; $259,400 if you are single and not head of household or a qualifying widow(er); or $155,650 if you are married filing separately. See Pub. 505 for details . . . 1 $

2 Enter: { $12,600 if married filing jointly or qualifying widow(er) / $9,300 if head of household / $6,300 if single or married filing separately } . . . . . 2 $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . 3 $

4 Enter an estimate of your 2016 adjustments to income and any additional standard deduction (see Pub. 505) 4 $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2016 Form W-4* worksheet in Pub. 505.) . . . . . 5 $

6 Enter an estimate of your 2016 nonwage income (such as dividends or interest) . . . . . 6 $

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . . . 7 $

8 **Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction 8

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 9

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" 2

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet 4

5 Enter the number from line 1 of this worksheet 5

6 **Subtract** line 5 from line 4 6

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . 7 $

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . 8 $

9 Divide line 8 by the number of pay periods remaining in 2016. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2016. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $9,000	0
6,001 - 14,000	1	9,001 - 17,000	1
14,001 - 25,000	2	17,001 - 26,000	2
25,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 75,000	5
44,001 - 55,000	6	75,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Direct Deposit Authorization

I hereby authorize City of Astoria, hereafter called COMPANY, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my (our) account indicated below and the depository name below, hereafter called DEPOSITORY, to credit and debit the same entries to such account.

Any new accounts set up for direct deposit will pre-note for up to two pay periods (typically ten working days). Paper checks will be sent during this pre-note period. Employee is responsible for notification of any change in bank information.

The authority is to remain in full force and effect until COMPANY has received written notification from me to terminate in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable time to act on it.

CLIENT NAME: _____

EMPLOYEE NAME: _____ SS NUMBER: _____

I elect to receive my pay stubs _____ electronically **OR** _____ in printed form

SIGNATURE: _____ DATE: _____

Payroll checks dated on or after (date):

NOTE: ATTACH VOIDED BLANK *CHECK* TO THE BACK OF THIS DOCUMENT TO VALIDATE ACCOUNT INFORMATION, OR YOUR DIRECT DEPOSIT CANNOT BE PROCESSED.

Account #1

DEPOSITORY (Bank) NAME: _____

CITY: _____ STATE: _____ ZIP: _____

ABA NUMBER: _____ ACCOUNT NUMBER: _____

IS THIS A (Select One): ☐ Checking Account **OR** ☐ Savings Account

DO YOU WANT TO DEPOSIT A: (Select One)
☐ Fixed Dollar Amount: $_____
OR
☐ Percentage of Net Pay: _____%

☐ Please inactivate direct deposit for the account listed above

Please attach a voided check for this account on reverse side.

Account #2

DEPOSITORY (Bank) NAME: _____

CITY: _____ STATE: _____ ZIP: _____

ABA NUMBER: _____ ACCOUNT NUMBER: _____

IS THIS A (Select One): ☐ Checking Account **OR** ☐ Savings Account

DO YOU WANT TO DEPOSIT A: (Select One)
☐ Fixed Dollar Amount: $_____
OR
☐ Percentage of Net Pay: _____%

☐ Please inactivate direct deposit for the account listed above

Please attach a voided check for this account on reverse side.

© 2011 Xenium. All rights reserved.

Direct Deposit Authorization

Account #1

Attach VOIDED Check Here

Account #2

Attach VOIDED Check Here

© 2011 Xenium. All rights reserved.

REQUEST FOR DRAW

Draw day is the 20th of the month, and can be up to one-half (1/2) of the monthly salary.

_____ I request a draw in the amount of $ _____.

_____ I want to cancel my current draw.

Effective Date: _____

_____ I wish to change my draw amount.

From: _____ To: _____

Effective Date: _____
(Draw Date)

_____	_____	_____
Print Name	Dept	Employee #

Signature: _____ Date: _____

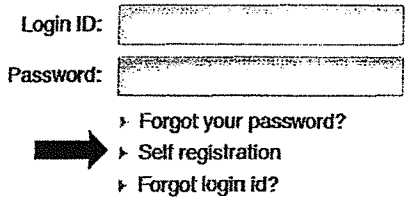
ONLINE ENROLLMENT INSTRUCTIONS

www.cisbenefits.org

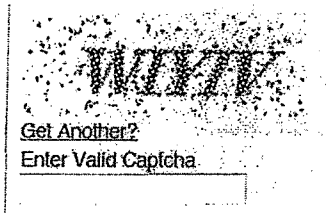
If enrolling dependents you will need to have your dependents DOBs and SSNs with you. If enrolling a spouse or domestic partner, it is recommended that you scan your marriage certificate and/or domestic partnership documentation before going online. If you don't have the documentation with you, you can upload at a later date. To get to the home page, click on the home icon.

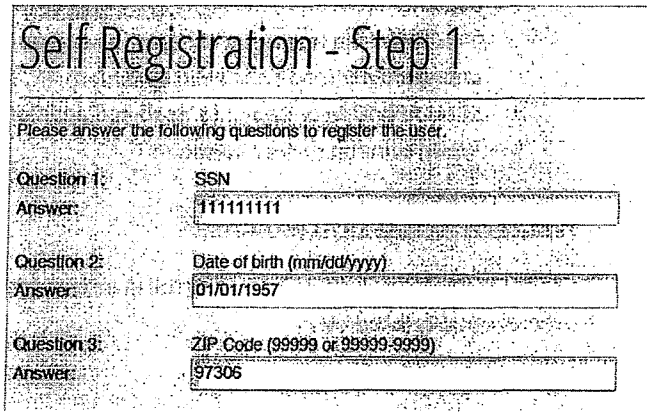
SECTION 1: LOGON AND PERSONAL INFORMATION

1. Go to www.cisbenefits.org
2. Click on **Self Registration**

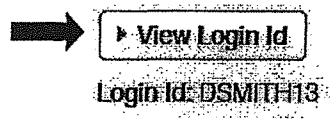


3. Enter SSN, DOB and mailing address zip code
4. Enter Captcha. Then click **Submit.**

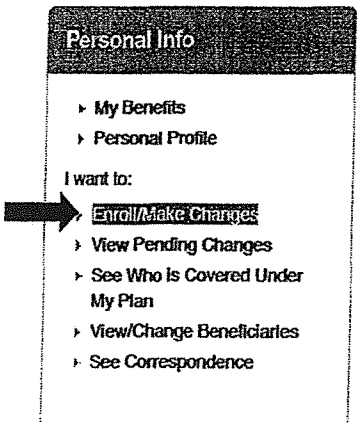




5. Click **View Login ID** and write Login here: _____
   (Note: Login Id will never change. Marriage/divorce will not create a new Login Id)
6. Create a password using password requirements. Click **Submit**
7. Select and answer three **Challenge Questions** then click **Save.**
8. Confirm Challenge Questions and click **Save.**
9. You have successfully saved your challenge questions, click **Close.**
10. Read Disclaimer and click the box next to **I accept.** Click **Save.**



11. Click **Enroll/Make Changes** located in the "Personal Info" box.



12. Click **Select Your Benefits** in the "Benefits to do list" box.
13. Confirm Address Information. If address needs to be updated or changed, click on the Mailing link. Update/Change address and click **OK**.
14. Enter Email Information by clicking on **Add New.** Indicate Email Type, enter email address and Email Preference and click **OK**. Highly recommend that an email address is entered so the system can notify the employee if follow-up steps are still pending (ie: marriage cert).
15. Enter Telephone Information by clicking on **Add New.** Enter type, number and preference and click **OK**.
16. If Address, Email and Telephone Information is correct, click **Continue**

SECTION 2: DEPENDENTS

Enter all dependents that are eligible for coverage even if you are not enrolling them at this time. Adding dependents now will simplify the beneficiary designation process.

1. Click **Add New Dependent**
2. Enter Dependent Information and click **OK**.
3. If adding spouse or domestic partner, documentation can be uploaded now or later. To upload documentation click the **Marriage Certificate** or **Domestic Partner Certificate** link. Click Browse to select file. When file is selected click **Upload**. *Enrollment will be pended and will not be reported to the carriers until documentation has been uploaded.*
4. Click on **Add New Dependents** to add additional dependents (court order required for legal guardianship)
5. When completed click **Continue**.

SECTION 3: ELECTING COVERAGE

These instructions include how to enroll in all coverages offered by CIS. Your employer may or may not offer all of the coverages listed below.

Medical/Dental Coverage

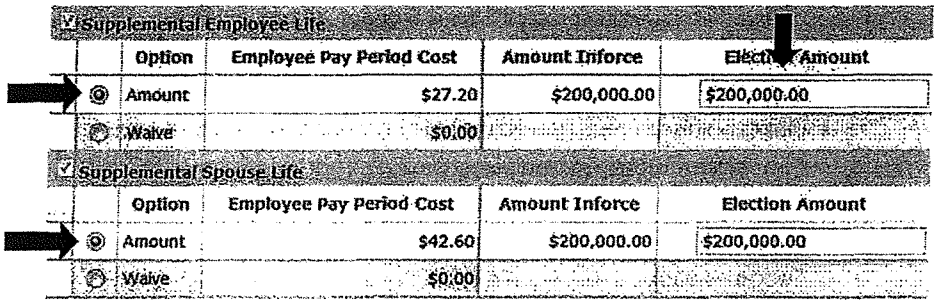
If your employer offers Medical, Dental and/or vision coverage, you will need to click on the radio button next to the plan name. (Note: Vision will automatically be selected if offered by your employer). To view/print a description of the plan(s) click on Summary Plan Description.

If you are enrolling a dependent(s), the box next to the dependent(s) name must be checked. Click **Continue** to proceed to each plan type offered by your employer.

Life/Disability Coverage

1. If offered, you are automatically enrolled in the employer paid basic life and AD&D coverage. This coverage will be displayed. Click **Continue**.
2. Assign a beneficiary to your Basic Life plan. If a beneficiary is not displayed, or you want to add additional beneficiaries, click on the Add New Beneficiary link. Enter the beneficiary information (only the relationship and first and last name is required) and click **Save Changes**.
3. If beneficiary is Primary, click Yes. If secondary, select No. Click **Continue.**

4. If electing supplemental employee/spouse life, **click the radio button next to Amount** and enter an amount in the Election Amount box. To elect Dependent Life click the radio button next to the $5,000 dollar amount. Click **Continue.**



Supplemental Employee Life

	Option	Employee Pay Period Cost	Amount Inforce	Election Amount
◉	Amount	$27.20	$200,000.00	$200,000.00
○	Waive	$0.00		

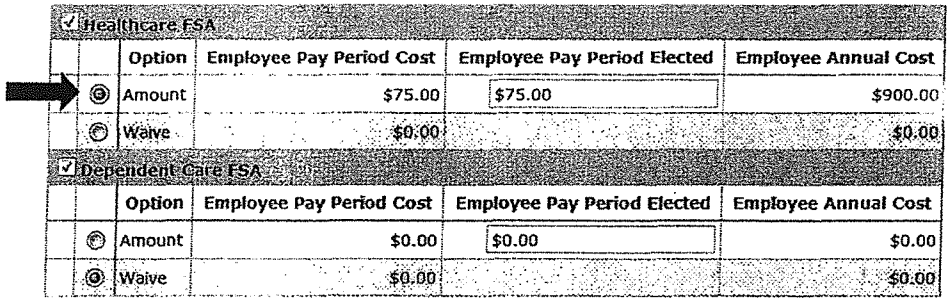
Supplemental Spouse Life

	Option	Employee Pay Period Cost	Amount Inforce	Election Amount
◉	Amount	$42.60	$200,000.00	$200,000.00
○	Waive	$0.00		

5. If supplemental employee life is elected, assign your beneficiaries and click **Continue.**
6. If offered, you are automatically enrolled in the employer paid Long Term Disability (LTD). This coverage will be displayed. Click **Continue.**

Flexible Spending Account (FSA) – Subject to change

Flexible Spending Account elections will be displayed if offered by your employer. To enroll in the healthcare or dependent care FSA, **click the radio button next to Amount** and enter the amount per pay period to contribute. Click **Continue.** *(The effective date will be the first of the month following the date your enrollment is completed. FSA enrollment will not be retroactive so the effective date may not match the effective date of your other coverage).*



Healthcare FSA

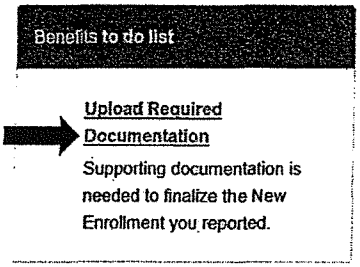
	Option	Employee Pay Period Cost	Employee Pay Period Elected	Employee Annual Cost
◉	Amount	$75.00	$75.00	$900.00
○	Waive	$0.00		$0.00

Dependent Care FSA

	Option	Employee Pay Period Cost	Employee Pay Period Elected	Employee Annual Cost
○	Amount	$0.00	$0.00	$0.00
◉	Waive	$0.00		$0.00

SECTION 4: COMPLETE YOUR ENROLLMENT

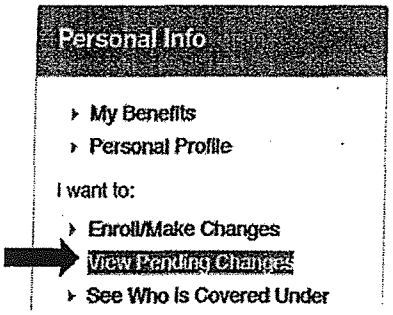
1. Review your elected benefits. If changes need to be made click Make Changes.
2. Read attestations at the bottom of the page and click each box. Click **Complete**.
3. Under "For Your Records", click **Save a Copy.** A box will display to open the confirmation statement in Adobe Acrobat. Click **OK**. Then click Print. *If you do not print the statement now you will not be able to view/print your statement until your coverage is effective.*
4. Review your confirmation statement. If a change needs to be made contact your HR/Benefits representative. Click **Return to Home.**
5. If documentation is required (marriage/DP certificate) the "Benefits to do list" box will display. See instructions in Section 3 to upload documentation after enrollment has been submitted. *Enrollment will not be reported to the carriers until required documentation is uploaded and approved. You have 31 days to submit supporting documentation.*



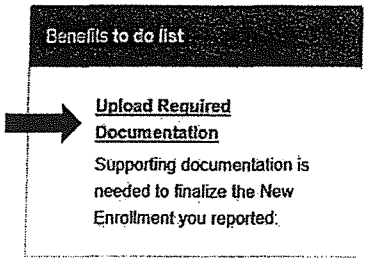
SECTION 5: UPLOAD DOCUMENTATION

Before logging on be sure documentation has been scanned and in a Word or pdf format.

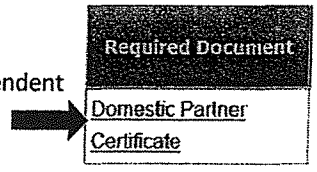
1. Click on **View Pending Changes** in "Personal Info box".



2. Click on the Upload Required Documentation link in the "Benefits to do list" box.

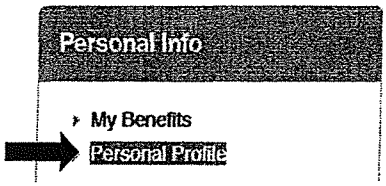


3. Click **Continue** on Personal Information Page.
4. Click on the link in the Required Documentation column on the Dependent Information page.
5. Click **Browse** and select document. Click **Open.** Then click **Upload.**
6. You will be required to view all benefits elections again. Click **Continue** through all pages until the end.
7. Click attestation boxes on last page and click **Complete.**



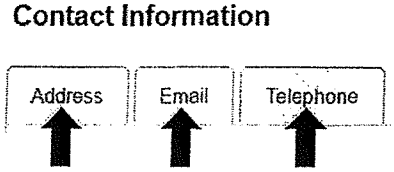
SECTION 6: CHANGE ADDRESS, EMAIL & PHONE NUMBER

1. Click on **Personal Profile** under "Personal Info" box.



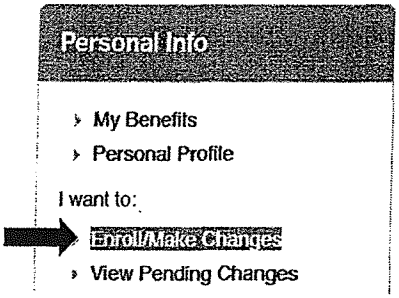
2. Under Contact Information click on appropriate tab.

3. Click **Update.** Enter information and click **Save.**



SECTION 7: MAKE AN ENROLLMENT CHANGE

1. Click on **Enroll/Make Changes** in the "Personal Info" Box.



2. Select the type of change. The system will walk you through each enrollment page. Click **Continue** until you come to the **Review and Change Your Benefits** page.

To add a dependent(s) to your coverage, you need to check the box next to the name of the dependent(s). To remove a dependent(s) from your coverage, uncheck the box next to the name of the dependent(s). In the event of a death or divorce the system will automatically make the enrollment change.

Birth, Adoption or Legal Guardianship
Death of a Child
Death of a Spouse/Domestic Partner
Divorce/Legal Separation
Domestic Partnership
Gain of Other Coverage
Loss of Other Coverage
Marriage
Terminate Domestic Partnership

You must click the attestation boxes and click Complete to submit a change.

NOTE: *All changes to enrollment, except birth or death, require supporting documentation. Have documentation scanned prior to going online. If you did not scan the supporting documentation, see Section 5 for instructions on how to upload documentation. You have 31 days from the date of the event to upload required documentation.*

Notice Procedures
Upon notification of a termination by your employer, CIS will send a COBRA notice to the employee using the address on file. If you are moving to a new location, you will need to notify your employer or contact CIS. Employees are required to return the COBRA election form within 60 days of loss of coverage. Continuation coverage will be reinstated to the date active coverage was terminated, as there can be no break in coverage.

