



ASTORIA PUBLIC SAFETY ASSOCIATION



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		
<i>File the following completed forms in Confidential or Benefits file</i>		
Medical Plan (BC/BS, Kaiser etc.)		
Vision Plan (BC/BS, Kaiser etc.)		
Dental Plan (BC/BS, MODA, Kaiser etc.)		
HSA/MSAVEBA 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

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: _____
 - Employee
 - Employee Spouse
 - Employee Child
 - Employee Children
 - Employee Family

CITY OF ASTORIA
Astoria Public Service Association (Police and Dispatch)
2017

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 – HDHP-2 w/HSA with Alternate Care Rider City pays 90%	Probationary & full time	1st after date of hire	Employee Only 45.18 EMP + Child 84.77 EMP + Spouse 96.63 EMP + Children 115.55 EMP + Family 132.90
Vision Service Plan VSP-3 (24/24/24) City pays 90%	Probationary & full time	1st after date of hire	Employee Only .84 EMP + Child 1.06 EMP + Spouse 1.20 EMP + Children 1.88 EMP + Family 2.16
Dental Plan -Delta Dental CIS – Dental II Plan City pays 90%	Probationary & full time	1st after date of hire	Employee Only 5.21 EMP + Child 8.01 EMP + Spouse 9.10 EMP + Children 13.76 EMP + Family 15.81
HSA Contribution	Probationary & full time	1st of month following date of employment. Contributions are made to HSA accounts the first week of January and the first week of July	Family \$ 4,000 Individual \$ 2,500 Accounts are funded on a prorated contribution at the 1 st pay period following hire date.
Basic Life Insurance City pays 100%	Probationary & full time	1st after date of hire	Hartford Insurance \$ 50,000 employee \$ 10,000 spouse \$ 10,000 qualified dependent
Accidental Death & Dismemberment (AD&D) City pays 100%	Probationary & full time	1st after date of hire	Hartford Insurance \$ 50,000 employee
Long Term Disability City pays 100%	Probationary & full time	1st after date of hire	66 2/3% of salary, 90 day wait, \$ 4,500 maximum benefit per month
Short Term Disability Employee pays 100%	Probationary & full time	1st after date of hire	Hartford Insurance Various benefit levels available/rates dependent upon age and level of benefit

BENEFIT	ELIGIBILITY	EFFECTIVE	DESCRIPTION
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/Incentive Pay	Full time	Based on length of service (stability) or certifications (incentive). Employee is eligible for either stability or incentive, but not both.	Employees eligible for Intermediate and Advanced Certification with 10 continuous years of regular employment shall receive 2% stability pay at their 10 th anniversary and each month thereafter, to be calculated at Step E of pay range. This stability pay may be used in conjunction with the incentive pay system. Employees not eligible for the Intermediate and Advanced Certification will receive stability as follows: 5 – 10 years = 2.0% 10 – 15 years = 3.5% 15 – 20 years = 4.5% > 20 years = 6.0% Stability pay is based on Step A of an employee's range.
Holidays	Probationary & full time	Immediately	10.5 holidays per year
Vacation	Probationary & full time	Accrue immediately; can use after 90 days continuous employment	0- 5 years 8.00 hrs/mo 6-10 years 10.00 hrs/mo 11-15 years 11.34 hrs/mo 16-20 years 13.34 hrs/mo > 20 years 16.67 hrs/mo < 10 yrs of Svc Maximum accrual is 280 hours > 10 yrs of Svc Maximum Accrual is 320 hours
Vacation Cash Out	Used 80 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 40 hrs within specific criteria
Personal Leave	Probationary & full time	Immediately	10 hours per fiscal year, not accrued, for specified personal business reasons

BENEFIT	ELIGIBILITY	EFFECTIVE	DESCRIPTION
Sick Leave	Probationary & full time	Immediately	8 hours accrue per month Maximum of 2080 hours May be used for immediate family illness
Sick Leave at Retirement Police Officers ONLY	Full time	At Retirement	All unused sick leave, up to 1640 hours, reported to PERS.
Sick Leave at Retirement (All others)	Full time	After 10 years of service	At retirement employee may convert 1/2 of up to 800 hours accumulated unused sick leave to cash subject to appropriate tax withholdings; maximum cash-out is 400 hours.
Deferred Compensation	Regular employees	1 st of month following six months of service	Employee option to reduce taxable wages by contributing to a tax deferred retirement plan. There are three 457 deferred plans available.
Aquatic Center Pass	Probationary & full time	Immediately	An individual Land and Water Pass for personal use is available for bargaining unit members to enhance Physical Fitness
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