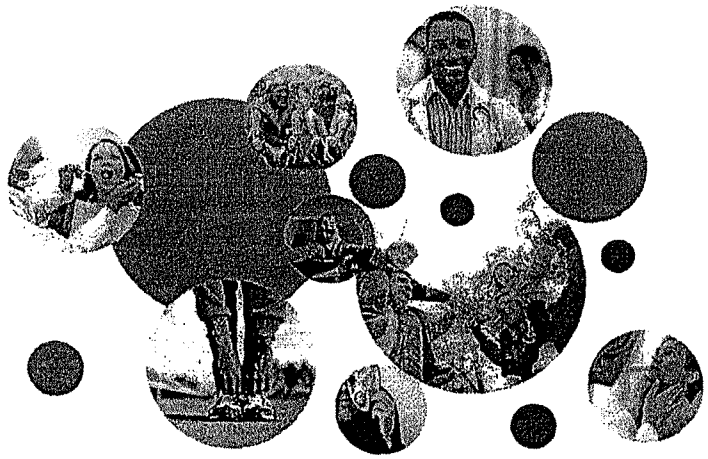
If terminating due to retirement, CIS will send both retiree information and COBRA information, as required by law. Most individuals will take retiree coverage because it can be continued up until Medicare eligibility, whereas COBRA can only be continued for a limited period of time. If retiree or COBRA continuation coverage is terminated, the retiree or COBRA participant cannot re-enroll at a future date.

Life/Disability Coverage
Life and disability insurance is not subject to COBRA. If you were covered under your employer's life and/or disability plan, or you elected supplemental life insurance, you may have the option to continue this coverage on a self-pay basis with the life insurance carrier. If you are interested in continuing this coverage, contact CIS Benefits at 855-763-3829.

cis benefits
cisbenefits.org

2016 CIS Benefits
Enrollment & Eligibility Guide:

- Benefit Eligibility
- Who Can I Cover?
- When Can I Make a Change to My Coverage?
- Loss of Coverage & Continuation Rights



This document defines who is considered an eligible dependent and allowed to be enrolled on your coverage. This document also explains the different types of IRS-qualified family status changes that may allow you to make a change to your coverage during the year.

When Am I Eligible for Insurance?
You must enroll for benefits online within 31 days from your benefits effective date. As long as you enroll within that time period, benefits will be effective the first of the month following the waiting period established by your employer (e.g., First After Date of Hire, First After 1 Month, etc.).

What Are My Options for Enrollment?
Your options are based on the choices made by your employer. If medical and dental insurance are offered, you may opt out of coverage if you have other group coverage (e.g., coverage through a spouse's plan). You must elect the opt out option online and you will be required to provide proof of the other coverage to your employer.

There is also an option to waive coverage. Waive means you don't want the medical or dental coverage offered by your employer, even if you don't have other coverage. You are required to waive both medical and dental coverage, if both are offered.

If you opt out or waive medical or dental coverage, you are still required to be covered by employer-paid life and/or disability coverage if it is offered through CIS.

Who Can I Cover on My Insurance?
The following individuals are considered eligible dependents and can be enrolled on your coverage.

1. A legally-married spouse.
2. A domestic partner who meets eligibility on CIS' Affidavit of Domestic Partnership* or who filed a Certificate of Registered Domestic Partnership (same-sex partners are eligible for coverage by law). *Employees who cover a domestic partner will be charged an imputed value amount.*
3. Child(ren) under the age of 26 who are:
    - The natural child of the employee, spouse or domestic partner;
    - The adopted child of, or child placed for adoption with, the employee, spouse or domestic partner, provided that the child is adopted or placed for adoption prior to attaining age 18;
    - A child for whom the employee, spouse or domestic partner has obtained court-ordered legal guardianship;
    - A child for whom the employee is obligated to provide benefits pursuant to a qualified medical child support order (QMCSO).
4. An unmarried child over the age of 26 who has been continuously covered and is incapable of self-support due to a physical, mental or developmental disability that occurred before the child's 26th birthday and for whom a handicapped dependent certification form has been received and approved by the insurer or administrator.

Please note that CIS has the right to conduct a dependent audit at any time.

**Effective January 1, 2016, new domestic partners can only be covered with a Certificate of Registered Domestic Partnership. CIS's Affidavit of Domestic Partnership will no longer be accepted.*

Leave of Absence

Employees are entitled to many different types of leaves of absence, including family medical leave, military leave, domestic violence leave and non-medical leave with or without pay. Each type of leave is governed by state and/or federal regulations, and termination/reinstatement of coverage differs for each. Most forms of leave will allow employees to maintain their existing coverage for a limited period of time, but specific timelines must be followed. If coverage is terminated during a leave, employees may have the option to continue their coverage on a self-pay basis, such as medical and/or dental continuation through COBRA. Employees planning on a leave of absence, or are returning from a leave, need to discuss their options with their employer.

Loss of Coverage – Continuation Rights

Medical/Vision/Dental Coverage
The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most group health plans to provide continuation of group health coverage when employment terminates.

COBRA requires continuation coverage be offered to covered employees, their spouses, their former spouses, and their dependent children when group health coverage would otherwise be lost due to certain specific events. Those events include the death of a covered employee, termination of employment, reduction in the number of hours per week making the employee ineligible for benefits, divorce or legal separation from a covered employee, and a child's loss of dependent status (turning 26 years of age).

The premium for continuation coverage is more expensive than the amount active employees pay for group health coverage. This is because employers pay part of the active employee's premium. With COBRA continuation coverage, the full cost, along with a 2% administrative fee, is typically passed on to the individual(s) electing coverage.

While COBRA continuation coverage must be offered, it only lasts for a limited period of time (18, 29 or 36 months) based on the reason for termination. COBRA coverage can be terminated by the participant any time during the continuation period. The administrator, however, will terminate coverage due to non-payment of premium on a timely basis, or at the end of the continuation period. If an employee was offered medical and dental coverage as an active employee, he/she cannot continue dental only through COBRA continuation.

Alternatives to COBRA Continuation Coverage
Under the Affordable Care Act (ACA), individuals who lose employer health insurance coverage now have the option to purchase health insurance benefits through an insurance exchange or directly through an insurance carrier, without the risk of being denied for pre-existing conditions. A local insurance agent can assist you in finding and purchasing health insurance coverage that will fit your needs.

10. Employee Loses Other Coverage

Employees have 31 days to report and submit appropriate documentation of an involuntary loss of other employer group coverage for self. Health care coverage is effective the first of the month following the date of loss. "Coverage" includes only other employer group coverage or termination of federal or state assistance programs. The following changes can be made:

Medical/Dental/Vision	Supplemental Life	Flexible Spending Account[2]	Documentation
Enroll self	*No changes allowed*	*Increase healthcare due to loss of other coverage*	*Documentation showing date of loss of other coverage and name of covered individual(s)*

11. Dependent Loses Other Coverage

Employees have 31 days to report and submit appropriate documentation of an involuntary loss of other employer group coverage for their dependents; if appropriate documentation is submitted within the 31-day period, health care coverage is effective the first of the month following the date of loss. "Coverage" includes only other employer group coverage or termination of federal or state assistance programs. The following changes can be made:

Medical/Dental/Vision	Supplemental Life	Flexible Spending Account[2]	Documentation
Enroll dependent(s) who lost coverage	*No changes allowed*	*Increase healthcare due to loss of other coverage*	*Documentation showing date of loss of other coverage and name of covered individual(s)*

12. Death of a Dependent

Upon notification of a dependent's death, coverage will be terminated at the end of the month for the dependent. The following changes can be made:

Medical/Dental/Vision	Supplemental Life[1]	Flexible Spending Account[2]	Documentation
Drop dependent	*Decrease coverage for self; supplemental spouse life and/or dependent life is terminated*	*Enroll/increase/decrease healthcare election (cannot decrease if annual election has been reimbursed)*	*No documentation is required*

13. Increase/Decrease in Cost of Dependent Care

Employees have 31 days to request a change in their dependent care FSA elections due to increase/decrease in cost. The election change has to be consistent with the event. The following changes can be made:

Medical/Dental/Vision	Supplemental Life	Flexible Spending Account[2]	Documentation
No changes allowed	*No changes allowed*	*Increase/decrease dependent care due to cost change*	*Completed FSA Enrollment Change form*

[1] *Effective the first of the month following 30 days from the date of approval.*

[2] *Effective the first of the month following the date the FSA Enrollment Form is signed.*

Events Impacting Supplemental Life

There are currently limited situations where a spouse can have more supplemental life in effect than the employee. For employees in this situation who experience an event allowing an election change, options are limited. The employee can only enroll in an amount equal to the spouse's amount, or both the employee and spouse have to apply for the same increased amounts.

When Can I Make A Change to My Coverage?

Changes to your elections are not allowed during the year unless you experience one of the IRS-qualified family status changes listed below. All changes (except Healthcare or Dependent Care FSA changes) will be completed online at www.cisbenefits.org. A description of each event, allowed changes and supporting documentation requirements are listed in the table below. Changes requiring documentation will not be approved until the appropriate documentation has been received.

IRS-Qualified Family Status Changes include:

1. Birth/Adoption
2. Court-Appointed Legal Custody or Guardianship
3. Qualified Medical Child Support Order
4. New Spouse
5. New Domestic Partner
6. Divorce/Legal Separation
7. Dissolution/Termination of Domestic Partnership
8. Employee Gains Other Coverage
9. Dependent Gains Other Coverage
10. Employee Loses Other Coverage
11. Dependent Loses Other Coverage
12. Death of a Dependent
13. Increase/Decrease in Cost of Dependent Care

1. Birth/Adoption

Employees have 31 days from the date of birth or adoption to enroll a new child; health care coverage is effective the date of birth/adoption. The following changes can be made:

Medical/Dental/Vision	Supplemental Life[1]	Flexible Spending Account[2]	Documentation
Enroll child, self and eligible dependent(s) in coverage	*Enroll or increase coverage (subject to medical underwriting); enroll in supplemental spouse or dependent life*	*Enroll/increase healthcare election*	*Copy of adoption papers*

2. Court-Appointed Legal Guardianship

Employees have 31 days from the date of a court-ordered Legal Custody or Guardianship to enroll a new child; health care coverage is effective the first of the month following the date the court order was signed. The following changes can be made:

Medical/Dental/Vision	Supplemental Life	Flexible Spending Account[2]	Documentation
Enroll child	*No changes allowed*	*Enroll/increase healthcare election*	*Copy of court order*

[1] *Effective the first of the month following 30 days from the date of the approval.*

[2] *Effective the first of the month following the date the FSA Enrollment Form is signed.*

3. Qualified Medical Child Support Order (QMCSO)

Employers will be notified when an employee is required to provide coverage due to a court order; health care coverage will be effective the first of the month following the date the order was signed. The following changes can be made:

Medical/Dental/Vision	Supplemental Life	Flexible Spending Account	Documentation
Enroll child	*No changes allowed*	*No changes allowed*	*Copy of QMCSO*

4. New Spouse

Employees have 31 days from the date of marriage to enroll a new spouse; health care coverage will be effective the date of marriage. The following changes can be made:

Medical/Dental/Vision	Supplemental Life [1]	Flexible Spending Account [1]	Documentation
Enroll spouse, self and eligible dependent(s) in coverage	*Increase coverage for self (subject to medical underwriting); enroll spouse in supplemental spouse life and/or dependent life*	*Enroll/increase healthcare election*	*Copy of marriage certificate/license*

5. New Domestic Partner

Employees have 31 days from the date of registration or affidavit* to enroll a new domestic partner; health care coverage will be effective the first of the month following the date the requirements for a domestic partnership have been met. The following changes can be made:

Medical/Dental/Vision	Supplemental Life [1]	Flexible Spending Account	Documentation
Enroll domestic partner, self and eligible dependent(s) in coverage	*Increase coverage for self (subject to medical underwriting); enroll domestic partner in supplemental spouse life and/or dependent life*	*No changes allowed; medical expenses for domestic partners are not typically eligible for reimbursement*	*Oregon Certificate of Registered Domestic Partnership or a signed CIS Affidavit of Domestic Partnership**

6. Divorce/Legal Separation

Employees have 60 days from the date of a final divorce/legal separation to report the event; health care coverage terminates the end of the month following the date of divorce. Failure to report this event in a timely manner will result in loss of continuation rights. The following changes can be made:

Medical/Dental/Vision	Supplemental Life [1]	Flexible Spending Account [2]	Documentation
Drop spouse and step-child(ren)	*Decrease coverage for self;supplemental spouse life and/or dependent life is terminated*	*Enroll/increase healthcare election due to loss of coverage; decrease election (cannot decrease if annual election has been reimbursed)*	*Copy of divorce decree (first page and last page) or other documentation showing date of divorce and judge's signature*

[1]Effective the first of the month following 30 days from the date of the approval.

[2]Effective the first of the month following the date the FSA Enrollment Form is signed.

**Effective January 1, 2016, new domestic partners can only be covered with a Certificate of Registered Domestic Partnership. CIS' Affidavit of Domestic Partnership will no longer be accepted.*

7. Dissolution/Termination of Domestic Partnership

Employees have 60 days from the date of the event to report a final dissolution/termination of domestic partnership; health care coverage terminates the end of the month following the date of dissolution/termination. Failure to report this event in a timely manner will result in loss of continuation rights. The following changes can be made:

Medical/Dental/Vision	Supplemental Life [1]	Flexible Spending Account [2]	Documentation
Drop domestic partner and child(ren) of domestic partner	*Decrease coverage for self; supplemental spouse life and/or dependent life is terminated*	*Enroll/increase healthcare election due to loss of coverage; decrease election (cannot decrease if annual election has been reimbursed)*	*Copy of dissolution if Registered; CIS Termination of Domestic Partnership form*

8. Employee Gains Other Coverage

Employees have 31 days to report a gain and provide proof of other coverage for self; health care coverage terminates the end of the month prior to the effective date of new coverage. "Coverage" includes other employer group coverage through spouse/domestic partner, Medicare, or eligibility for federal or state assistance programs. Policies purchased individually or through an Insurance Exchange program do not qualify as group coverage. The following changes can be made:

Medical/Dental/Vision	Supplemental Life	Flexible Spending Account [2]	Documentation
Drop self	*No changes allowed*	*Decrease healthcare if other coverage is gained*	*Documentation showing effective date of other coverage and name of covered individual(s)*

9. Dependent Gains Other Coverage

Employees have 31 days to report a gain and provide proof of other coverage for dependent(s); health care coverage terminates the end of the month prior to the effective date of new coverage. "Coverage" includes other employer group coverage, Medicare, or eligibility for federal or state assistance programs. Policies purchased individually or through an Insurance Exchange program do not qualify as group coverage. The following changes can be made:

Medical/Dental/Vision	Supplemental Life	Flexible Spending Account [2]	Documentation
Drop dependent(s) who gained coverage	*No changes allowed*	*Decrease healthcare if other coverage is gained*	*Documentation showing effective date of other coverage and name of covered individual(s)*

[1]Effective the first of the month following 30 days from the date of the approval.

[2]Effective the first of the month following the date the FSA Enrollment Form is signed.

CIS - Copay Plan A Rx4 with Alternative Care
$20 Copay
$250 Deductible, 80/60/60% Coinsurance

cis benefits
www.cisbenefits.org

Effective Date: January 1, 2016
Visit www.regence.com for a detailed description of your plan benefits listed below

Benefit Summary	
Deductible per calendar year (Applies to 3 Claimants)	$250 Individual/$750 Family
Out-of-Pocket maximum **(Includes Deductible)	$2,250 Individual/$4,750 Family (Preferred & Participating Providers) $4,250 Individual/$8,750 Family (Non-Participating Providers)
After the Out-of-Pocket maximum is met, the plan pays	100% for the remainder of the calendar year except where noted

****Important Note**: The Family Out-of-Pocket Maximum for a Calendar Year is satisfied when two or more Family Members' Deductibles, Copayments and Coinsurance for Covered Services for that Calendar Year total and meet the Family's Out-of-Pocket Maximum amount. One Member may not contribute more than the individual Out-of-Pocket Maximum amount.

Covered Medical Service (Per Member)	*Member Responsibility Category 1*	*Member Responsibility Category 2*	*Member Responsibility Category 3*
Preventive Care For a list of services covered under this benefit, please visit our website (sign in and from there select "Preventive Care List")	0% (deductible waived)	0% (deductible waived)	40%
Office Visits	$20 copay (deductible waived)	40%	40%
Outpatient Laboratory and Radiology Services (Upfront Benefit) ▪ The first $400 per calendar year	0% (deductible waived)	N/A	N/A
After the Upfront Benefits are Exhausted ▪ Laboratory and radiology services	20%	40%	40%
Professional Services ▪ Surgery, inpatient visits, diagnostic procedures and therapeutic injections	20%	40%	40%
Alternative Care ▪ Covers acupuncture and spinal manipulations ▪ $1,000 per Claimant per Calendar Year	$20 (deductible waived)	$20 (deductible waived)	$20 (deductible waived)
Ambulance Services	20%	20%	20%
Durable Medical Equipment	20%	40%	40%
Emergency Room (Including Professional Charges) ▪ Copay applies to the facility charge, whether or not the deductible has been met ▪ Copay waived if admitted directly to a hospital or facility on an inpatient basis	20% after $100 copay (for each visit)	20% after $100 copay (for each visit)	20% after $100 copay (for each visit)
Hospital Care ▪ Inpatient, Outpatient and Ambulatory Service Facility	20%	40%	40%
Maternity Care	20%	40%	40%
Mental Health/Chemical Dependency Services - Inpatient, Residential	20%	20%	40%
Outpatient ▪ Copayment applies to therapy visit only	$20 Copay (deductible waived for outpatient services)	$20 Copay (deductible waived for outpatient services)	40%
Rehabilitation Services ▪ Inpatient: Unlimited per calendar year ▪ Outpatient: 77 visit limit per calendar year	20%	40%	40%

Covered Prescription Medication Services (Per Member)	Member Responsibility Generic	Member Responsibility Formulary Brands	Member Responsibility Non-Formulary Brands
Prescription Medications from a Pharmacy ▪ Retail: 34-day supply for each prescription ▪ Mail Order: 2x copay for 90-day supply ▪ $2,500 out-of-pocket maximum	$5	$25	$50
How to find Pharmacy Information in www.regence.com			
Preventive Medications – Sign in, from there select "Resources," then "Pharmacy Benefits," then "Learn more about OmedaRx," then "Formularies and Other Drug Lists," then "Preventive Medications Coverage."			
Optimum Value Medications – Sign in, from there, select "Resources," then "Pharmacy Benefits," then "Learn more about OmedaRx," then "Formularies and Other Drug Lists," then "Optimum Value Medications List."			
Participating Pharmacies – Sign in, from there, select "Resources," then "Pharmacy Benefits," then "Learn more about OmedaRx," then "Pharmacy Directories."			
Brand-Name Prescription Medication Instead of Generic			
If an equivalent generic medication is available and a brand-name medication is chosen, the member is responsible for paying the applicable brand-name co-payment plus the difference in price between the equivalent generic medication and the brand-name medication, not to exceed total retail cost. The exception is when the prescribing provider specifies that the brand-name medication must be dispensed, in which case the member will not be responsible for payment of the difference in cost.			

Case Management
Receive one-on-one help and support in the event you have a serious or sudden illness or injury. An experienced, compassionate case manager will serve as your personal advocate during a time when you need it most. Your case manager is a licensed health care professional who will help you understand your treatment options, show you how to get the most out of your available Plan benefits and work with your physician to support your treatment plan. To learn more or to make a referral to case management, please call 1 (866) 543-5765.
Disease Management
Regence Disease Management is a support and education program for people with chronic conditions such as diabetes, heart disease, asthma and/or depression. The Claims Administrator's nurses and behavioral health care coordinators provide tailored educational materials, tools and other services to help you get on track with your care and stay there. They can help you understand the care plan you've developed with your physician, and make smarter choices for better health. To learn more, please call 1 (866) 543-5765.
Special Beginnings Program
Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions. Special Beginnings can provide answers and assistance so that you can relax and enjoy those nine life-changing months. This program offers expectant mothers access to a nurse 24 hours a day, 7 days a week, an informative maternity book or DVD and educational materials tailored to their needs. To learn more call 1 (888) JOY-BABY (569-2229).
Quit for Life® Tobacco Cessation Program
CIS offers a tobacco cessation program for all eligible members. For details go to www.cisbenefits.org; from there select "Healthy Benefits & Wellness," then "Enroll in a Tobacco Cessation Program."
Weight Management and Obesity Treatment
CIS also offers a weight management program for all eligible members. For details go to www.cisbenefits.org; from there select "Healthy Benefits & Wellness," then "Enroll in a Weight Management Program."
MDLive (Telehealth)
With MDLive's telehealth service, you can see a doctor or therapist from home, work or on the go, 24/7/365. Board-certified doctors visit with you by phone or secure video to treat non-emergency medical conditions. They can diagnose symptoms, prescribe medication, and send prescriptions to your pharmacy. To learn more call 1 (888) 725-3097.
BlueCard® Program (Out of Area Services)
The BlueCard Program is a unique program that enables you to access hospitals and physicians when outside the four-state area Regence serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world. Find a provider near you at **www.bcbs.com** or call **1 (800) 810-BLUE (2583)**.

Please note: This benefit summary provides a brief description of your health care plan benefits and is not a guarantee of payment. Once enrolled, please review your plan booklet (online at www.regence.com) for a complete list of benefits, limitations and/or exclusions, and a definition of medical necessity.

Your health coverage is insured by CIS, but administered by Regence BlueCross BlueShield of Oregon. This means CIS, not Regence BlueCross BlueShield of Oregon, pays for your covered medical services and supplies.

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

CIS - Copay Plan A RX4 with Alternative Care

Coverage Period: 01/01/2016 - 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual & Eligible Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.regence.com or by calling 1 (888) 370-6159. **Please Note:** Your health coverage is insured by CIS, but administered by Regence BlueCross BlueShield of Oregon. This means that CIS, not Regence BlueCross BlueShield of Oregon, pays for your covered medical services and supplies.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** claimant / **$750** family per calendar year. Doesn't apply to the following in-network services: preventive care, diagnostic x-ray / laboratory / imaging or outpatient mental health and substance abuse. Copayments or amounts in excess of the allowed amount do not count toward the deductible.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. Preferred & Participating: **$2,250** claimant / **$4,750** family per calendar year. Non-Participating: **$4,250** claimant / **$8,750** family per calendar year.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Copayments for alternative care, premiums, prescription drugs out-of-pocket limit, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Does this plan use a network of providers?	Yes. See www.regence.com or call 1 (888) 370-6159 for lists of preferred or participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out–of–network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out–of–network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred** and participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non–Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay / visit	40% coinsurance	40% coinsurance	**Copayment** applies to each **preferred** office visit only, **deductible** waived. All other services are covered at the **coinsurance** specified, after **deductible**.
	Specialist visit	$20 copay / visit	40% coinsurance	40% coinsurance	
	Other practitioner office visit	$20 copay / visit for alternative care – acupuncture and spinal manipulations	$20 copay / visit for alternative care – acupuncture and spinal manipulations	$20 copay / visit for alternative care – acupuncture and spinal manipulations	Coverage is limited to $1,000 for all alternative care combined per claimant / year. **Deductible** waived. **Copayment** does not apply to the **out–of–pocket limit**.
	Preventive care/ screening/immunization	No charge	No charge	40% coinsurance	No charge for childhood immunizations from non–participating **providers**.
If you have a test	Diagnostic test (x–ray, blood work)	No charge for the first $400 / year, then 20% coinsurance	40% coinsurance	40% coinsurance	No charge for the first $400 per year for upfront outpatient diagnostic tests for **preferred providers**, **deductible** waived. Once the limit has been met and for all inpatient services, services are covered at the **coinsurance** specified, after **deductible**.
	Imaging (CT/PET scans, MRIs)	No charge for the first $400 / year, then 20% coinsurance	40% coinsurance	40% coinsurance	
If you need drugs to treat your illness or	Generic drugs	$5 copay / retail prescription $10 copay / mail order prescription			**Out-of-pocket limit** $2,500 / claimant / year Coverage is limited to a 34-day supply retail or

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non–Participating Provider	Limitations & Exceptions
condition More information about prescription drug coverage is available at www.regence.com.	Preferred brand drugs	$25 copay / retail prescription $50 copay / mail order prescription			90-day supply mail order. Coverage is limited to a 34-day supply for specialty drugs (includes specialty self-injectable medications) and 34-day supply retail or 90-day supply mail order for self-injectable medications. No charge for certain preventive drugs, women's contraceptives and immunizations at a participating pharmacy. No charge for generic and preferred brand drugs designated as preventive for treatment of chronic diseases that are on the Optimum Value Medication List. You are responsible for the difference in cost between a dispensed brand–name drug and the equivalent generic drug, in addition to the **copayment** and/or **coinsurance**, unless your **provider** specifies "dispense as written." The first fill for specialty drugs may be provided at a retail pharmacy. Additional fills and any fills for self-administrable cancer chemotherapy drugs must be provided at a specialty pharmacy.
	Non-preferred brand drugs	$50 copay / retail prescription $100 copay / mail order prescription			
	Specialty drugs	Refer to generic, preferred brand and non–preferred brand drugs above, for specialty medication or self-administrable cancer chemotherapy drug coverage.			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	40% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	20% coinsurance after $100 copay / visit	20% coinsurance after $100 copay / visit	20% coinsurance after $100 copay / visit	**Copayment** applies to the facility charge for each visit (waived if admitted), whether or not the **deductible** has been met.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	Covered the same as the **If you visit a health care provider's office or clinic** or **If you have a test** Common Medical Events.			——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non–Participating Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fee	20% coinsurance	40% coinsurance	40% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay / visit	$20 copay / visit	40% coinsurance	**Deductible** waived for outpatient services for **preferred** and participating **providers**.
	Mental/Behavioral health inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	
	Substance use disorder outpatient services	$20 copay / visit	$20 copay / visit	40% coinsurance	
	Substance use disorder inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	40% coinsurance	——————none——————
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	40% coinsurance	Coverage is limited to 180 visits / year.
	Rehabilitation services	20% coinsurance	40% coinsurance	40% coinsurance	Coverage is limited to 77 outpatient visits for all rehabilitation and habilitation services, including neurodevelopmental services / year.
	Habilitation services	20% coinsurance	40% coinsurance	40% coinsurance	Coverage for neurodevelopmental therapy is limited to services for claimants through age 17.
	Skilled nursing care	20% coinsurance	40% coinsurance	40% coinsurance	Coverage is limited to 120 inpatient days / year.
	Durable medical equipment	20% coinsurance	40% coinsurance	40% coinsurance	——————none——————
	Hospice service	No charge	No charge	No charge	Coverage is limited to 14 respite days / lifetime.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered	——————none——————
	Glasses	Not covered	Not covered	Not covered	——————none——————
	Dental check–up	Not covered	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery, except congenital anomalies
- Dental care (Adult or child)
- Infertility treatment
- Long–term care
- Private–duty nursing
- Routine eye care (Adult)
- Routine foot care
- Vision hardware
- Weight loss programs, except for nutritional counseling

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care, including spinal manipulations
- Hearing aids for claimants 18 or younger or for enrolled children 19 years of age or older and enrolled in a secondary school or an accredited educational institution
- Non–emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1 (888) 370-6159. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444–3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1 (877) 267–2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at 1 (888) 370-6159 or visit www.regence.com. You may also contact the Oregon Insurance Division by calling (503) 947-7984 or the toll free message line at 1 (888) 877-4894; by writing to the Oregon Insurance Division, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx; or by E-mail at: cp.ins@state.or.us or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444–3272 or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1 (888) 370-6159.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,730
- **Patient pays:** $1,810

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$250
Copays	$10
Coinsurance	$1,400
Limits or exclusions	$150
Total	$1,810

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,000
- **Patient pays:** $1,400

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$250
Copays	$1,080
Coinsurance	$30
Limits or exclusions	$40
Total	$1,400

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out–of–pocket expenses are based only on treating the condition in the example.
- The patient received all care from in–network **providers**. If the patient had received care from out–of–network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out–of–pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out–of–pocket expenses.

A NEW BENEFIT BROUGHT TO YOU BY CIS AND REGENCE

MDLIVE® Telehealth Resources: Get 24/7/365 Access to a Doctor or Therapist

National Institutes of Health found the average Emergency Room cost for an upper respiratory infection was $1,101; the average cost for a headache was $1,727.* Since CIS spent $2 million on unnecessary Emergency Room services last year, CIS and Regence want to offer this exciting technology alternative to you.

MDLIVE will allow you to visit a doctor or therapist from anywhere, at anytime — no driving or time away from home or work.

Board-certified doctors can diagnose your symptoms and prescribe medications for specific services. They can even send your prescriptions to the pharmacy of your choice. Best of all, the cost for a consultation is right around $38 and it is covered in full for all plan members except those on a High Deductible Health Plan with HSA.**

When are telehealth services a good choice for me?

Telehealth consultants do not replace your regular doctor, but they do offer a way to save time.

How do I receive care?

Primary care consults are offered by phone or video. Video consults take place on a secure network. Appointments may be made by phone or online.

Is my information private?

MDLIVE is compliant with federal laws about health care privacy. Information about your care is shared only with your doctor and pharmacy.

Common treatments
- Cold & Flu Symptoms
- Allergies
- Asthma
- Bronchitis
- Ear Infections
- Nausea
- Behavioral Health***

Reg-1. See other side.→

*"How Much Will I Get Charged for This? Patient Charges for Top Ten Diagnoses in the Emergency Department", Nolan Caldwell, et al, DOI: 10.1371/journal.pone.0055491, February 27, 2013

**By law, all expenses have to be applied to the deductible. Once the deductible is met, MDLIVE visits will be paid in full.

***Some restrictions may apply.

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

10153-OR/09-15
© 2015 Regence BlueCross BlueShield of Oregon

cis benefits
www.cisbenefits.org

Regence

A QUICK GUIDE TO GET THE MOST OUT OF YOUR CIS HEALTH PLAN

Administered by Regence BlueCross BlueShield of Oregon

What's New

New Member ID Cards

All members will receive new member ID cards in December. The cards should be used on or after Jan. 1, 2016. Please give your new card to your doctor and pharmacist when accessing services for the first time in 2016.

MDLIVE®: On-Demand Primary Care

With MDLIVE's telehealth service, you can see a doctor or therapist from home, work or on the go, 24/7/365. Board-certified doctors visit with you by phone or secure video to treat non-emergency medical conditions. They can diagnose symptoms, prescribe medication and send prescriptions to your pharmacy.

Infusion Therapy

Save money by using an alternative site of care for your infusions instead of the hospital. You may even be able to receive the infusion services in your home.

Chiropractic Care

The Affordable Care Act (ACA) required a change to how naturopathic and chiropractic services are covered under medical plans. Benefits will now be paid based on the type of service provided. For more information on this change, please call Regence Member Services at 1 (888) 370-6159.

Additional services offered to you at no cost:

Why not take advantage of the offerings? Call your dedicated CIS Member Services number, 1 (888) 370-6159:

- Chronic Care/Disease Management
- Case Management
- Special Beginnings®

Member Services

The first customer service connection we make is a human one. Call us at 1 (888) 370-6159 for assistance with your benefits questions.

regence.com

Looking for a claim or a doctor? Want to compare treatment costs? Visit **regence.com** for all that and more.

CIS
cis benefits
www.cisbenefits.org

Regence

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

09995-or/08-15
© 2015 Regence BlueCross BlueShield of Oregon

Your Vision Benefits Summary

VSP Vision care for life

CIS cis benefits cisbenefits.org

CIS Benefits and VSP® Vision Care provide you an affordable eye care plan.

Using your VSP benefit is easy.

- **Register at vsp.com.** Once your plan is effective, review your benefit information.
- **Find an eye care provider who's right for you.** The decision is yours to make—choose a VSP doctor, a participating retail chain, or any out-of-network provider. To find a VSP provider, visit vsp.com or call **800.877.7195.**
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com.**

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Eye Exams for Children

80% of what we learn is through our eyes. Many states require that children get a comprehensive eye exam before Kindergarten. Schedule an eye exam for your child at the beginning of every school year and start the year off right. Visit **vsp.com** to find a VSP provider that specializes in child eye care.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands, like Anne Klein, bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more[1]. Visit **vsp.com** to find a provider who carries these brands.

Plan Information

VSP Provider Network: VSP Signature
VSP Coverage Effective Date:
01/01/2016 - 12/31/2016

Visit **vsp.com** or call **800.877.7195** for more details on your vision coverage and exclusive savings and promotions for VSP members.

VSP provides vision claims payment services only and does not assume financial risk or obligation with respect to payment of claims.

1. Brands/Promotion subject to change.

©2015 Vision Service Plan. All rights reserved.
VSP, VSP Vision care for life, and WellVision Exam are registered trademarks of Vision Service Plan. Flexon is a registered trademark of Marchon Eyewear, Inc. All other brands are trademarks or registered trademarks of their respective owners.

Benefit	Description	Copay
Your Coverage with VSP Providers		
WellVision Exam®	• Focuses on your eyes and overall wellness • Every other calendar year - Adults • Every calendar year - Children	$0
Prescription Glasses		
Frame	• $120 allowance on a wide selection of frames • 20% savings on the amount over your allowance • Every other calendar year	$0
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Progressive lenses • Polycarbonate lenses covered for dependent children • Every other calendar year - Adults • Every calendar year - Children	$0 $50 $0
Lens Enhancements	• Average savings of 35% - 40% on lens enhancements	
Contacts (instead of glasses)	• $166 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation) • Every other calendar year - Adults • Every calendar year - Children	$0
Extra Savings	**Glasses and Sunglasses** • 30% off additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% off from any VSP provider within 12 months of your last WellVision Exam	
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible,) for sunglasses from any VSP doctor	

Your Coverage with Out-of-Network Providers

If you see a non-participating provider, visit **vsp.com** for details or to submit a claim online. All claims must be submitted within one year from the date of service. If not filing a claim online, send an itemized receipt with employee name, DOB, last 4 digits of SS#, patient name and DOB to: VSP, PO Box 997105, Sacramento, CA 95899-7105. Keep a copy for your records.

Exam ..... up to $71	Frame ..... up to $66
Lenses	Contacts ..... up to $166
Single Vision ..... up to $51	
Lined Bifocal ..... up to $77	
Lined Trifocal ..... up to $100	

VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

JOB#21825CM 7/15

Vision every 24 months - VSP-3

(over)

Big Value. More Savings with VSP® Vision Care.

With Exclusive Member Extras, savings never looked so good. We put our members first by providing exclusive special offers from leading industry brands, totaling more than $2,500 in savings.

- Limited time: Extra $40 to spend on bebe, Calvin Klein, Flexon and Nike frames through December 31, 2015[1,3]
- Extra $20 to spend on featured frame brands[1,3]
- Mail-in rebate savings and free trials on popular contact lens brands
- Up to 50% savings on UNITY® digital lenses[2,3]
- Up to 40% savings on sunsync® light-reactive lenses[2,3]
- Satisfaction guarantee on Transitions everyday lenses
- Up to $500 savings on LASIK at NVision and TLC eye centers
- Savings for VSP members and their extended family on digital hearing aids (up to $2,400 per pair) and replacement batteries through TruHearing®[4]
- Savings on EyePromise EZ Tears dry eye and contact lens comfort formula
- Financing for vision care expenses with the CareCredit credit card

BONUS

Visit vsp.com to find our Premier Program locations that offer wide selections of featured frame brands and Bonus Offers to maximize value.

For more great offers, scan or visit vsp.com/specialoffers.

BAUSCH+LOMB
See better. Live better.