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 **F** _____
 (Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

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	<h2 style="margin:0;">Employee's Withholding Allowance Certificate</h2> <p style="margin:0;">► 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.</p>	OMB No. 1545-0074 <h1 style="margin:0;">2016</h1>
1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> 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. ► <input type="checkbox"/>
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: $\left\{ \begin{array}{l} \$12,600 \text{ if married filing jointly or qualifying widow(er)} \\ \$9,300 \text{ if head of household} \\ \$6,300 \text{ if single or married filing separately} \end{array} \right\}$ 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

Table 2

Married Filing Jointly		All Others		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	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 - \$6,000	0	\$0 - \$9,000	0	\$0 - \$75,000	\$610	\$0 - \$38,000	\$610
6,001 - 14,000	1	9,001 - 17,000	1	75,001 - 135,000	1,010	38,001 - 85,000	1,010
14,001 - 25,000	2	17,001 - 26,000	2	135,001 - 205,000	1,130	85,001 - 185,000	1,130
25,001 - 27,000	3	26,001 - 34,000	3	205,001 - 360,000	1,340	185,001 - 400,000	1,340
27,001 - 35,000	4	34,001 - 44,000	4	360,001 - 405,000	1,420	400,001 and over	1,600
35,001 - 44,000	5	44,001 - 75,000	5	405,001 and over	1,600		
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						

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.



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):

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 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. <i>(See instructions)</i>	
<p><i>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.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	
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
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)
Document Title		<div style="border: 1px solid black; padding: 5px;">Additional Information</div>		<div style="border: 1px solid black; padding: 5px; text-align: center;"> QR Code - Sections 2 & 3 Do Not Write In This Space </div>
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

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	LIST B Documents that Establish Identity	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (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. 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 	<p style="text-align: center;">OR</p> <ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <p style="text-align: center;">For persons under age 18 who are unable to present a document listed above:</p> <ol style="list-style-type: none"> 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	<p style="text-align: center;">AND</p> <ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of Birth Abroad issued by the Department of State (Form FS-545) 3. Certification of Report of Birth issued by the Department of State (Form DS-1350) 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. Native American tribal document 6. U.S. Citizen ID Card (Form I-197) 7. Identification Card for Use of Resident Citizen in the United States (Form I-179) 8. Employment authorization document issued by the Department of Homeland Security

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

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

**Direct Deposit
Authorization**

Account #1

Attach VOIDED Check Here

Account #2

Attach VOIDED Check Here



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: _____

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

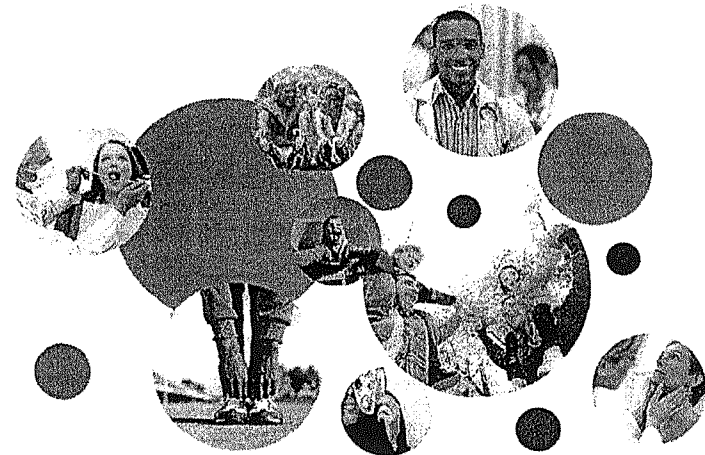
Life and disability insurance is not subject to COBRA. If you were covered under your employer's life and/or disability plan, or you elected supplemental life insurance, you may have the option to continue this coverage on a self-pay basis with the life insurance carrier. If you are interested in continuing 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 ¹	Documentation
<i>Enroll self</i>	<i>No changes allowed</i>	<i>Increase healthcare due to loss of other coverage</i>	<i>Documentation showing date of loss of other coverage and name of covered individual(s)</i>