CareCredit

CooperVision

EXTRA $20 TO SPEND

eyeconic

EyePromise

Flexon

NVISION EYE CENTERS

sunsync

TLC Laser Eye Centers

Transitions

TruHearing

UNITY

1. Brands/promotion subject to change 2. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. 3. Available only to VSP members with applicable plan benefits. 4. Savings compared to national average retail prices on state-of-the-art digital hearing aids; offer not available in WA

©2015 Vision Service Plan. All rights reserved.
VSP, UNITY, and sunsync are registered trademarks of Vision Service Plan. All other brands are trademarks or service marks of their respective owners.

JOB#21830XA 8/15

cis benefits
www.cisbenefits.org

Dental Plan II
CIS
Effective January 1, 2016

How To Use this Dental Plan

When you visit your dental provider, tell him or her that you are a member of a Delta Dental program.

Calendar year maximum, per member*	**$1,500**
Calendar year deductible, per member	**$0**

Service	Benefit Amount
CLASS I - PREVENTIVE [1] - Examination/X-rays - Prophylaxis - Fissure Sealants	** 1st year - 70% 2nd year - 80% 3rd year - 90% 4th year - 100%
CLASS II - BASIC - Restorative Dentistry (treatment of tooth decay with amalgam or composite) - Oral Surgery (surgical extractions & certain minor surgical procedures) - Endodontic (pulp therapy & root canal filling) - Periodontics (treatment of tissues supporting the teeth) - Space Maintainers - Repair or reline of dentures and bridges	** 1st year - 70% 2nd year - 80% 3rd year - 90% 4th year - 100%
CLASS III - MAJOR[2] - Crowns - Implants - Denture and Bridge Work (construction of fixed bridges, partials and complete dentures)	50%

* Annual dental maximum does not apply to members under age 16.

** Under this plan, benefits start at 70% your first calendar year of coverage. Thereafter, payments increase by 10% each calendar year (up to a maximum benefit of 100%) provided the individual has visited the dentist at least once during the previous calendar year. If in any calendar year the individual fails to receive covered dental services, the percentage for Class I and II services will decrease by 10% the next calendar year, but it will never be reduced below 70%.

[1] Any amount paid by the plan for Preventive services does not apply towards the calendar year maximum.

[2] There is a 12 month waiting period for Late Enrollees. A Late Enrollee is anyone not enrolled when initially eligible.

MEMBER SERVICES

Through our online service, **myModa**, you can download your member handbook, view claims status and payment information, search for participating providers, order ID cards, view personal information, and email dental customer service. You can access myModa at **www.modahealth.com,** or the CIS website at **www.cisbenefits.org.**

Dental Optimizer™ is a free resource on myModa that enables you to assess your risk level for oral health concerns and use that assessment to learn about reducing your risks and treatment costs. Dental Optimizer is comprised of a cavities risk assessment, dental health suggestions, and a Savings Optimizer based on a personal survey.

DELTA DENTAL

Delta Dental provides dental claims payment services only and does not assume financial risk or obligation with respect to payment of claims

This is a benefit summary only. Any errors or omissions are unintentional.
For a more detailed description of benefits, refer to your member handbook, which can be accessed through myModa, or by calling Customer Service for a copy.

Delta Dental Customer Service 888-217-2365 - Delta Dental's website www.modahealth.com

See back for additional information

ADVANTAGES

DELTA DENTAL

* **Freedom to choose your dentist:** Delta Dental is unique in that we have contracts with more than 2,300 licensed dentists in Oregon.
* **Professional Arrangements:** Delta Dental has specific fee arrangements with our participating dentists in Oregon to ensure that actual charges made by the dentist do not exceed his or her accepted fees on file with Delta Dental. We believe that the unique feature in all Delta Dental programs is that every participating dentist becomes a party to cost control as well as the quality of care. Participating dentists will update your records with your new information and will submit claims to Delta Dental for you.
* **Pre-determination:** As a service to our customers, your dental office can submit a pre-treatment plan to Delta Dental on your behalf, and we will return it to your dentist, indicating the dollar allowance that will be covered by your plan **before** you go forward with treatment.

LIMITATIONS

If an eligible person selects a more expensive plan of treatment than is functionally adequate, Delta Dental will pay the applicable percentage of the maximum plan allowance for the least costly treatment. The patient will then be responsible for the remainder of the dental providers' fees.

Class I - Preventive

* **Diagnostic:** Supplementary bitewing x-rays are covered once in any 12-month period. Complete series x-rays or a panoramic film are covered once in any 5-year period.

Class II - Basic

* **Restorative:** A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures. A separate charge for anesthesia may be covered when, in our judgment, it is necessary for complex oral surgery or due to the existence of a concurrent medical condition.

Class III - Major

* **Restorative:** If a tooth can be restored with a material such as amalgam, but another type of restoration is selected by the patient and dentist, the covered expense will be limited to the cost of amalgam. Crowns and other cast restorations (including onlays and replacement inlays) are covered once in a seven (7) year period on any tooth.

* **Prosthodontic:** A prosthetic device will be covered once in a seven (7) year period provided the tooth has not been crowned within the past seven (7) years. Specialized or personalized prosthetics are limited to the cost of standard devices.

EXCLUSIONS

* Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
* Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing teeth.
* Services started prior to the date the individual became eligible for services under the program.
* Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
* Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
* General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office.
* Plaque control and oral hygiene or dietary instructions.
* Experimental procedures.
* Missed or broken appointments.
* Orthodontic services.
* Services for cosmetic reasons.
* Claims submitted more than 12 months after the date of rendition of the services.
* All other services or supplies, not specifically covered.

Delta Dental Customer Service 888-217-2365 - Delta Dental's website www.modahealth.com

Delta Dental provides dental claims payment services only and does not assume financial risk or obligation with respect to payment of claims.

cis benefits
cisbenefits.org

Healthy Benefits 2016

Wellness For You and Your Family

Health care is changing for all of us. However, you can continue to count on CIS' Healthy Benefits program to provide free or low-cost wellness programs, resources, and services to help you achieve your goals. Active employees, retirees, spouses, domestic partners and dependents ages 18 and older covered by a CIS medical plan are invited to participate.

Visit www.cisbenefits.org for complete program details and web links and select Healthy Benefits & Wellness from the page menu.

Available through Healthy Benefits at no or minimal participant cost:

- Receive up to $400 reimbursement from CIS per plan year for participation in qualified **healthy eating & weight management** programs. Reimbursement is limited to five plan years.
- **Quit for Life® tobacco cessation** includes Quit Coaching, nicotine replacement therapy, and coordination of quit medications with your medical plan prescription benefit. Call Quit for Life® 24-hours-a day, 7 days-a-week at 1.866.784.8454.

QUESTIONS?

Email healthybenefits@cisoregon.org or call 1-800-922-2684 x3826

CIS Benefits remains committed to provide you and your family with high-quality Healthy Benefits and exceptional service at the best possible prices.

503-763-3800 855-763-3829
www.cisbenefits.org
1212 Court St. NE, Salem, OR 97301

HB

cis benefits
cisbenefits.org

- **Employee Assistance Program** (Reliant Behavioral Health) includes telephonic and in-person counseling, and Life Balance services such as Identity Theft, Will Preparation, and others. For assistance, call 1-866-750-1327.
- **CIS Benefits Facebook** page provides regular health and wellness tips for you and your family. Follow CIS Benefits at www.facebook.com/cisbenefits.

Benefits Partner Resources and Websites

- **Weight Management** programs available through Regence and Kaiser.
- Earn points towards **Regence REWARDS** by completing the Health Assessment, logging in to see your claims and benefits information, recording your health and wellness activities, etc. Insured family members 13 and older can create a REWARDS account. Collecting enough points earns you a $25 gift card. To access your wellness tools, sign in on the Regence website and go to Member dashboard.
- **CHP Active & Healthy program** includes discounts that offer something for virtually everyone – gym memberships, movie tickets, theme park discounts, etc.
  - Kaiser members: To get started, visit chpactiveandhealthy.com, create a username and pasword, and then enter your HRN number.
  - Regence members: Login at regence.com and type CHP in the search box and then follow the instructions.

Access to partner websites requires a separate login. Follow the website's login directions.

- Regence BlueCross BlueShield of Oregon – www.Regence.com
- Kaiser Permanente – www.kp.org
- ODS Dental – www.odscompanies.com/members
- Willamette Dental – www.willamettedental.com
- Reliant Behavioral Health - http://www.myrbh.com (Access code: Oregon)

cis benefits
cisbenefits.org

Supplemental Life & Voluntary Dependent Life Coverage

CIS offers life and disability coverage through The Hartford. Employers pay for basic coverage, and choose whether to make available optional employee paid Supplemental Employee/ Spouse/Domestic Partner (DP) Life and/or Voluntary $10,000 Dependent Life coverage. ***If either of these options are offered by your employer, you will see these plans online and will be given the opportunity to enroll for the first time or increase your current election(s).***

Supplemental Employee/Spouse/DP Life

Employees can elect amounts from $10,000 to $300,000 in $10,000 increments. Any amount elected for supplemental life requires medical review – completion of a Personal Health Application (PHA) - by The Hartford.

If electing supplemental life coverage for your spouse or domestic partner, the amount must be equal to or less than the supplemental life amount elected for yourself.

Note: The PHA completion is a different process this year as we now have a single sign-on process with The Hartford.

If electing coverage that needs approval, a link to the PHA will be provided on the last page. If enrolling in coverage for yourself only, you can click on the link and complete the PHA immediately. If enrolling in coverage for you and your spouse, the PHA will include questions for both of you and must be completed at the same time.

BENEFICIARIES

ARE YOUR BENEFICIARY DESIGNATIONS CORRECT?

Please take the time to review beneficiary designations to ensure they are correct. The beneficiary(ies) listed on the system are the ones who will receive any life insurance benefits.

You are automatically the beneficiary for the Supplemental Spouse/DP Life and the Voluntary $10,000 Dependent Life. Beneficiaries for the Basic Life and Supplemental Employee Life coverage need to be designated online. If you are adding coverage for the first time, you will be offered the opportunity to assign a beneficiary during the enrollment process.

503-763-3800 855-763-3829
www.cisbenefits.org
1212 Court St. NE, Salem, OR 97301

cis benefits
cisbenefits.org

If you cannot complete the PHA on behalf of your spouse, then you will need to complete it later (but no later than 60 days from the date the election was made). To access it later, sign on to the same site and click on "Access Supplemental Life PHA Link" in the Personal Info box on the right hand side.

Coverage approved prior to December 10 will be effective January 1, 2016. Coverage approved after that date will be approved February 1 or later. If you wish to discontinue Supplemental Life, you must elect the waive option.

Supplemental Employee/Spouse/DP Life Rates

As of January 1, for the first time rates will be different for employees and spouses. The age-based rates for spouses will stay the same while the rates for employees will decrease. Rates will continue to adjust for anyone who changed age categories during the 2015 calendar year.

Age	Employee Cost/$1K	Spouse Cost/$1K
0-29	$0.034	$0.039
30-34	$0.043	$0.049
35-39	$0.059	$0.068
40-44	$0.084	$0.097
45-49	$0.118	$0.136
50-54	$0.185	$0.213
55-59	$0.345	$0.398
60-64	$0.529	$0.610
65-69	$0.998	$1.150
70-74	$1.570	$1.810
75 & Older	$4.838	$5.580

If you elect $100,000 of coverage and are 45 years old, your premium would be: $0.118 x 100 = $11.80. This amount would be the monthly payroll deduction.

Voluntary $10,000 Dependent Life

You can elect the $10,000 Dependent Life during the enrollment process. Coverage is $2.96 per month and will cover a spouse, DP, and/or children under the age of 26. Coverage is available on a guarantee issue basis and just needs to be elected during open enrollment.

If you prefer to complete the PHA by hardcopy, click on the PHA link and it will take you to the online version. You have to complete the first two pages of the form and then on the third page (Health Questions) you will see a link to print out the form (Print Personal Health Application).

It will be pre-populated with the information provided on the first two pages. Then, answer the questions and mail the completed form to The Hartford.

Age & Premium Reduction Provision

The age/premium reduction at age 70 provision has been eliminated. Employees and/or spouses whose supplemental life coverage was previously reduced (or will be reduced during October – December) has had (or will have) their coverage reinstated to the initial amount elected. This means coverage and premiums will increase effective 1/1/16. If employees don't want the increased coverage, they will need to change it during open enrollment.

PERS Oregon Public Employees Retirement System

11410 SW 68th Parkway, Tigard OR 97223
Mailing Address – PO Box 23700, Tigard OR 97281-3700
Toll free - 888-320-7377 fax - 503-598-0561
Website - http://oregon.gov/pers

IAP: Pre-Retirement Designation of Beneficiary Packet

Important: Read instructions before you complete and submit the enclosed forms.

You must fill out a beneficiary form for the Individual Account Program (IAP) even if you have already submitted a PERS Tier One or Tier Two Pre-Retirement Beneficiary form.

Determining which form to complete

If you are married, or there exists at the time of death any other person who is constitutionally required to be treated in the same manner as a spouse for the purpose of retirement benefits, you must fill out the IAP Pre-Retirement Designation of Beneficiary: Married Applicant form.

General instructions

- Type or print clearly in dark ink. Illegible forms are void and will be returned to you.
- Do not change anything on the form; alterations will void the form.
- Make sure any form requiring a notary is notarized.
- Fill out only the form that applies to your situation.
- Read the specific instructions for each form. You will find instructions on pages 2, 3, and 4.

Things to consider

- **It is important that you file a separate Designation of Beneficiary form with PERS for your IAP account.** If you die before retirement and there is no IAP Designation of Beneficiary form on file, distribution of your IAP account will be in accordance with statute: your surviving spouse or other person who is constitutionally required to be treated in the same manner as a spouse, your surviving children, and your estate.
- If your designated beneficiary predeceases you, any IAP death benefits that might be due and payable will be distributed in accordance with statute.

Information for married members

- If you are married, your IAP account must be paid to your spouse unless your spouse consents to a different beneficiary.
- If you want to designate someone other than your spouse, your spouse must sign a notarized consent.
- Your spouse can revoke this consent up to the time of your death. To revoke spousal consent, your spouse must complete and submit the IAP: Revocation of Spousal Consent of Beneficiary Designation form. You will find this form on the PERS website (http://oregon.gov/pers), or contact PERS Customer Service at 503-598-7377 or toll free at 888-320-7377. Once PERS accepts and approves the revocation form, your spouse will be considered the beneficiary unless you file another valid change of beneficiary form, with your spouse's consent, with PERS.
- If you name your spouse as beneficiary and you get divorced, your spouse will be deemed as having predeceased you unless you or a court order expressly designates your former spouse to continue as beneficiary after the effective date of your divorce. This means that your former spouse is no longer your beneficiary unless otherwise provided by you or a court order.
- In the event of your death, any pre-retirement death benefit will be paid to the designated beneficiary indicated on the most recent valid IAP Designation of Beneficiary form PERS has on file.

Important reminder

You must sign this form. If you do not, your beneficiary designation is void. The form will be rejected and returned to you.

Important: If you have a complex beneficiary situation, you might want to consult an estate planning attorney.

Instructions for married applicants

Use the IAP Pre-Retirement Designation of Beneficiary: Married Applicant form if you are married.

Section A: Applicant information

- Fill in the member information section completely.
- Providing your Social Security number (SSN) is voluntary. It will be used for confirmation purposes. If you choose not to supply your SSN, it may take PERS staff longer to process your form.
- If you do not know your PERS number, leave the space provided blank.
- Please provide your phone number so we can reach you with information or questions about your form. If you prefer not to be contacted by phone, leave that field blank.

Section B: Spousal designation

- Your beneficiary must be your spouse unless your spouse consents to a different beneficiary. Check the **acknowledgment box** if your spouse is your beneficiary.
- You must fill in your spouse's name. Use his/her **full given name** (e.g., Mary A. Jenkins, not Mrs. Robert Jenkins). A designation without your spouse's name is void and will be returned to you.
- Your spouse must sign and date this form in front of a notary if you designate a different beneficiary in Section C, D, or E.
- Sign and date the statement in Section H at the bottom of page 5, and mail the form to PERS. **You must sign this form. If you do not, your beneficiary designation is void. The form will be rejected and returned to you.**

Section C: Specific beneficiary designation

Do not complete this option if your spouse is your beneficiary and you have completed Section B.

- If your spouse consents to another beneficiary, check the **consent box** in this section.
- Fill in your beneficiary designations in the space provided. Make sure you fill out this section completely. If you choose more than one beneficiary, you must include the percentage of your account you want to go to each beneficiary.
- If you use percentages when designating specific beneficiaries, you must name an alternate beneficiary for each beneficiary.
- Use **full given names** (e.g., Mary A. Jenkins, not Mrs. Robert Jenkins).