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 ¹	Documentation
<i>Enroll dependent(s) who lost coverage</i>	<i>No changes allowed</i>	<i>Increase healthcare due to loss of other coverage</i>	<i>Documentation showing date of loss of other coverage and name of covered individual(s)</i>

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 ¹	Documentation
<i>Drop dependent</i>	<i>Decrease coverage for self; supplemental spouse life and/or dependent life is terminated</i>	<i>Enroll/increase/decrease healthcare election (cannot decrease if annual election has been reimbursed)</i>	<i>No documentation is required</i>

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 ¹	Documentation
<i>No changes allowed</i>	<i>No changes allowed</i>	<i>Increase/decrease dependent care due to cost change</i>	<i>Completed FSA Enrollment Change form</i>

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

²Effective 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 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
<i>Enroll child, self and eligible dependent(s) in coverage</i>	<i>Enroll or increase coverage (subject to medical underwriting); enroll in supplemental spouse or dependent life</i>	<i>Enroll/increase healthcare election</i>	<i>Copy of adoption papers</i>

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
<i>Enroll child</i>	<i>No changes allowed</i>	<i>Enroll/increase healthcare election</i>	<i>Copy of court order</i>

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

²Effective 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
<i>Enroll child</i>	<i>No changes allowed</i>	<i>No changes allowed</i>	<i>Copy of QMCSO</i>

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 ²	Documentation
<i>Enroll spouse, self and eligible dependent(s) in coverage</i>	<i>Increase coverage for self (subject to medical underwriting); enroll spouse in supplemental spouse life and/or dependent life</i>	<i>Enroll/increase healthcare election</i>	<i>Copy of marriage certificate/license</i>

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
<i>Enroll domestic partner, self and eligible dependent(s) in coverage</i>	<i>Increase coverage for self (subject to medical underwriting); enroll domestic partner in supplemental spouse life and/or dependent life</i>	<i>No changes allowed; medical expenses for domestic partners are not typically eligible for reimbursement</i>	<i>Oregon Certificate of Registered Domestic Partnership or a signed CIS Affidavit of Domestic Partnership*</i>

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 ¹	Documentation
<i>Drop spouse and step-child(ren)</i>	<i>Decrease coverage for self; supplemental spouse life and/or dependent life is terminated</i>	<i>Enroll/increase healthcare election due to loss of coverage; decrease election (cannot decrease if annual election has been reimbursed)</i>	<i>Copy of divorce decree (first page and last page) or other documentation showing date of divorce and judge's signature</i>

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

²Effective the first of the month following the date the PSA 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
<i>Drop domestic partner and child(ren) of domestic partner</i>	<i>Decrease coverage for self; supplemental spouse life and/or dependent life is terminated</i>	<i>Enroll/increase healthcare election due to loss of coverage; decrease election (cannot decrease if annual election has been reimbursed)</i>	<i>Copy of dissolution if Registered; CIS Termination of Domestic Partnership form</i>

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
<i>Drop self</i>	<i>No changes allowed</i>	<i>Decrease healthcare if other coverage is gained</i>	<i>Documentation showing effective date of other coverage and name of covered individual(s)</i>

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
<i>Drop dependent(s) who gained coverage</i>	<i>No changes allowed</i>	<i>Decrease healthcare if other coverage is gained</i>	<i>Documentation showing effective date of other coverage and name of covered individual(s)</i>


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

²Effective the first of the month following the date the PSA Enrollment Form is signed.



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**

Login ID:

Password:

- > Forgot your password?
- > Self registration
- > Forgot login id?

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



Self Registration - Step 1

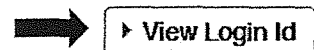
Please answer the following questions to register the user.

Question 1: SSN
Answer:

Question 2: Date of birth (mm/dd/yyyy)
Answer:

Question 3: ZIP Code (99999 or 99999-9999)
Answer:

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**.



Login Id: DSMITH13

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

Personal Info

- > My Benefits
- > Personal Profile

I want to:

- Enroll/Make Changes**
- > View Pending Changes
- > See Who is Covered Under My Plan
- > View/Change Beneficiaries
- > See Correspondence

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**.

- 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**.


<input checked="" type="checkbox"/> Supplemental Employee Life				
	Option	Employee Pay Period Cost	Amount Inforce	Election Amount
	<input checked="" type="radio"/> Amount	\$27.20	\$200,000.00	<input type="text" value="\$200,000.00"/>
	<input type="radio"/> Waive	\$0.00		

<input checked="" type="checkbox"/> Supplemental Spouse Life				
	Option	Employee Pay Period Cost	Amount Inforce	Election Amount
	<input checked="" type="radio"/> Amount	\$42.60	\$200,000.00	<input type="text" value="\$200,000.00"/>
	<input type="radio"/> Waive	\$0.00		

- If supplemental employee life is elected, assign your beneficiaries and click **Continue**.
- 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).*

<input checked="" type="checkbox"/> Healthcare FSA				
	Option	Employee Pay Period Cost	Employee Pay Period Elected	Employee Annual Cost
	<input checked="" type="radio"/> Amount	\$75.00	<input type="text" value="\$75.00"/>	\$900.00
	<input type="radio"/> Waive	\$0.00		\$0.00

<input checked="" type="checkbox"/> Dependent Care FSA				
	Option	Employee Pay Period Cost	Employee Pay Period Elected	Employee Annual Cost
	<input type="radio"/> Amount	\$0.00	<input type="text" value="\$0.00"/>	\$0.00
	<input checked="" type="radio"/> 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.*

Benefits to do list

[Upload Required Documentation](#)

Supporting documentation is needed to finalize the New Enrollment you reported.

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".

Personal Info

- › My Benefits
- › Personal Profile
- I want to:
 - › [Enroll/Make Changes](#)
 - › [View Pending Changes](#)
 - › See Who Is Covered Under

2. Click on the [Upload Required Documentation](#) link in the "Benefits to do list" box.

Benefits to do list

[Upload Required Documentation](#)

Supporting documentation is needed to finalize the New Enrollment you reported.

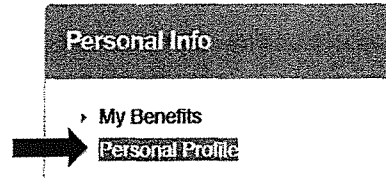
3. Click **Continue** on Personal Information Page.
4. Click on the link in the Required Documentation column on the Dependent Information page.
5. Click **Browse** and select document. Click **Open**. Then click **Upload**.
6. You will be required to view all benefits elections again. Click **Continue**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

Required Document

[Domestic Partner Certificate](#)

SECTION 6: CHANGE ADDRESS, EMAIL & PHONE NUMBER

1. Click on **Personal Profile** under “Personal Info” box.



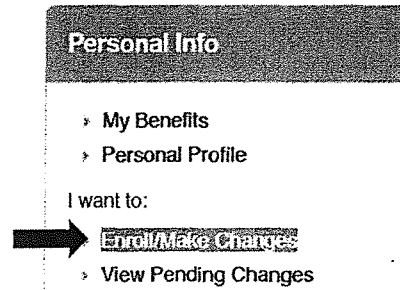
2. Under Contact Information click on appropriate tab.
3. Click **Update**. Enter information and click **Save**.

Contact Information



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.

CIS - HDHP – 2 HSA with Alternative Care

\$2,500/\$4,000 Single/Family Deductible

80/80/60% 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	\$2,500 Individual/\$4,000 Family
Out-of-Pocket maximum ^{**}(Includes Deductible)	\$3,300 Individual/\$6,050 Family
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 one or more Family Members' Deductibles and Coinsurance for Covered Services for that Calendar Year total and meet the Family's 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%
Outpatient Laboratory and Radiology Services	20%	20%	40%
Professional Services <ul style="list-style-type: none"> ▪ Surgery, inpatient visits, diagnostic procedures and therapeutic injections 	20%	20%	40%
Alternative Care <ul style="list-style-type: none"> ▪ Spinal manipulations and Acupuncture – Subject to deductible and coinsurance; limited to \$1,000 per year 	20%	20%	40%
Ambulance Services	20%	20%	20%
Durable Medical Equipment	20%	20%	40%
Emergency Room (Including Professional Charges) <ul style="list-style-type: none"> ▪ Coinsurance will be applied to the Out-of-Pocket Maximum. 	20%	20%	20%
Hospital Care <ul style="list-style-type: none"> ▪ Inpatient, Outpatient and Ambulatory Service Facility 	20%	20%	40%
Maternity Care	20%	20%	40%
Mental Health/Chemical Dependency Services - Inpatient, Residential and Outpatient	20%	20%	40%
Rehabilitation Services <ul style="list-style-type: none"> ▪ Inpatient: Unlimited per calendar year ▪ Outpatient: 77 visit limit per calendar year 	20%	20%	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 & Mail Order: 90-day supply		20%	
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 - HDHP-2 HSA 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 <u>deductible</u> ?	\$2,500 single / \$4,000 family per calendar year. Doesn't apply to in-network preventive care. Amounts in excess of the <u>allowed amount</u> do not count toward the <u>deductible</u> .	Single: You must pay all the costs up to the single <u>deductible</u> amount before this plan begins to pay for covered services you use. Family: Claimants collectively must pay all the costs up to the family <u>deductible</u> amount before this plan begins to pay for any claimant's covered services. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$3,300 single / \$6,050 family per calendar year.	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	<u>Premiums</u> , balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Does this plan use a <u>network of providers</u> ?	Yes. See www.regence.com or call 1 (888) 370-6159 for lists of <u>preferred</u> or participating <u>providers</u> .	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a <u>specialist</u> .	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1 (888) 370-6159 or visit us at www.regence.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary.