Specific beneficiary #1	Specific beneficiary #2	Specific beneficiary #3
#1 primary beneficiary (if living; otherwise, to #1 alternates) Name: Mary Ann Jenkins Social Security # (optional)* 555-55-5555 **Percentage: 40%** Date of birth* (optional)*: 06/01/1957 Relationship (optional)* Sister	**#2 primary beneficiary** (if living; otherwise, to #2 alternates) Name: Arnold McMillan Social Security # (optional)* 555-55-5555 **Percentage: 40%** Date of birth ((optional)*: 06/01/1960 Relationship (optional)*: Brother	**#3 primary beneficiary** (if living; otherwise, to #3 alternates) Name: Greg Murray Social Security # (optional)* 555-55-5555 **Percentage: 20%** Date of birth (optional)*: 04/01/1957 Relationship (optional)*: Friend
Alternate beneficiary 1a (Benefit will go to those named here if #1 specific beneficiary is deceased.) Name: Susie Jenkins Social Security # (optional)* 555-55-5555 **Percentage[1]: 25%** Date of birth (optional)*: 05/12/1993 Relationship (optional): Niece	*Alternate beneficiary 2a* (Benefit will go to those named here if #2 specific beneficiary is deceased.) Name: Anna Marie McMillan Social Security # (optional)* 555-55-5555 **Percentage[1]: 25%** Date of birth (optional)*: 05/12/1993 Relationship (optional): Niece	*Alternate beneficiary 3a* (Benefit will go to those named here if #3 specific beneficiary is deceased.) Name: Sandy Murray Social Security # (optional)* 555-55-5555 **Percentage[1]: 15%** Date of birth (optional)*: 11/12/1959 Relationship (optional)*: Friend
Alternate beneficiary 1b (Benefit will go to those named here if #1 specific beneficiary is deceased.) Name: Jordan Jenkins Social Security # (optional)* 555-55-5555 **Percentage[1]: 15%** Date of birth (optional)*: 06/01/1992 Relationship (optional)*: Nephew	*Alternate beneficiary 2b* (Benefit will go to those named here if #2 specific beneficiary is deceased.) Name: Lora McMillan Social Security # (optional)* 555-55-5555 **Percentage[1]: 15%** Date of birth (optional)*: 05/12/1985 Relationship (optional)*: Step-niece	*Alternate beneficiary 3b* (Benefit will go to those named here if #3 specific beneficiary is deceased.) Name: Mary Ann Jenkins Social Security # (optional) 555-55-5555 **Percentage[1]: 5%** Date of birth (optional)*: 06/01/1957 Relationship (optional)*: Sister

[1]The **total** of the percentages you enter for alternate beneficiaries must equal the percentage you entered for that primary beneficiary.

*This information helps PERS locate the people you designate. If you specifically designate a charity or organization, please provide the address underneath the name of the charity or organization.

Naming a charity, estate, or trust

You can designate an estate, charity, or trust by checking the appropriate box and providing the name and address of that entity. You may also assign percentages between specific beneficiaries and/or charities in Sections C and D.
The total percentages must equal 100 percent. Estate and trust designations must be a 100 percent designation. Your spouse must consent to this designation.

Section D: Charity designation

Check the box to indicate you want to designate a charity as your beneficiary. Enter the name and address for the charity in the space provided. Your spouse must consent to this designation. Check the **consent box** in this section.

Section E: Estate designation

Check the box to indicate you want to designate your estate as the beneficiary. Your spouse must consent to this designation. Check the **consent box** in this section. Enter the name of the personal representative of your estate and the address in the spaces provided.

Section F: Trust designation

Check the box to indicate you want to designate a trust as the beneficiary. Your spouse must consent to this designation. Check the **consent box** in this section. Enter the legal name of the trust, the address, and the date the trust was established in the spaces provided.

Section G: Spousal consent, signature, and notary

If your spouse has consented to another beneficiary and you have designated a different beneficiary in Section C, D, E, or F your spouse must sign the form in front of a notary.

Section H: Applicant statement (required)

Your signature is **required.** Sign and date in the space provided. **You must sign this form. If you do not, your beneficiary designation is void. The form will be rejected and returned to you.**

Instructions for single applicants

Use the IAP Pre-Retirement Designation of Beneficiary: Single Applicant form if you are single.

Section A: Applicant information

- Fill in the member information section completely.
- Providing your Social Security number (SSN) is voluntary. It will be used for confirmation purposes. If you choose not to supply your SSN, it may take PERS staff longer to process your form.
- If you do not know your PERS number, leave the space provided blank. Please provide your phone number so we can reach you with information or questions about your form. If you prefer not to be contacted by phone, leave that field blank.

Section B: Beneficiary designation

- Check **either** the standard beneficiary designation box **OR** the specific beneficiary designation box.
- If you check the **standard beneficiary designation box**, sign and date the statement on page 4, and mail the form to PERS. (See page 1 under Things to consider for the order of standard beneficiaries.)
- If you check the **specific beneficiary box,** you must also provide a **specific person, charity, estate,** or **trust.**
- If you check the **specific person, charity, estate,** or **trust designation box.** Fill in your beneficiary information in Section C.

Section C: Specific beneficiary designation

Complete this section if you are naming specific person(s) as beneficiaries. Include the beneficiary's name, Social Security number (optional*), the percentage you would like to go to him/her, his/her date of birth (optional*), and his/her relationship to you (optional*). You can also name an alternate beneficiary to whom your benefit would be paid in the event the primary beneficiary predeceases you.

*This information helps PERS locate the people you designate. If you specifically designate a charity or organization, please provide the address underneath the name of the charity or organization.

PERS Oregon Public Employees Retirement System
11410 SW 68th Parkway, Tigard OR 97223
Mailing Address – PO Box 23700, Tigard OR 97281-3700
Toll free - 888-320-7377 fax - 503-598-0561
Website - http://oregon.gov/pers

12208

IAP Pre-Retirement Designation of Beneficiary: Married Applicant

This form is strictly for the IAP. Call PERS or visit our website if this is not the form you need.

Section A: Applicant information (Type or print clearly in dark ink. Illegible forms may be returned to you, which could delay your request.)

First name	MI	Last name	PERS number (optional)
Mailing address (street or PO box)			Social Security number*
City	State	Zip Country	Phone number

Section B: Spousal designation (Do not fill this out if you complete Section C.)

A married applicant's account(s) must be paid to the spouse unless the spouse consents to a change of beneficiary. Notarized spousal consent is required to designate a beneficiary other than the spouse.

Acknowledgment box: ☐ I acknowledge my beneficiary is my spouse. (If this box is checked, your spouse's signature is not needed.)

Spouse's name (required): _____

Section C: Specific beneficiary designation (Do not fill this out if you completed Section B.)

Consent box: ☐ My spouse consents to the following specific beneficiary designations. (See page 2 for complete instructions.)

Specific beneficiary #1	Specific beneficiary #2	Specific beneficiary #3
#1 Primary Beneficiary (if living; otherwise, to #1 alternates) Name _____ Social Security # (optional) _____ **Percentage** _____ Date of birth (optional) _____ Relationship (optional) _____	**#2 Primary Beneficiary** (if living; otherwise, to #2 alternates) Name _____ Social Security # (optional) _____ **Percentage** _____ Date of birth (optional) _____ Relationship (optional) _____	**#3 Primary Beneficiary** (if living; otherwise, to #3 alternates) Name _____ Social Security # (optional) _____ **Percentage** _____ Date of birth (optional) _____ Relationship (optional) _____
Alternate beneficiary 1a (Benefit will go to those named here if #1 specific beneficiary is deceased.) Name _____ Social Security # (optional) _____ **Percentage**[1] _____ Date of birth (optional) _____ Relationship (optional) _____	*Alternate beneficiary 2a* (Benefit will go to those named here if #2 specific beneficiary is deceased.) Name _____ Social Security # (optional) _____ **Percentage**[1] _____ Date of birth (optional) _____ Relationship (optional) _____	*Alternate beneficiary 3a* (Benefit will go to those named here if #3 specific beneficiary is deceased.) Name _____ Social Security # (optional) _____ **Percentage**[1] _____ Date of birth (optional) _____ Relationship (optional) _____
Alternate beneficiary 1b (Benefit will go to those named here if #1 specific beneficiary is deceased.) Name _____ Social Security # (optional) _____ **Percentage**[1] _____ Date of birth (optional) _____ Relationship (optional) _____	*Alternate beneficiary 2b* (Benefit will go to those named here if #2 specific beneficiary is deceased.) Name _____ Social Security # (optional) _____ **Percentage**[1] _____ Date of birth (optional) _____ Relationship (optional) _____	*Alternate beneficiary 3b* (Benefit will go to those named here if #3 specific beneficiary is deceased.) Name _____ Social Security # (optional) _____ **Percentage**[1] _____ Date of birth (optional) _____ Relationship (optional) _____
[1]The **total** of the percentages you enter for alternate beneficiaries must equal the percentage you entered for that primary beneficiary.		
Additional beneficiaries? Please provide an additional sheet of paper that lists the same information used above for each beneficiary. Label the attached pages Additional Beneficiaries. Include your full name and Social Security number.		

☐ If any of the primary beneficiaries named above predecease me and I have not named an alternate beneficiary, I want the portion of my benefit that was designated to that beneficiary to be shared equally among the remaining primary beneficiaries living at the time of my death.

Name: _____ SSN/PERS number: _____

Section D: Charity designation

☐ I designate the following charity as my beneficiary.

☐ My spouse consents to the following beneficiary designation:

Indicate percentage amount to be designated. _____%

Name: _____

Address: _____

Section E: Estate designation

☐ I designate my estate as my beneficiary. Estates must receive 100 percent of the designation.

☐ My spouse consents to the following beneficiary designation:

Name of personal representative: _____

Address of personal representative: _____

Section F: Trust designation

☐ I designate a trust as my beneficiary. Trusts must receive 100 percent of the designation.

☐ My spouse consents to the following beneficiary designation:

Legal name of trust (e.g., The Sara Smith Living Trust): _____

Address of trust: _____

Date trust established: _____

Section G: Spousal consent, signature, and notary (Spouse's signature must be notarized in box below.)

I hereby consent to the designation of beneficiary(ies) named in section C, D, E, and F.

_____ _____

Spouse signature (do not print) Date

_____

Print signature

Notary Public	*State of*	*County of*
	Spouse signed before me on:	
	Spouse's name	
	By (notary's signature)	
	My commission expires	

Section H: Applicant statement (required)

I hereby revoke any and all previous beneficiary designations for my IAP account. (Notarization not necessary.)

_____ _____

Applicant signature (do not print) Date

_____

Print signature

***Providing your Social Security number (SSN) is voluntary. It will be used for confirmation purposes. If you choose not to supply your SSN, it could take PERS staff longer to process your form.**

In compliance with the Americans with Disabilities Act, PERS will provide help filling out this form upon request. You may request help by phoning 503-598-7377, toll free 888-320-7377, or TTY 503-603-7766.

PERS Oregon Public Employees Retirement System
11410 SW 68th Parkway, Tigard OR 97223
Mailing Address – PO Box 23700, Tigard OR 97281-3700

12208

IAP Pre-Retirement Designation of Beneficiary: Single Applicant

This form is strictly for the IAP. Call PERS or visit our website if this is not the form you need.

Section A: Applicant information (Type or print clearly in dark ink. Illegible forms may be returned to you. This could delay your request.)

First name	MI	Last name	PERS number (optional)
Mailing address (street or PO box)			Social Security number*
City / State / Zip / Country			Phone number

Section B: Beneficiary designation (Refer to instructions for explanation of beneficiary options.)

- ☐ I would like to use the **standard beneficiary designation**.
- ☐ I would like to use a **specific beneficiary**. If you choose this option, select from the list below.
  - ☐ I want to designate a **specific person or persons** as my beneficiary.
  - ☐ I want to designate a **person or persons and a charity** as my beneficiaries. (Fill out Section C and Section D.) Percentages must equal 100 percent.
  - ☐ I want to designate a **charity** as my beneficiary. (Fill out Section D.)
  - ☐ I want to designate my **estate** as my beneficiary. (Fill out Section E.) Estates must receive 100 percent of the designation.
  - ☐ I want to designate a **trust** as my beneficiary. (Fill out Section F.) Trusts must receive 100 percent of the designation.

Section C: Specific beneficiary designation (Do not fill this out if you chose the standard beneficiary designation.)

Specific beneficiary #1	Specific beneficiary #2	Specific beneficiary #3
#1 Primary Beneficiary (if living; otherwise, to #1 alternates) Name _____ Social Security # (optional) _____ **Percentage** _____ Date of birth (optional) _____ Relationship (optional) _____	**#2 Primary Beneficiary** (if living; otherwise, to #2 alternates) Name _____ Social Security # (optional) _____ **Percentage** _____ Date of birth (optional) _____ Relationship (optional) _____	**#3 Primary Beneficiary** (if living; otherwise, to #3 alternates) Name _____ Social Security # (optional) _____ **Percentage** _____ Date of birth (optional) _____ Relationship (optional) _____
Alternate beneficiary 1a (Benefit will go to those named here if #1 specific beneficiary is deceased.) Name _____ Social Security # (optional) _____ **Percentage** _____ Date of birth (optional) _____ Relationship (optional) _____	*Alternate beneficiary 2a* (Benefit will go to those named here if #2 specific beneficiary is deceased.) Name _____ Social Security # (optional) _____ **Percentage** _____ Date of birth (optional) _____ Relationship (optional) _____	*Alternate beneficiary 3a* (Benefit will go to those named here if #3 specific beneficiary is deceased.) Name _____ Social Security # (optional) _____ **Percentage** _____ Date of birth (optional) _____ Relationship (optional) _____
Alternate beneficiary 1b (Benefit will go to those named here if #1 specific beneficiary is deceased.) Name _____ Social Security # (optional) _____ **Percentage** _____ Date of birth (optional) _____ Relationship (optional) _____	*Alternate beneficiary 2b* (Benefit will go to those named here if #2 specific beneficiary is deceased.) Name _____ Social Security # (optional) _____ **Percentage** _____ Date of birth (optional) _____ Relationship (optional) _____	*Alternate beneficiary 3b* (Benefit will go to those named here if #3 specific beneficiary is deceased.) Name _____ Social Security # (optional) _____ **Percentage** _____ Date of birth (optional) _____ Relationship (optional) _____

[1]The **total** of the percentages you enter for alternate beneficiaries must equal the percentage you entered for that primary beneficiary.

Additional beneficiaries? Please provide an additional sheet of paper that lists the same information used above for each beneficiary. Label the attached page Additional Beneficiaries. Include your full name and Social Security number.

- ☐ If any of the above named primary beneficiaries predecease me and I have not named an alternate beneficiary, I want the portion of my benefit that was designated to that beneficiary to be shared equally among the remaining primary beneficiaries living at my death.

Name: _____ SSN/PERS number: _____

Section D: Charity designation

❑ I designate the following charity as my beneficiary.

Indicate percentage amount to be designated. _____%

Name: _____

Address: _____

❑ I designate the following charity as my beneficiary.

Indicate percentage amount to be designated. _____%

Name: _____

Address: _____

Section E: Estate designation

❑ I designate my estate as my beneficiary. Estates must receive 100 percent of the designation.

Name of personal representative: _____

Address: _____

Section F: Trust designation

❑ I designate a trust as my beneficiary. Trusts must receive 100 percent of the designation.

Legal name of trust (e.g., The Sara Smith Living Trust): _____

Address: _____

Date trust established: _____

Section G: Applicant statement (required)

I hereby revoke any and all previous beneficiary designations for my IAP account.

_____ _____

Applicant signature (do not print) Date

_____

Print name

***Providing your Social Security number (SSN) is voluntary. It will be used for confirmation purposes. If you choose not to supply your SSN, it could take PERS staff longer to process your form.**

In compliance with the Americans with Disabilities Act, PERS will provide help filling out this form upon request. You may request help by phoning 503-598-7377, toll free 888-320-7377, or TTY 503-603-7766.

FLEXIBLE BENEFITS ENROLLMENT FORM

2015 Plan Year

COMPLETE THIS FORM AND RETURN TO YOUR BENEFITS REPRESENTATIVE

cis benefits
www.cisbenefits.org

Entity Name: _____

PART 1 – EMPLOYEE DATA

EMPLOYEE NAME (LAST, FIRST, MI.)	SOCIAL SECURITY NUMBER	
HOME ADDRESS (INCLUDE APARTMENT NUMBER)		
CITY	STATE	ZIP
DATE OF BIRTH	DATE OF HIRE	

PART 2 – ELECTIONS

Premium Only Plan – CIS Medical/Dental Premiums Only

☐ I elect to participate – I have enrolled for medical and/or dental insurance and have been provided with information identifying my portion of the premiums for such coverages. These premiums will be taken on a pre-tax basis. This election will continue from year-to-year unless I discontinue it.

☐ I elect to waive all pre-tax benefits under the Premium Only Plan.

Healthcare Flexible Spending Account

(Calendar year maximum is $2,500.)

☐ I elect to contribute $ _____ per pay period x _____ remaining pay periods = $ _____ Plan Year Total

☐ I elect to waive coverage.

Dependent Care Flexible Spending Account

(Calendar year maximum is $5,000 for married filing jointly or single, or $2,500 if married filing separately.)

☐ I elect to contribute $ _____ per pay period x _____ remaining pay periods = $ _____ Plan Year Total

☐ I elect to waive coverage.

PART 3 – AUTHORIZATION

I have reviewed the terms of CIS' Flexible Benefits Plan. I understand that I may elect coverage under any or all of the above components, if offered. I understand that contributions will be deducted from my compensation on a pre-tax basis and the deductions cannot be changed until the next plan year unless I experience a qualified status change. I have read and agree to the terms of participation.

_____ EMPLOYEE'S SIGNATURE

_____ DATE

FOR EMPLOYER USE ONLY:

COMPANY NAME	DIVISION	EFFECTIVE DATE	PAY CYCLE	ENTERED IN PAYROLL	INITIAL:

HEALTHCARE & DEPENDENT CARE FSA SUMMARY

What is a Flexible Spending Account (FSA)?

A Flexible Spending Account is a year-to-year tax-free account that allows you to save money to pay for your out-of-pocket healthcare expenses, including prescription drug costs, over-the-counter health care products, medical, dental, vision and hearing expenses and/or your work-related child or dependent care expenses, including day care, baby sitting, in-home care for older dependents and before & after school care expenses.

When you enroll in an FSA, you decide how much to contribute to each account for each year. For the Healthcare FSA you can set aside up to $2,550, ***but remember that the amount elected must be for expenses incurred during the plan year - January 1, 2016 - December 31, 2016.*** For the Dependent Care FSA the calendar year maximum is $5,000 ($2,500 if you are a married individual and file a separate tax return from your spouse) per household. The money is deducted from your paycheck pre-tax (before Federal & State income taxes and FICA taxes are deducted) in equal amounts, over the course of the plan year. After you incur expenses that qualify for reimbursement, you submit claims (reimbursement requests) to ASIFlex to request tax-free withdrawals from your FSA to reimburse yourself for these expenses.

What healthcare expenses can I use my Healthcare FSA for?

Partial list of qualified medical expenses:

- ✓ Deductibles & copayments
- ✓ Doctor's fees, Chiropractor's fees
- ✓ Dental expenses, orthodontia (see specific requirements)
- ✓ LASIK surgery, eyeglasses, contact lenses, lens cleaning solutions
- ✓ Prescription drugs & insulin
- ✓ Over-the-counter health care products (see the FSA Store link on www.asiflex.com)

Your FSA cannot be used for:

- ✓ Insurance premiums
- ✓ Cosmetic procedures (such as face lifts, teeth whitening, veneers, hair replacement, etc.)
- ✓ Clip-on or nonprescription sunglasses
- ✓ Toiletries
- ✓ Long-term care expenses
- ✓ Drugs, herbs, or vitamins for general health
- ✓ Warranties

Check out www.asiflex.com for more eligible expenses

How do I determine how much to contribute?

Estimate your expected or routine healthcare expenses that will not be reimbursed by your medical, vision or dental plans during the 2016 Plan Year (January 1 - December 31, 2016). Be sure to consider over-the-counter health care products like Bandaids, Sunscreen, wrist braces, pill holders, etc. **Remember that expenses for your tax dependents qualify for reimbursement through your Healthcare FSA program, even if they are not covered on your medical/vision/dental insurance through your employer.**

Runout Period – Deadline to Submit Claims

While claims have to be incurred during the plan year (January 1 – December 31, 2016), you have until March 31 the following year to file for reimbursement. This 90-day deadline is called the "Runout Period". If you miss this claim filing deadline, the IRS rules require that unused dollars in your account be forfeited.

Healthcare FSA – Carryover Up to $500!

At the end of the Runout Period, **participants are allowed to carryover up to $500 of unused contributions into the following plan year!** This means you have more flexibility in estimating the amount to contribute to your account because you no longer forfeit all of what you don't use – you can carry over up to $500 to the next year. The carryover amount will not reduce your new plan year election. For example, since the annual contribution limit is $2,550, you can carry over up to $500 of unused funds for a total of $3,050. For unused contributions over $500, the IRS still requires that those dollars be forfeited.

Dependent Care FSA

Dependent Care FSAs create a tax break for work-related dependent care expenses for children under the age of 13 or older dependents who are not capable of self-care (typically child care or day care expenses) that enable you to work. If you are married, your spouse must be working, looking for work or be a full-time student. **If you have a stay-at-home spouse, you should not enroll in the Dependent Care FSA.** The IRS allows no more than $5,000 per household ($2,500 if you are married and file a separate tax return) to be set-aside in the Dependent Care FSA in a calendar year.

(over)

Dependent Care FSA (cont'd)

Please note that IRS regulations disallow reimbursement for services that have not yet been provided, so even if you pay in advance for your expenses, you can only claim service periods that have already occurred. **Eligible expenses** include day care, baby-sitting, & general purpose day camps. **Ineligible expenses** include overnight camps, care provided by a dependent, your spouse or your child under the age of 19 & care provided while you are not at work.

Dependent Care "Use It Or Lose It"

The carryover provision does not apply to the Dependent Care FSA. Claims incurred for the Dependent Care FSA must be incurred during the plan year (January 1 – December 31, 2016) **AND** be submitted to ASIFlex no later than March 31 each year following the close of the plan year. If you miss this claim filing deadline, the IRS requires that the unused dollars remaining in your account be forfeited.

How do I enroll?

Employees must enroll online during open enrollment. Paper enrollment forms are not accepted.

Remember you must re-enroll in the Healthcare and Dependent Care FSA programs each year (even if you don't want the deduction amount to change).

When can I start requesting reimbursement?

You can start submitting requests as soon as services are provided, but eligible expenses can only be incurred on, or after, January 1, 2016. For the Healthcare FSA, the full annual contribution amount is available on the date your enrollment begins. For the Dependent Care FSA, you can only be reimbursed up to the amount you have had deducted from your paycheck at that point, but requests in excess of this amount will be pended and reimbursed as additional deductions are taken from your paycheck. You may submit reimbursement requests for either account as frequently, or infrequently, as you prefer. You can file claims in several ways:

ASIFlex Mobile App – You can file claims on-the-go and review your account statement. Just snap a picture of your documentation and submit the claim. The app is free and available at asiflex.com, at Google play, or through the App Store.
ASIFlex Online – You can submit claims online through the secure website at www.asiflex.com. You'll need your ASIFlex PIN to complete the request.
Fax or Mail – Obtain a claim form at asiflex.com, complete and send with appropriate documentation by toll-free fax or mail to ASIFlex.
Toll-free fax: 1-877-879-9038 or Mail to: ASIFlex
P.O. Box 6044
Columbia, MO 65205-6044

How will I receive reimbursement?

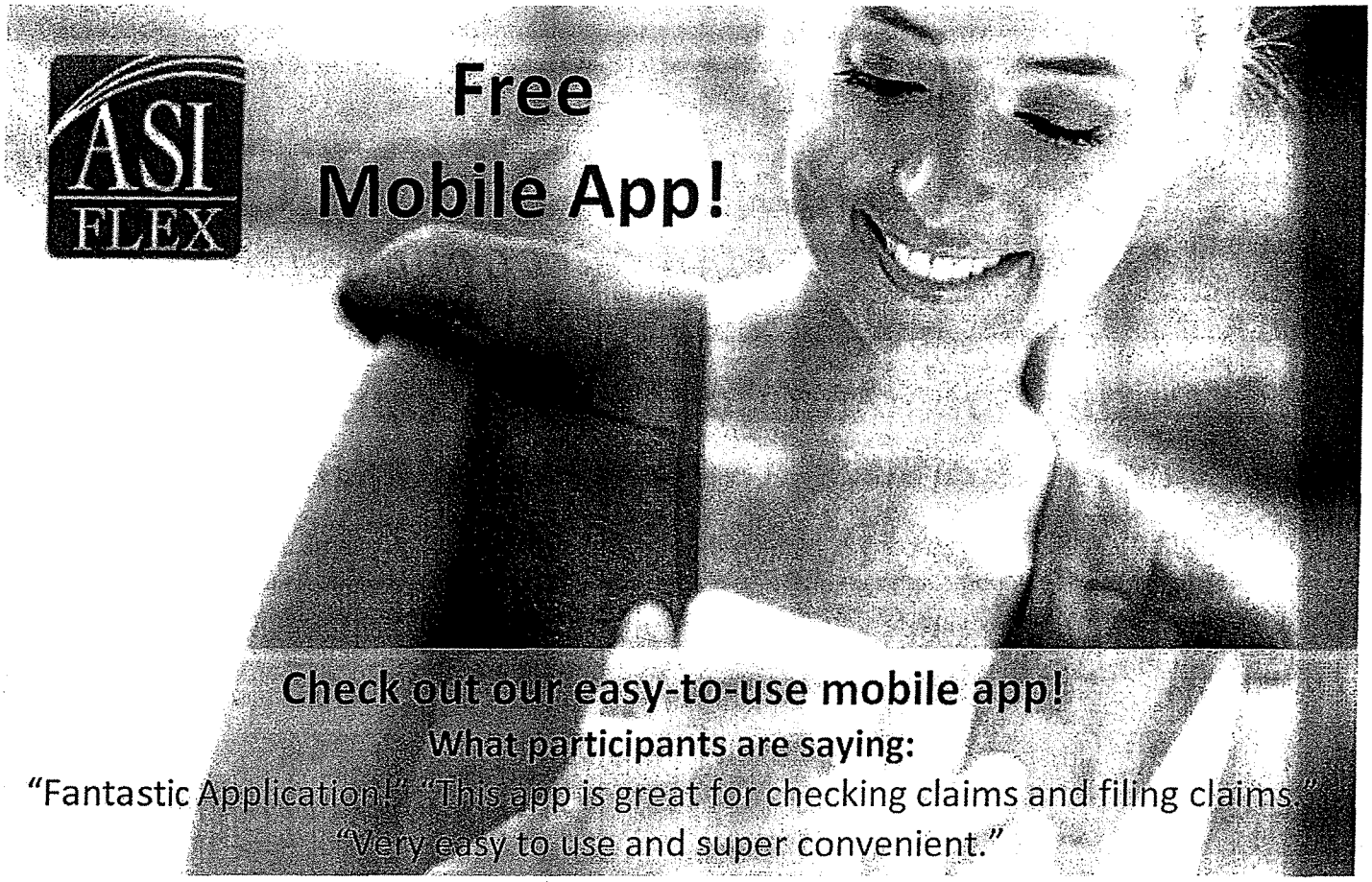
The default reimbursement method for ASIFlex will be to mail you a check. However, you also have the option to sign up to receive reimbursements by direct deposit to a checking or savings account. You can find this form online at www.asiflex.com. ASIFlex will issue your reimbursement within one to three business days of receipt of your claim, as long as acceptable documentation is also provided. You may change your bank account for reimbursement or request to receive reimbursement by check at any time by completing the Direct Deposit/E-mail Form that is available on www.asiflex.com. Your direct deposit information will stay the same until you tell ASIFlex you would prefer deposits to a different bank.

When is the last day I can file a claim?

Claims with dates of service between January 1, 2016 – December 31, 2016 must be submitted to ASIFlex no later than March 31, 2017.

Whom do I contact if I have questions?

ASIFlex Customer Service	1-800-659-3035 Monday – Friday, 5 a.m. – 5 p.m. Pacific Time Saturday, 7 a.m. – 11 a.m. Pacific Time
E-mail	asi@asiflex.com
ASIFlex's Web site	www.asiflex.com



Free Mobile App!

Check out our easy-to-use mobile app!

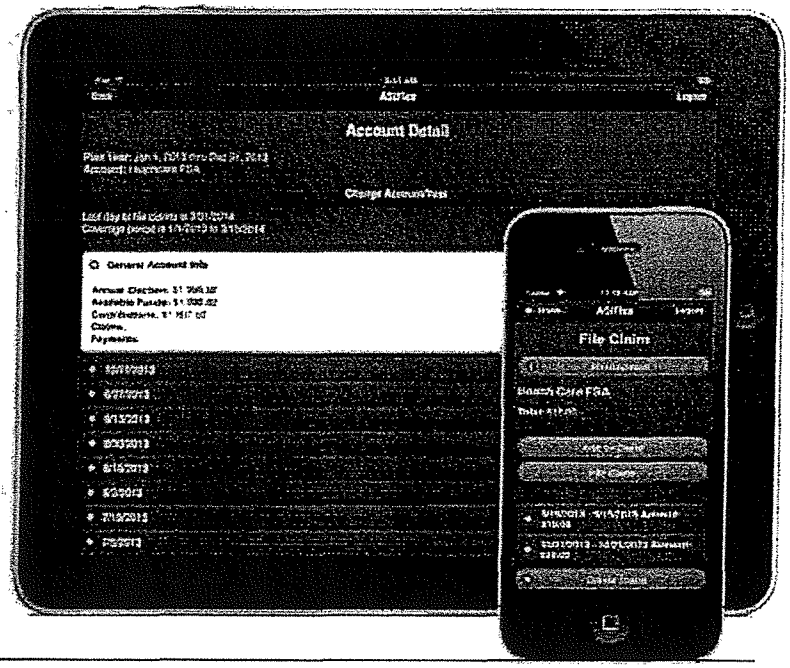
What participants are saying:

"Fantastic Application!" "This app is great for checking claims and filing claims."

"Very easy to use and super convenient."

Features

- Use your phone/tablet to file claims.
- Take a picture with your device's camera to attach as documentation.
- View information regarding your account(s).
- Access your account statement.



Just scan the code with your mobile device to get the new app!

Visit WWW.ASIFLEX.COM for more information.

FSA Store

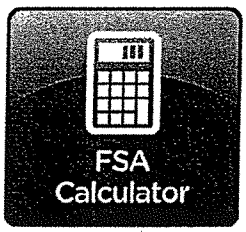
THE FLEXIBLE SPENDING ACCOUNT SITE

Flexible Spending Account Resources and Eligible Products are Available at FSA Store

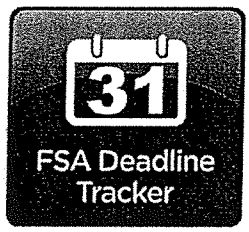
FSA Store is exclusively stocked with FSA eligible products so there are no guessing games about what is and is not reimbursable by an FSA. The site also offers tools and resources to help you better understand and use your funds.

Go to asiflex.com and click on the FSA Store banner

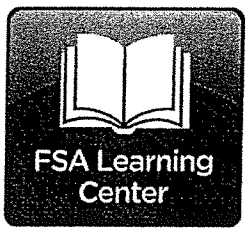
Eliminate eligibility guessing games



Estimate your annual FSA spending



Receive deadline reminders.



Get answers to all your FSA questions!

Shop Now and Get **$5** Off Orders **$35+**

Coupon Code: ASIFLEX5

Coupon code valid through 12/31/2016
Cannot be combined with other offers. 1 use per customer

Foresters Financial Services, Inc. offers 457(b) participant-directed programs. Professionally managed mutual funds may allocate your contributions among our stock, bond and money market funds based on your personal goals and risk profile.

This information is general in nature and should not be considered tax advice. Please consult a tax or legal adviser as to how this information affects your particular circumstances.

For more information about mutual funds from Foresters Financial, when planning your 457(b) program, you may obtain a free prospectus or summary prospectus by contacting your Representative, writing to the address below, calling 800.423.4026 or visiting our website at foresters financial.com. You should consider the investment objectives, risks, charges and expenses of the funds carefully before investing. The prospectus and summary prospectus contain this and other information about the funds, and should be read carefully before you invest or send money. An investment in these funds is not a bank deposit and is not insured or guaranteed by the Federal Deposit Insurance Corporation (FDIC) or any other government agency.

Foresters Financial and Foresters are trade names and trademarks of the Independent Order of Foresters (a fraternal benefit society) 789 Don Mills Road, Toronto, Canada M3C 1T9 and its subsidiaries, including Foresters Financial Services, Inc. Forester Financial Services, Inc. is a subsidiary of Foresters Financial Holding Company, Inc.

All securities products are offered through Foresters Financial Services, Inc.

Foresters Financial Services, Inc.
40 Wall Street
New York, New York 10005
(800) 423-4026

foresters financial.com

13-0028BR-457BRO16M-LG (1/15)

Foresters Financial

Find Foresters Financial on Social Media

Retirement

457(b)

Foresters Financial

Jason Tei
Investment Advisor Representative

Foresters Advisory Serv
9400 SW Beaverton Hill
Suite 250
Beaverton, OR 97005-32

T: 503-296-7676, ext. 2
F: 503-296-9071
C: 503-314-8679
jason.tei@foresters.com

foresters financial.com

40 Wall Street, New York

Opportunity to benefit from a tax-advantaged investment program

A governmental 457(b) program is a tax-advantaged investment account designed state and local government employees, s as public school employees, police office and firefighters. These accounts encourag individuals to prepare for their own retire

Why establish a 457(b) account?

We all need to supplement Social Security and pension benefits with personal retire savings to help provide the level of incom we will need in retirement. This is especial true with longer life expectancies and few employers offering traditional pension be

Did you know that...

The average American age 65, will spend years in retirement—a long period of time which living expenses will continue and lik increase with inflation.

Experts say we need 70–85 percent of ou pre-retirement income to cover expenses

For most Americans, full Social Security be are not payable until age 67.

much can I contribute?

generally allowed to contribute up to the lesser percent of your applicable compensation (as by the IRS); or

Pre-employee contributions

General Limit	Age 50 and Over
$18,000	$24,000
Indexed for inflation thereafter	Add $6,000 to general limit

on, special rules allow employees in their last ars before normal retirement to make significantly ontributions. Your Representative can assist you in ning your maximum contribution amount.

457(b) accounts be consolidated?

our employer offers Foresters 457(b) accounts, instruct your existing 457(b) custodian or trustee tly transfer your existing account to Foresters l. Since you will not take actual possession of the this type of transfer is not a taxable event.

if I change jobs or retire?

nange jobs or retire, you will need to evaluate tions. You may be eligible to roll your 457(b) into a Traditional IRA or other type of plan, or it as a 457(b) account. In such cases, earnings on count continue to be tax-deferred. Distributions 457(b) retirement plan must be directly rolled o a Traditional IRA or other type of plan in order tain tax-deferred status, and avoid 20 percent ding.

re a penalty for early rawals?

advantage of your 457(b) account is that wals, due to retirement or termination, even ge 59½, are not subject to a 10 percent early wal penalty. Regular income taxes will apply, r.

What are some of the advantages of a traditional 457(b) account?

There are significant advantages:

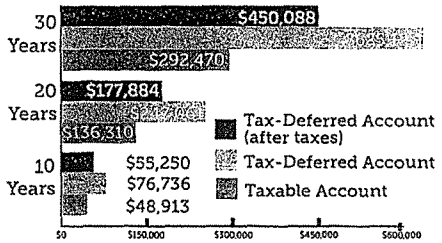
Pretax contributions. You do not pay current federal income taxes on your contributions into a 457(b) account. For example, if you are in the 25 percent tax bracket and contribute $100 per pay period to your 457(b) account, your "take-home" pay will be reduced by just $75.

Tax-deferred growth. Your 457(b) account grows on a tax-deferred basis, meaning that any appreciation, earnings, interest, capital gains and dividends are not taxed until the funds are withdrawn. This allows assets to accumulate at a faster pace, a major advantage when saving for the long term. Also, you may be in a lower tax bracket after you retire, which will allow you to keep more of what you have accumulated.

Convenience. Contributions are deducted automatically from your paycheck, so there is no need to worry about writing a check or missing an investment opportunity.

What is the impact of pretax contributions and tax-deferred growth?

The chart below compares hypothetical end-of-year values for a pretax investment of $5,000 annually made into a tax-deferred account with a nondeductible investment of $5,000 annually made into a taxable investment account. In each case, the investment is made in equal monthly installments.