You can view the Glossary at www.cciio.cms.gov or call 1 (888) 370-6159 to request a copy.

Claims Administrator: Regence BlueCross BlueShield of Oregon

M-191



- **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% coinsurance	20% coinsurance	40% coinsurance	_____none_____
	Specialist visit	20% coinsurance	20% coinsurance	40% coinsurance	
	Other practitioner office visit	20% coinsurance for alternative care – acupuncture and spinal manipulations	20% coinsurance for alternative care – acupuncture and spinal manipulations	40% coinsurance for alternative care – acupuncture and spinal manipulations	Coverage is limited to \$1,000 for all alternative care combined per claimant / year.
	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)	20% coinsurance	20% coinsurance	40% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information	Generic drugs	20% coinsurance / retail and mail order prescription			Coverage is limited to a 90-day supply from either a retail or mail order supplier. Coverage is limited to a 34-day supply for specialty drugs (includes specialty self-injectable medications) and 90-day supply for self-
	Preferred brand drugs	20% coinsurance / retail and mail order prescription			
	Non-preferred brand drugs	20% coinsurance / retail and mail order prescription			

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
about <u>prescription drug coverage</u> is available at www.regence.com .	Specialty drugs	Refer to generic, preferred brand and non-preferred brand drugs above, for specialty drugs or self-administrable cancer chemotherapy drug coverage.			<p>injectable medications from either retail or mail order supplier.</p> <p>No charge for certain preventive drugs, women's contraceptives and immunizations at a participating pharmacy.</p> <p>Deductible waived for generic and preferred brand drugs designated as preventive for treatment of chronic diseases that are on the Optimum Value Medication List.</p> <p>You are responsible for the difference in cost between a dispensed brand-name drug and the equivalent generic drug, in addition to the coinsurance, unless your provider specifies "dispense as written."</p> <p>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.</p>
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	40% coinsurance	_____none_____
	Physician/surgeon fees	20% coinsurance	20% coinsurance	40% coinsurance	_____none_____
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	20% coinsurance	_____none_____
	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	20% coinsurance	40% coinsurance	_____none_____
	Physician/surgeon fee	20% coinsurance	20% coinsurance	40% coinsurance	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	20% coinsurance	40% coinsurance	_____none_____
	Mental/Behavioral health inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	
	Substance use disorder outpatient services	20% coinsurance	20% coinsurance	40% coinsurance	
	Substance use disorder inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	20% coinsurance	40% coinsurance	_____none_____
	Delivery and all inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	40% coinsurance	Coverage is limited to 130 visits / year.
	Rehabilitation services	20% coinsurance	20% coinsurance	40% coinsurance	Coverage is limited to 77 outpatient visits for all rehabilitation and habilitation services, including neurodevelopmental services / year.
	Habilitation services	20% coinsurance	20% coinsurance	40% coinsurance	Coverage for neurodevelopmental therapy is limited to services for claimants through age 17.
	Skilled nursing care	20% coinsurance	20% coinsurance	40% coinsurance	Coverage is limited to 120 inpatient days / year.
	Durable medical equipment	20% coinsurance	20% coinsurance	40% coinsurance	_____none_____
	Hospice service	20% coinsurance	20% coinsurance	40% coinsurance	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: \$3,930
- Patient pays: \$3,610

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	\$2,500
Copays	\$0
Coinsurance	\$960
Limits or exclusions	\$150
Total	\$3,610

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays: \$2,300
- Patient pays: \$3,100

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	\$2,500
Copays	\$0
Coinsurance	\$560
Limits or exclusions	\$40
Total	\$3,100

"Patient pays" amounts in this coverage example are based on Individual coverage. Different amounts may apply in Family coverage. Consult your plan documents for more information about your cost-sharing.