Assumptions:

- Annual contributions of $5,000, in equal monthly installments.
- Hypothetical 8 percent investment return, compounded monthly with reinvestment of dividends and capital gains.
- 28 percent assumed tax rate.
- The value of the tax-deferred account after a lump sum withdrawal taxed at 28 percent, is $55,250 if taken after 10 years, $177,884 if taken after 20 years, and $450,088 if taken after 30 years.*

Hypothetical results are for illustrative purposes only and are not intended to represent the past or future performance of any specific securities. Investment return and principal will fluctuate so that shares, when redeemed, may be worth more or less than their original value. Withdrawals before age 59 ½ may be subject to ordinary income tax and a 10 percent penalty.

Lower maximum tax rates on capital gains and dividends would make the return of the taxable investment more favorable; thereby reducing the difference in performance between the accounts.

Changes in tax rates and tax treatment of investment earnings may impact the comparative results. You should consider your personal investment horizon and income tax bracket, both

How is the Foresters Financial 457(b) Program different?

Foresters Financial™ has built its reputation by providing financial services with a personal touch, managing assets effectively, and offering a wide variety of quality products.

Unlike other 457(b) programs that limit your investment choices to bank or insurance company products, your Foresters Financial 457(b) account offers you a choice of mutual funds with a wide range of investment objectives and risk levels—from conservative to aggressive.** In addition, you have the flexibility to change from one fund to another when you want to change your investment strategy. There is no tax consequence or early withdrawal penalty for this exchange, and you don't have to wait for one trustee to transfer your money to another trustee.***

* Your actual tax rate on the withdrawal of gains from a tax-deferred account could be more or less than 28 percent, depending upon the applicable tax rates that are then in effect, and whether you make your withdrawal in a lump sum or over time. Your effective tax rate on gains from a taxable account could also be more or less than 28 percent, depending upon your adjusted gross income and the nature of the gains. Currently, qualifying dividend income and long-term gains from a taxable account are taxed at an individual's capital gains rate, which is 15 percent or lower. Capital gains taxation is not available for gains taken from a tax-deferred account. The differences between the tax-deferred and taxable returns shown in the example would therefore be smaller if (a) your effective federal tax rate on the gains from a taxable account were lower than 28 percent or (b) your federal tax rate on a withdrawal from a tax-deferred account were greater than 28 percent.

** Mutual funds are not insured by the FDIC or any other entity, are not guaranteed by any bank and are subject to investment risks, including possible loss of principal.

*** If your needs and investment goals change, you may exchange the assets from one First Investors fund into your choice of many other First Investors funds without a sales charge. Shares of a particular Class may be

ICMA-RC
Building Retirement Security

IMPORTANT NOTICE: *Before you begin to fill out this form, please remove it from the enrollment book. Carefully tear perforation along the left edge, keeping the parts together.*

457

457 Deferred Compensation Plan Employee Enrollment Form — Page 1 of 2

Complete this form to open an account with ICMA-RC by carefully reading the attached instructions on the back of the form pages and printing legibly in blue or black ink.

1. REQUIRED PERSONAL INFORMATION

Employer Plan Number 303234

Employer Plan Name CITY OF ASTORIA

Social Security Number *(for tax-reporting purposes)*

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Full Name of Participant

Last _____ First _____ M.I. _____

Mailing Address/Street

_____

City _____ **State** ___ **Zip Code** _____

Date of Birth ___ / ___ / ___ (Month / Day / Year)

Date Employed/Rehired ___ / ___ / ___ (Month / Day / Year)

Rehire? ☐ Check if YES

Email Address *(optional for Delivery)*

Go Green with Electronic Delivery! ICMA-RC can notify you by email when your enrollment is processed and when statements and transaction confirmations are available online for you.

Please provide your email address if you would like to receive electronic delivery notifications. ☐ Yes, I'd like to receive electronic delivery notifications.

Job Title _____ **Department** _____ **Daytime Phone Number** (___) ___ - ___ (Area Code)

Evening Phone Number (___) ___ - ___ (Area Code)

Gender ☐ Male ☐ Female **Marital Status** ☐ Married ☐ Single

2. CONTRIBUTION AMOUNT

Specify the total percentage and/or dollar amounts you wish to contribute each pay period. Contributions will begin as soon as administratively possible following the month in which this form is signed.

☐ **Pre-tax** deferrals of _____ % or $ _____ from my pay each pay period.

3. BENEFICIARY DESIGNATION

Please use whole percentages (e.g., 50%, not 33 1/3%) and be sure the percentages total 100% when designating primary and contingent beneficiaries.

Primary Beneficiary(ies):

NAME	DATE OF BIRTH	RELATIONSHIP TO YOU*	SOCIAL SECURITY NUMBER *(for tax-reporting purposes)*	% OF BENEFIT *(whole %)*
	___/___/____		___ ___ ___ - ___ ___ - ___ ___ ___ ___	
	___/___/____		___ ___ ___ - ___ ___ - ___ ___ ___ ___	
	___/___/____		___ ___ ___ - ___ ___ - ___ ___ ___ ___	
				Total = 100%

Contingent Beneficiary(ies), if any:

	___/___/____		___ ___ ___ - ___ ___ - ___ ___ ___ ___	
	___/___/____		___ ___ ___ - ___ ___ - ___ ___ ___ ___	
	___/___/____		___ ___ ___ - ___ ___ - ___ ___ ___ ___	
				Total = 100%

*The beneficiary relationship options are spouse, non-spouse, trust, estate, and charity.

IMPORTANT NOTICE: *Before you begin to fill out this form, please remove it from the enrollment book. Carefully tear perforation along the left edge, keeping the parts together.*

457

ICMA-RC
Building Retirement Security

457 Deferred Compensation Plan Employee Enrollment Form — Page 2 of 2

Employer Plan Number	Social Security Number	Name *(please print)*
303234	___ ___ ___ - ___ ___ - ___ ___ ___ ___	

4. COMMUNITY PROPERTY STATE SPOUSAL CONSENT

If you are married and live in a community property state (AZ, CA, ID, LA, NV, NM, TX, WA, or WI), you must generally name your spouse as a primary beneficiary for at least 50% of the account unless your spouse consents to waive this right. Your spouse's written consent must be witnessed by a notary public.

SPOUSAL CONSENT (to be completed by participant's spouse):

By signing below, I agree to waive my right to at least 50% of my spouse's account upon his or her death. I understand each beneficiary designation is not valid unless I consent to it.

_____ ___ / ___ / ___ ___ ___ ___

Signature of Participant's Spouse — Month Day Year

_____

Print Name of Participant's Spouse

Notary Public:
Subscribed and sworn before me this _____ day of _____ (month), 20 ___ ___

_____

Notary Public's Signature

Notary Public's SEAL _____ My commission expires _____

5. INVESTMENT SELECTION

Choose only one of the investment selections. Your selection will determine how contributions to your account will be invested. If this section is not completed, or if you make an invalid selection, your contributions will be invested in the default investment selected by the plan sponsor until you provide additional instructions. Please refer to the *Investment Options Sheet* for a list of funds and codes. If you elect to participate in the optional Managed Accounts service, you are charged an ongoing asset-based fee for the additional services provided.

Simplify and diversify with one fund

☐ **Milestone Fund.** You will be invested in the Milestone Fund, also known as a "Target Date" fund, which most closely matches the year in which you will reach your plan's default retirement age. For most plans this is age 60. The Milestone Fund is a diversified fund designed for investors who expect to retire and/or begin withdrawals around a target year. Note that you may change this investment at any time.

☐ **Model Portfolio Fund.** Fund Code ___ ___ ___ = 100%

OR

☐ ***Build your own investment portfolio***

Input the fund codes and allocation percentages (must total 100%) to show how contributions to your account will be invested. A list of funds and codes can be found on the Investment Options Sheet. Read Section 5 of the form instructions for information on how assets will be invested in the absence of accurate and complete instructions.
Note: Please use whole percentages only.

INVESTMENT ALLOCATION			
Code	Percent	Code	Percent
			TOTAL = 100%

6. AUTHORIZED SIGNATURES

Submit this form to your employer promptly to avoid investment delay. If this form is faxed to ICMA-RC, please do not mail the original.

_____ ___ / ___ / ___ ___ ___ ___ Employee ID _____

Participant's Signature — Month Day Year — For Employer Use Only

_____ ___ / ___ / ___ ___ ___ ___

Authorized Employer Official's Signature — Month Day Year

Beneficiary Designation for Death Benefits Form

Deferred Comp Plan - Certain Employees - City of Astoria

#409112

TheStandard®

See reverse for instructions and explanation.

PARTICIPANT *Complete this section (and Spouse section, if necessary), and submit to your employer*

Name of Participant

Social Security Number | Date of Birth

I have read the explanation on the back of this form. I understand that if I am married, (1) and if I die before I retire, my Plan Benefits will be paid to my spouse in the form of a Qualified Preretirement Survivor Annuity (QPSA, a life annuity), (2) I have the right to waive the form of payment, provided my spouse consents to the waiver, (3) I have the right to waive payment to my spouse as sole beneficiary, provided my spouse consents to the waiver, and (4) I can revoke these waivers at many time. If I am under age 35, I understand that this election will become invalid when I reach 35; I may then make a new election. This designation supersedes any previous designation.

I designate as my beneficiary for benefits from this plan:

Name of Primary Beneficiary *(please print)*

Relationship | Date of Birth

Current Address

Name of Contingent Beneficiary *(please print)*

Relationship | Date of Birth

Current Address

I am ☐ married ☐ unmarried

If I am married and have designated someone other than my spouse as my primary beneficiary, this designation will be effective only if my spouse consents to it by signing in the spouse section below.

☐ I choose to waive payment of death benefits in the form of a QPSA and instead choose payment in the form of _____. (Consult the Plan Administrator for alternate forms.) I acknowledge that this choice will be effective only if my spouse consents to it by signing below. (The beneficiary may elect another form at the time a death benefit is payable.)

X _____ _____

Participant Signature | Date

Please keep a copy of this form for your records

SPOUSE ***Complete this section if the participant designated a non-spouse beneficiary or waived the QPSA. Your consent must be witnessed by a Plan Representative or Notary Public.***

I have read the explanation on the back of this form. I understand the terms of the QPSA and I understand that my consent is irrevocable unless the participant revokes that election.

BLOODBORNE PATHOGENS EXPOSURE CONTROL PLAN

Facility Name: City of Astoria, Public Works

Date of Preparation: August 23, 1993

We, the management staff of City of Astoria, are committed to the prevention of incidents or happenings which result in employee injury and illness: and to comply with the Oregon OSHA Bloodborne Pathogens Standard, Oregon Administrative Rule (OAR) 437-02-1910.1030; and through this written exposure control plan share assigned responsibility to ensure performance under that responsibility; and hereby adopt this exposure control plan as an element of the City of Astoria Safety and Health Program.

A. PURPOSE

The purpose of this exposure control plan is to:

1. Eliminate or minimize employee occupational exposure to blood or other body fluids;

2. Identify employees occupationally exposed to blood or other potentially infectious materials while performing their regular job duties.

3. To provide employees exposed to blood and other potentially infectious materials information and training. A copy of this plan is available to all employees during the work shift at two locations - the Shops at 550 - 30th Street, and the Public Works administrative offices at 1095 Duane Street.

4. Comply with OR-OSHA Bloodborne Pathogen Standard, Oregon Administrative Rules (OAR) 437-02-1910.1030.

B. EXPOSURE DETERMINATION

The City of Astoria has performed an exposure determination for all common job classifications which may be expected to incur occupational exposures to blood or other potentially infectious materials. This exposure determination is made without regard to use of personal protective equipment (PPE).

The following is a list of job classifications in which some employees may have occupational exposures. Not all of these employees are expected to incur exposure to blood or other potentially infectious material. The job classification, tasks, and procedures are listed below:

Job Classifications	Task Procedure
Category 2-Tasks involve no exposure to blood, body fluids, or tissues but employment tasks may require performing unplanned Category 1 tasks.	
Utility Worker (levels I, II, and Senior,) Utility Technician including senior level, Wastewater Treatment Plant Operator, Assistant Wastewater Treatment Plant Operator.	Contact with sewage potentially containing infectious materials and blood or blood products.
All department classifications-mechanics, servicer, utility workers and technicians,waste water and water classes, administrative and supervisory positions.	Assisting injured persons and/or providing CPR.
	Routine environmental cleaning of materials, surfaces and equipment.

C. COMPLIANCE METHODS

1. Universal Precautions

"Universal precautions" recognizes all body fluids as though they are infected with bloodborne pathogens. This method of infection control requires the employer and employee to assume that **all** human blood and specified human body fluids are infectious for HIV, HBV, and other bloodborne pathogens. Where differentiation of types of body fluids is difficult or impossible, **all** body fluids **are** to be considered as **potentially infectious.**

2. Engineering Controls and Work Practices

Engineering and work practice controls will be used by all employees to eliminate or minimize occupational exposures at this facility. The **engineering controls** are:

a. Use of gloves where blood, blood products, or body fluids may be encountered.

b. Clean surfaces as soon as they become contaminated, or as soon as possible thereafter using household bleach diluted at 1:100 parts water (1/4 cup bleach to one gallon of water). Place potentially infective waste in impervious bags and dispose of them in the garbage (for disposal of sharps, see item 6).

c. Employee training.

d. Prevention of cutting or needle stick injures. Needles shall not be bent or re-capped. Sharp instruments shall be placed in a specially designated puncture-resistent container.

e. Use of mouthpieces and resuscitation bags to minimize exposure to saliva during resuscitation procedure.

f. First Aid kits are kept in all public works vehicles.

The **work practices** are:

a. Hand washing is a major means of infection control. Hands should be washed thoroughly after removing gloves, and immediately after contact with blood or body fluids. Antiseptic towelettes will be provided if no hand washing facilities are available and, if used, employees must wash their hands as soon as feasible.

b. Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure.

c. Eyes and mucous membranes shall be flushed with water immediately after any exposure.

d. Broken glass shall not be cleaned up by picking it up with bare hands. Gloves, tongs, brooms or other protective devices shall be used.

3. **Personal Protective Equipment (PPE)**

The following PPE will be provided at not cost to employees:

a. Body Protection such as full cover-up for working in or with untreated sewage.

b. Gloves for working in or with untreated sewage.

c. Resuscitation devices.

The Public Works Superintendent is assigned the responsibility to ensure that appropriate PPE is available and readily accessible, without cost, to employees. Hypoallergenic glove, glove liners, powderless gloves, or other similar alternatives shall be readily accessible to those employees who are allergic to the gloves normally provided.

All PPE will be removed prior to leaving the work area.

All PPE will be cleaned, laundered, and disposed of by the employer at no cost to the employee.

PPE, when removed, shall be disposed of.

4. Housekeeping

This facility will be cleaned and decontaminated according to the following schedule:

AREA	SCHEDULE	CLEANER
Public Works Shops	Monday-Friday, cleaning tasks vary day to day	As contracted by City, currently with Coast Rehabilitation (effective 7/94).
Counter tops such as in employee lounge and kitchen areas	Daily	Employees using soap and water (environmental disinfection used for any spill of blood or bodily fluid).
Wastewater Treatment Plant surfaces and equipment that may be contaminated with sewage.	Daily	WWTPO Supervisor using environmental disinfectant; 1:10 bleach per water solution.

5. Contaminated Laundry

Contaminated laundry will be laundered on-site. Rinse will contain a bleach solution.

Such contaminated laundry shall be placed in a biohazard red bag and securely tide. If it presents the possibility of soak through, it shall be double-bagged in a leak proof bag. Employees handling such laundry shall wear protective gloves and any other needed personal protective equipment.

6. Regulated Waste

The following procedures will be followed:

Any sharps visible on ground, water, or in garbage shall be placed in a puncture resistent, disposable container, that is labeled and color coded. Such containers shall be taken to Columbia Memorial Hospital for disposal.

In the event of any other unanticipated regulated wastes, the supervisor in charge shall immediately call the Astoria Fire Department for advice and assistance.
Should they be unavailable, the Astoria Police Department should be contacted.

7. **Hepatitis B Vaccine and Post-Exposure Evaluation and Follow-up**

Hepatitis B vaccination

The City of Astoria will offer at no cost to exposed employees the hepatitis B vaccine and vaccination series, within 10 working days after receiving the initial job assignment, and the post exposure follow-up to those who have had an exposure incident.

The Public Works Superintendent is in charge of the Hepatitis B vaccination and is responsible to send all records regarding this to the Human Resources Director for maintenance in a confidential medical file.

The Hepatitis B vaccination series shall be offered to persons in the following job classifications: Utility worker, Utility Technician, Wastewater Treatment Plant Operator, Water Source Operator, Water Technician, Sweeper Operator, and Mechanics.

The vaccination shall be made available after training and within 10 working days of initial assignment unless the employee has previously received the series, is immune, or the vaccine is contraindicated for medical reasons.

The employee may decline the vaccination in writing and later accept it, and it shall be made available.

The Human Resources Director will ensure that all medical evaluations and procedures for the post exposure follow-up, including prophylaxis are:

a. Made available at no charge to the employee at a reasonable place and time.

b. Performed or supervised by a licensed health care professional according to the recommendations of the CDC.

Post Exposure Evaluation and Follow-up

When an employee has an exposure incident, it will be reported to the immediate supervisor, department head and Human Resources Director.

Following a reported exposure incident, the exposed employee will immediately receive a confidential medical evaluation including the following elements:

a. Documentation of the investigation including routes of exposure, activity at time of exposure, extent to which appropriate work practices and protective equipment were used and a description of the source exposure.

b. Identification and documentation of the source individual unless infeasible or prohibited by law.

c. Results of the source individuals testing shall be made available to the employer by a health care professional. The employee shall be notified of applicable laws and regulations concerning the disclosure of such information by same professional.

d. An exposed employee's blood shall be collected as soon as feasible and when consent is given. If the employee consents to baseline blood collection but not to HIV serologic testing such blood will be preserved for 90 days. If within 90 days the employee elects to have the test, it will be done as soon as feasible.

e. For exposure to a source individual found to be positive for Hepatitis B, a single dose of Hepatitis B immune globulin will be given within seven days.

f. If exposed on the job, a workers compensation 801 form will be completed.

g. Counseling and medical evaluation will be provided by the employee.