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.

Questions: Call 1 (888) 370-6159 or visit us at www.regence.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary.

You can view the Glossary at www.cciio.cms.gov or call 1 (888) 370-6159 to request a copy.

Claims Administrator: Regence BlueCross BlueShield of Oregon

8 of 8
M-191



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 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



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. →

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

**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.

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



cis benefits
www.cisbenefits.org



Your Vision Benefits Summary



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! 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®	<ul style="list-style-type: none"> • Focuses on your eyes and overall wellness • Every other calendar year - Adults • Every calendar year - Children 	\$0	
Prescription Glasses			
Frame	<ul style="list-style-type: none"> • \$120 allowance on a wide selection of frames • 20% savings on the amount over your allowance • Every other calendar year 	\$0	
Lenses	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Average savings of 35% - 40% on lens enhancements 		
Contacts (instead of glasses)	<ul style="list-style-type: none"> • \$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	<p>Glasses and Sunglasses</p> <ul style="list-style-type: none"> • 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 <p>Laser Vision Correction</p> <ul style="list-style-type: none"> • 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			
<p>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.</p>			
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		
<p><small>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.</small></p>			

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



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.

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.

BAUSCH + LOMB
See better. Live better.

CareCredit
Making care possible...today.



CooperVision[®]

EXTRA \$20
TO SPEND

eyeconic
.com

EyePromise

Flexon
COLLECTION



NVISION
EYE CENTERS

sunsync[®]

T L C[®]
Laser Eye Centers

Transitions

TruHearing

UNITY
See the moment.



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 - <u>Examination/X-rays</u> - <u>Prophylaxis</u> - <u>Fissure Sealants</u>	** 1st year - 70% 2nd year - 80% 3rd year - 90% 4th year - 100%
CLASS II - BASIC - <u>Restorative Dentistry</u> (treatment of tooth decay with amalgam or composite) - <u>Oral Surgery</u> (surgical extractions & certain minor surgical procedures) - <u>Endodontic</u> (pulp therapy & root canal filling) - <u>Periodontics</u> (treatment of tissues supporting the teeth) - <u>Space Maintainers</u> - <u>Repair or reline of dentures and bridges</u>	** 1st year - 70% 2nd year - 80% 3rd year - 90% 4th year - 100%
CLASS III - MAJOR² - <u>Crowns</u> - <u>Implants</u> - <u>Denture and Bridge Work</u> (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 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
--

ADVANTAGES



- * **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.
- * **Prosthetic:** 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.

High Deductible Health Plan (HDHP) w/Health Savings Account (HSA) - Supplemental Enrollment Form

- ___ I am not covered by any other medical plan (excluding an IRS-qualified HDHP), including my spouse/domestic partner's employer coverage, Medicare, Veterans' Administration coverage, Tricare, or Indian Health Services coverage.
- If I am going to be eligible for Medicare, VA coverage, Tricare or Indian Health Services anytime during the next plan year, I will notify my employer prior to the start of the plan year.
 - If I become covered by other medical coverage, I agree to notify my employer immediately. I understand that any amount contributed to my HSA if I become ineligible is taxable to me.
- ___ Neither myself nor my spouse can be enrolled in an employer sponsored Section 125 pre-tax plan (sometimes referred to as a Healthcare FSA or Medical Spending Account) unless it is a limited plan that reimburses only for dental or vision. My spouse also can't be enrolled in a Health Reimbursement Arrangement (HRA)/Voluntary Employee's Beneficiary Association (VEBA) unless it is a "limited purpose" plan that reimburses only for dental or vision expenses.
- ___ I understand that if I am covered by my spouse's medical plan (excluding an IRS-qualified HDHP) after January 1 and I choose not to waive coverage (or my spouse is unable to drop me from coverage until his/her next open enrollment period) that I will be ineligible for a HSA (funded by employer or employee). I will, however, still be covered by the employer's HDHP. Pro-rated contributions may be made to an HSA account once you provide proof that you have lost the other coverage and are eligible to receive them.
- ___ I understand that myself and/or any family member who is covered by this HDHP and enrolled in Medicare Part A or B must enroll in Medicare Part D when initially eligible for Medicare, or upon the effective date of coverage under this plan. If Medicare Part D is not elected during this time, the eligible person may pay a late enrollment penalty for life.
- ___ I understand that I cannot use HSA funds on a tax-free basis to reimburse healthcare expenses for children over 18 (or over 24 if enrolled in a qualifying school) that do not qualify as a tax dependent based on IRS regulations. If the eligibility of a dependent is in question, the employee should contact their tax professional or the IRS.
- ___ If I enroll a domestic partner on my medical plan, I understand there are limitations on using my HSA funds on a tax-free basis to reimburse his/her healthcare expenses. I also understand that the contributions in excess of the maximum allowable contributions for a single filing status may be taxable under IRS guidelines. Questions regarding these issues should be directed to a tax or legal advisor for guidance.
- ___ I understand that City of Astoria makes total payments of \$2,500 (for single) and \$4,000 (for family) annually (payable half in January and half in July). If I terminate my employment prior to December 31, (2017) and I do not continue coverage on the HDHP through COBRA or Retiree basis, I can no longer make contributions to my HSA unless I enroll in another qualified-HDHP privately or through new employment. I understand if I am a new employee that I have a waiting period before I am eligible for HSA funding and that the HSA contribution may be pro-rated for the remainder of the plan year.
- ___ I understand that the annual HSA contribution limits (for employers and employees combined) is \$3,400/single or \$6,750/family for 2017. I further understand that I can contribute an additional \$1,000 per year if I am 55 years or older (up until Medicare eligibility).
- ___ I have read this overview and the materials provided to me by my employer and banking partner regarding the rules governing contributions and reimbursements from my HSA account. If I accept contributions from my employer for the purpose of establishing a HSA and I am not eligible to receive them or if I am reimbursed for any ineligible medical expenses, I understand I am liable for any taxes and penalties that may be incurred.

Signature

Date

Print Name

Rev 12-20-2016



cis benefits
www.cisbenefits.org



Supplemental Life & Voluntary Dependent Life Coverage

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

Supplemental Employee/Spouse/DP Life

Any amount elected for supplemental life during open enrollment is subject to medical review by The Hartford. You will see the monthly premium online for the amount you elect and premiums are listed on the back side of this flyer. If electing coverage for your spouse or domestic partner, the amount must be equal to or less than the amount elected or in force for you.

If Hartford approves the requested amount prior to December 10, coverage will be effective January 1, 2015. If approved after that date, the effective date will be February 1 or later. If you want to discontinue your current Supplemental Life coverage, you must elect Waive under the Supplemental Employee or Spouse Life sections during open enrollment.

If an email address has been provided, The Hartford will send you instructions and a link to complete the Personal Health Application (PHA) for you and/or your spouse/DP. The e-mail will come from ***medical.uw@hartfordlife.com*** with a subject line of "The Hartford Group Benefits: Evidence of Insurability

ARE YOUR BENEFICIARY DESIGNATIONS CORRECT?

New: CIS transitioned to a different on-line enrollment system and all the benefit data, including beneficiary designations, was transferred over.

Please take the time to review your beneficiary designations as errors can happen when transferring data.

The beneficiary(ies) listed on the system are the ones who will receive the life insurance benefit.

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



cis benefits
www.cisbenefits.org

Required*. If an email address has not been provided, instructions will be mailed to the address on file. There is a 45-day window to complete the PHA.

Voluntary \$10,000 Dependent Life – Increased Amount

The amount of Voluntary Dependent Life is increasing from \$5,000 to \$10,000. If you are currently enrolled, your coverage will automatically be increased. If you are not enrolled, you can elect the coverage during open enrollment. The cost for the increased coverage is \$2.96 per month and continues to cover a spouse, DP and/or children under the age of 26. If you do not want the increased amount, you must elect Waive under the Voluntary Dependent Life section during open enrollment.

Age & Premium Reductions at Age 70

Like your employer-paid life insurance, the Supplemental Life coverage reduces to 65% of the elected amount at age 70 if you are still an active employee. If the coverage reduces, so does the premium. The coverage and premium reduce the first of the month following the day you turn 70.