All employees who incur an exposure incident will be offered post exposure evaluation and follow-up in accordance with the standard. All post exposure follow-ups will be performed by Clatsop County Health Department.

Information Provided to the Health care Professional

The Human Resources Director will ensure that the health care professional responsible for the employee's after exposure evaluation is provided the following:

a. Copy of bloodborne pathogens regulations.

b. A description of the exposed employee's duties as related to the exposure incident.

c. Results of incident investigation including routes of exposure.

d. Results of the source individual's blood testing if available.

e. Medical records relevant to the appropriate treatment of the employee.

Health Care Professional's Written Opinion

The Human Resources Director will obtain and provide the employee with a copy of the evaluating health care professional's written opinion within 15 days of the completion of the evaluation.

The health care professional's written opinion for HBV vaccination will be limited to whether HBV is indicated for an employee, and if the employee has received such vaccination.

The health care professional's written opinion for post exposure follow-up will be limited to the following information:

a. That the employee has been informed of the results of the evaluation.

b. That the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

8. Labels and Signs

The Public Works Superintendent will ensure biohazard labels are on each container of regulated waste.

9. Information and Training

The Public Works Superintendent and appropriate department head will ensure that training is provided at the time of initial assignment to tasks where occupational exposure may occur, and that it shall be repeated with 12 months of the previous training. The training program will be tailored to the education and language level of the employee, and offered during the normal work shift. The training will contain the following information:

1. An accessible copy of the bloodborne standard and an explanation of its contents.

2. A general explanation of the epidemiology and symptoms of bloodborne diseases.

3. An explanation of the modes of transmission of bloodborne pathogens.

4. An explanation of the employer's exposure control plan and the means by which the employee can obtain a copy of the written plan.

5. An explanation of the appropriate methods of recognizing tasks and other activities that may involve exposure to blood or other potentially infectious materials.

6. An explanation on the use and imitation of methods that will prevent or reduce exposure including appropriate engineering controls, work practices, and personal protective equipment.

7. Information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment.

8. An explanation of the basis for selection of personal protective equipment.

9. Information on the Hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge.

10. Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.

11. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and medical follow-up that will be made available.

12. Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident.

13. An explanation of the signs and labels and/or color coding.

14. An opportunity for interactive questions and answers with the training instructor.

Additional training will be given to employees when there are any changes of tasks or procedures affecting the employee's occupational exposure.

10. Recordkeeping

The Human Resources Director is responsible for maintaining the following records for exposure incidents. These records will be kept in a confidential medical employee file in Human Resources.

The record shall contain:

a. Name and social security number of employee.

b. Any pertinent Hepatitis B information, such as vaccination dates.

c. A copy of all medical tests, examinations, and follow-up procedures as required by OAR 437-02-1910.1030 (f)(3).

d. The employee's copy of the health care professional's opinion as required by the above statute paragraph (f)(5); and

e. A copy of the information provided to the health care professional as required by the above statute, paragraphs (f)(4)(ii)(B)(C) and (D).

The records shall not be disclosed without the employee's written consent except as required by law.

The records shall be maintained for length of employment plus 30 years in accordance with 29 CFR 1910.20.

11. Training Records

The Public Works Director or designee is responsible for maintaining the following records. These records will be kept in the Public Works Department in City Hall.

Training records shall include the following information:

a. Dates of training sessions.

b. Contents or summary of training sessions.

c. Names and qualifications of persons conducting the training; and

d. Names and job titles of all persons attending the sessions.

Training shall be maintained at least three years from the date held.

All employee records will be made available to the employee.

D. EVALUATION AND REVIEW

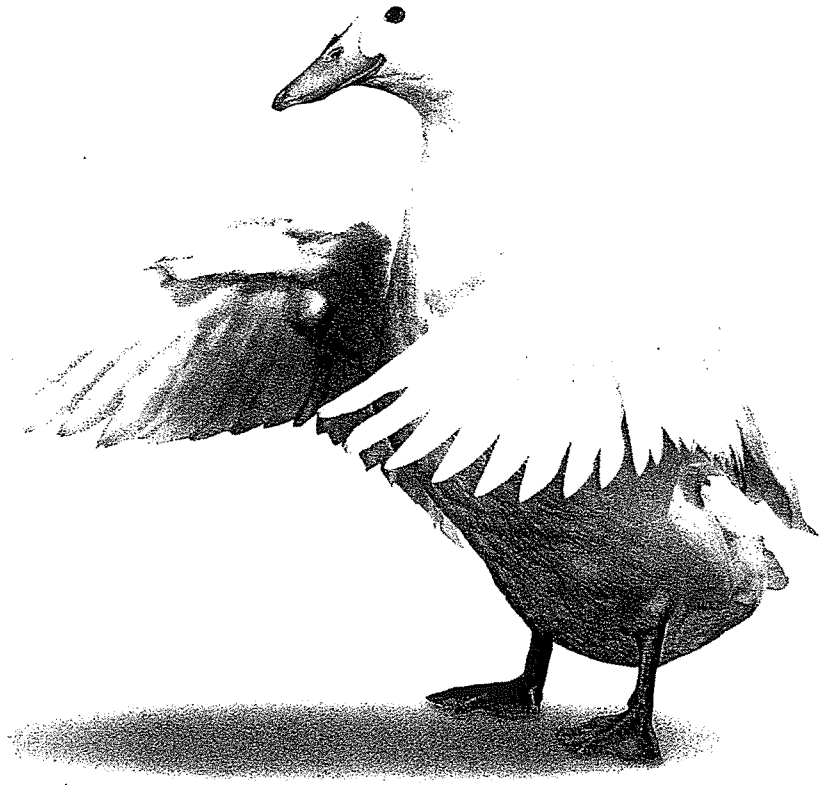
The Public Works Director is responsible for annually reviewing this program, and its effectiveness, and for updating as needed.

Adopted this August 23, day of 1993, by Public Works.

Reviewed (2/7/95)	Reviewed_____
Reviewed (8/97)	Reviewed_____
Reviewed_____	Reviewed_____

We've got you *and* your employees covered.

David Reid
100 39th St., Suite 206
Astoria, OR 97103
(503) 338-2909



PRODUCT OVERVIEW

I

Aflac®

We've got you under our wing.®

AFLAC HELPS YOU

YOUR EMPLOYEES

PROTECT YOUR EMPLOYEES' INCOME

Like most people today, your employees rely heavily on their paychecks. So, what happens if they get sick or hurt and have to be out of work for an extended period—without a regular income?

By offering individual insurance policies from Aflac, you'll be helping employees get cash benefits—that can be used to help cover rent, groceries, and other daily living expenses—if they're out of work.

And the best part is you can offer your employees these benefits with no direct cost to you or your company.

INDIVIDUAL PRODUCTS

- Short-Term Disability
- Life

$9,788

The average hospital expense, adjusted per inpatient stay.[1]

SUPPLEMENT YOUR MAJOR MEDICAL PLAN

You may already offer major medical insurance to your employees. But in the event of an illness or injury, there may be out-of-pocket medical expenses that aren't covered by your major medical coverage. Our insurance policies are designed to help with those too.

Which means your employees can use those cash benefits to help with unexpected medical expenses and daily living expenses.

INDIVIDUAL PRODUCTS

- Hospital Confinement Indemnity
- Hospital Confinement Sickness Indemnity
- Dental
- Vision

39.4 million

The number of visits to hospital emergency departments due to injuries in 2007.[2]

HELP YOUR EMPLOYEES HOLD ON TO WHAT'S THEIRS

If one of your employees has a serious accident or illness, that family's finances could be impacted. Medical expenses can quickly eat into savings. Individual insurance policies from Aflac let employees protect what they've worked hard for with cash benefits to help cover the costs of everyday life.

INDIVIDUAL PRODUCTS

- Accident
- Cancer/Specified-Disease
- Critical Illness
- Specified Health Event

1-in-2

The lifetime risk of U.S. men for developing cancer.

For women the risk is a little more than one-in-three.[3]

INDIVIDUAL POLICIES HIGHLIGHTS

SHORT-TERM DISABILITY

Policy Series A57600

In the case of illness or injury, it helps your employees maintain their standard of living and helps them pay bills.

- Selection of:
  - Monthly benefit amount
  - Elimination period
  - Benefit period
- Guaranteed-renewable to age 75
- Benefits paid directly to your employees, unless they choose otherwise
- Benefits paid regardless of any other insurance

LIFE

Policy Series A64000

Provides term or whole life insurance.

- Can provide up to $250,000 of whole life insurance or term life insurance
- Waiver of Premium Benefit
- Accelerated Death Payment
- Optional Spouse and Child Term Life Insurance Riders
- Optional Accidental-Death Benefit Rider

HOSPITAL CONFINEMENT INDEMNITY

Policy Series A46000

Helps with the noncovered expenses of a hospital stay.

- Annual Hospitalization Confinement Benefit
- Daily Hospital Confinement Benefit
- Surgical Benefit
- Rehabilitation Unit Benefit
- Invasive Diagnostic Exams Benefit

HOSPITAL CONFINEMENT SICKNESS INDEMNITY

Policy Series A-45000

Provides a physician feature that helps cover sickness, accident, and wellness visits in addition to the plan's basic sickness-only benefits.

- Physician Visits Benefit
- Initial Hospitalization Benefit
- Major Diagnostic Exams Benefit
- Surgical Benefit
- Hospital Confinement Benefit

DENTAL

Policy Series A82000

A portable, no-deductible plan that offers freedom of choice and no coordination of benefits.

- No network restrictions
- Portable
- Guaranteed-renewable
- Pays regardless of any other insurance your employees have
- No deductible
- Easy to understand

VISION

Policy Series VSN100

Helps defray the cost of regular eye exams and treatment of eye diseases.

- Eye Examination Benefit
- Vision Correction Benefit
- Specific Eye Diseases/Disorders Benefit
- Eye Surgery Benefit
- No network restrictions

HOSPITAL INTENSIVE CARE

Policy Series A18400

Helps cover expenses related to confinement in a hospital intensive care unit (ICU).

- Daily Hospital Intensive Care Unit Confinement Benefit
- Daily Step-Down Intensive Care Unit Confinement Benefit
- Ambulance Benefit
- Major Human Organ Transplant Benefit

ACCIDENT

Policy Series A35000

Helps provide a financial cushion if an accident occurs.

- Emergency Treatment Benefit
- Specific-Sum Injuries Benefit
- Accidental-Death Benefit
- Initial Hospitalization Benefit
- Hospital Confinement Benefit

CANCER/SPECIFIED-DISEASE

Policy Series A78000

Helps with medical expenses related to cancer treatment.

- Initial Diagnosis Benefit
- Hospital Confinement Benefit
- Radiation and Chemotherapy Benefits
- Surgical/Anesthesia Benefit
- Ambulance, Transportation, and Lodging Benefits
- Cancer Wellness Benefit

LUMP SUM CRITICAL ILLNESS

Policy Series A72000

Provides a single cash benefit to your employees if they're diagnosed or treated for critical illness events.

- Pays a lump sum benefit up to $30,000 for a critical illness event: heart attack, stroke, coma, paralysis, major human organ transplant, end-stage renal failure
- Pays a benefit for a recurrence of the same critical illness event or an occurrence of a different critical illness event with no lifetime maximum

CRITICAL CARE AND RECOVERY (SPECIFIED HEALTH EVENT)

Policy Series A71000

Helps with the medical expenses related to a covered serious health event.

- Pays a First-Occurrence Benefit, as well as Hospital Confinement and Continuing Care Benefits for heart attack, stroke, sudden cardiac arrest, coronary artery bypass surgery, end-stage renal failure, major human organ transplant, major third-degree burns, coma, paralysis

This is a brief policy overview only. Policies may not be available in all states. Benefits and coverage are determined by state and plan level selected. Please see your Aflac insurance agent for policy benefits, limitations, and exclusions.

We've got you under our wing.®

aflac.com/business | **1.800.99.AFLAC** (1.800.992.3522)

Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999

Individual coverage underwritten and offered by:
American Family Life Assurance Company of Columbus
In New York, individual coverage is underwritten and offered by American Family Life Assurance Company of New York.

[1]Hospital Statistics® 2010 Edition, Health Forum LLC, an affiliate of the American Hospital Association.
[2]*Injury Facts*, 2011 Edition, National Safety Council.
[3]*Cancer Facts & Figures 2012*, American Cancer Society.

Employee Assistance Program

The EAP provides services to help people privately resolve problems that may interfere with work, family, and life.

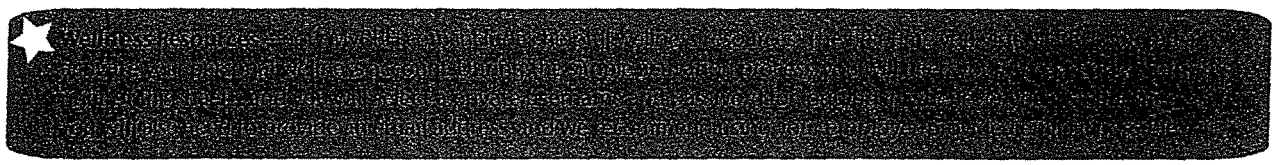
The EAP is provided for **FREE** (no out of pocket cost), and confidential services cover employees and their dependents, living at or away from home, and all household members, related or not.

Counseling

- **Confidential Counseling** - up to **5** face-to-face counseling sessions for each new issue, including family, relationship, stress, anxiety, and other common challenges.
- **24-hour Crisis Help** - toll-free access for you or a family member experiencing a crisis.
- **RBH *eAccess*™** - convenient access to on-line consultations with licensed counselors.

Life Balance

- **Legal Services** – a free, half-hour consultation, by phone or in person, followed with a 25% discount in legal fees. *Legal services are not provided for any employer related issues.*
- **Will Preparation** – a free, simple kit for member completion, returned for review by a legal professional.
- **Mediation Services** – free consultations for personal, family, and non-work related issues such as divorce, neighbor disputes, or real estate. A discount of 25% is available if a professional mediator is retained.
- **Financial Services** – free telephone consultations for financial issues such as debt counseling, budgeting, and college or retirement planning. A discount of 25% is available if a CPA is retained.
- **Home Ownership Program** – free support and information about making smarter choices when shopping for a new home; making financing and/or refinancing decisions; relocating; or selling a home.
- **Identity Theft Services** – support in planning the recovery process for restoring your identity and credit after an incident.
- **Personal Advantage** – a life balance website with current articles on health conditions, tools for parenting, health assessments, health-topic movies, and other interactive tools including access to more than 50 on-line trainings.
- **Worksite Services** – telephonic supervisor consultations, on-site orientations, topical trainings, critical incident response, and on-line supervisor resources.



RBH
the road to better health

1-866-750-1327

www.MyRBH.com
Access Code:
oregon

CITY OF ASTORIA
PERSONNEL RULES

Any action which is a hindrance to the effective performance of City functions or reflects discredit upon the City will be considered just cause for disciplinary action. By way of illustration and **not limitation**, the following list provides examples of just cause for disciplinary actions:

1. Buying, selling, consuming, distributing or possessing drugs or alcohol while on City property, in City vehicles or equipment **or** during working hours, including rest and meal periods.

2. Reporting for work or being at work under the influence of alcohol or drugs.

   An employee is considered "under the influence" of alcohol if his/her alcohol concentration is .02 or greater by weight of alcohol in the breath or by volume of breath expressed in terms of grams of alcohol per 210 liters of breath on an evidential breath test. An employee is considered "under the influence" of drugs (excluding lawfully prescribed substances which are being used in a manner consistent with a physician's instructions) if the employee tests positive for having such substances present in his/her body.

   "Drugs" refers to the following five substances: opiates, cocaine, marijuana (THC), phencyclidine (PCP) and amphetamines.

3. Insubordination, including intentional failure or refusal to follow supervisory directives.

4. Violation of the provisions of City rules or any rules, regulations and policies prescribed by the City or department head.

5. Being absent from work without permission.

6. Unsatisfactory attendance, including unauthorized or excessive absenteeism or tardiness, failure to notify your supervisor of intended absence or tardiness or to comply with other reporting policies.

7. Abuse of sick leave (using sick leave for unauthorized purposes).

8. Careless, inaccurate, unreliable or otherwise unsatisfactory work performance or productivity.

9. Abusive language or conduct toward the public or fellow employee or other conduct unbecoming a City employee.

10. Being wasteful of material, property or working time.

11. Conducting a private business or excessive personal activities on City time.

12. Failure or inability to get along with employees that interferes with work performance, productivity or cooperative working relationships.

13. Being convicted or pleading guilty to a crime which brings discredit to the City or hinders the employee's ability to successfully perform their job.

14. Using religion or political or family influence to obtain favorable employment terms or conditions.

15. Non-compliance or disregard of established safety policies or failure to promptly report injuries, accidents, and unsafe conditions.

16. Theft or unauthorized removal of City property.

17. Release of confidential information regarding the City or City business.

18. Falsification or material omission of facts of forms, records, or reports including time cards, and other, employment-related records.

19. Engaging in a violation of City's equal employment opportunity policy or policy prohibiting sexual, racial, religious and other forms of harassment.

20. Unauthorized possession of firearms, weapons, explosives or other hazardous devices on City property, including parking lots or in City vehicles or equipment.

21. Threatening another employee, provoking or instigating fights or fighting during work time or on City property or engaging in horseplay that results in injury or property damage.

22. Sleeping on the job.

23. Gambling on City property or during work time.

24. Using City property, vehicles, equipment or facilities for personal use or financial gain.

25. Destroying or damaging City property, tools, vehicles or equipment.

26. Engaging in other conduct which is serious enough to justify discharge or other disciplinary action.

I have read and understand the above

Printed Name	Signature	Date