Supplemental Employee/Spouse/DP Life Rates

Age is determined as of January 1 for those that change age categories during the calendar year. Premiums change on January 1 as employees or spouses move into a new age category.

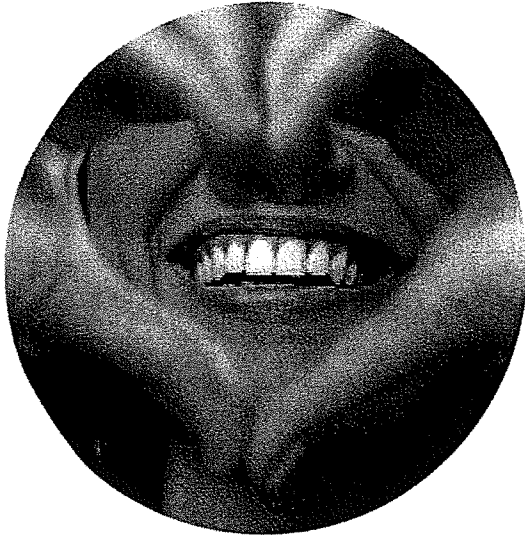
Age	Cost per \$1,000 coverage
0-29	\$0.039
30-34	\$0.049
35-39	\$0.068
40-44	\$0.097
45-49	\$0.136
50-54	\$0.213
55-59	\$0.398
60-64	\$0.610
65-69	\$1.150
70-74	\$1.810
75 & Older	\$5.580

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.

If you elect \$100,000 of coverage and are 45 years old, your premium would be: $\$0.136 \times 100 = \13.60 . This amount would be the monthly payroll deduction.



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



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 password, 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
www.cisbenefits.org

Open Enrollment Annual Notices

The federal government requires the following notices be provided to you each year. Those that are required to be distributed in hard copy are attached.

- HIPAA Privacy Notice
- HIPAA Special Enrollment Rights
- Women's Health and Cancer Rights Act of 1998 (WHCRA)
- Medicare Prescription Drug Coverage - Part D
- Children's Health Insurance Program (CHIP)
- Children's Health Insurance Program Reauthorization Act (CHIPRA)

HIPAA Privacy Notice

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) governs how group health plans and other "covered entities" use and disclose "protected health information." CIS is considered a covered entity and is therefore required to notify you of how your protected health information is allowed to be used and your rights related to that information. **The Notice is available on CIS' website at www.cisbenefits.org.**

HIPAA Special Enrollment Rights

The HIPAA legislation also included a "Special Enrollment Rights" provision. Employees who decline to participate in a group health plan may enroll themselves and their dependents within 30 days of these events:

- Losing coverage provided through a group health plan or health insurance, whether coverage is cancelled due to job loss, disability, divorce, or death
- Marriage, birth, adoption or the placement of a child for adoption

Employees have 30 days from the date of the event – the job loss, marriage, birth or placement – to request enrollment in the plan.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

WHCRA includes important protections for breast cancer patients who choose to have breast reconstruction in connection with a mastectomy. The coverage outlined below is included in your medical plan:

BENEFITS OFFICE • 1212 Court Street NE, Salem, OR 97301 • Phone 503-763-3800 or 800-922-2684 • Fax 503-763-3900

A membership service of:



Non-Cred

Reconstruction of the breast on which the mastectomy was performed

- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas

The attending physician and the patient will determine together the manner of treatment. All coverage is subject to any deductibles, copayments, and/or coinsurance according to the provisions of your medical insurance benefits and federal requirements. Please see your benefits booklet for additional information.

Medicare Prescription Drug Coverage - Part D

See attached "Important Notice About Your Prescription Drug Coverage and Medicare" notice. When prescription drug coverage was added to Medicare ("Part D"), it was mandated that employees be told whether their employer medical coverage is "creditable" or "non-creditable". Creditable means it is, on average, as good as the standard Medicare Part D coverage. Non-creditable means it is not, on average, as good.

For most active employees and some retirees, this notice doesn't apply because you are not yet covered by Medicare. However, for those who are covered by Medicare or have a dependent covered by Medicare, this information is very important.

Children's Health Insurance Program (CHIP)

See attached Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families Notice. The Notice is required to inform employees of the opportunities that "currently exist" for premium assistance under Medicaid and CHIP for coverage for employees or dependents.

Children's Health Insurance Program Reauthorization Act (CHIPRA) – Special Enrollment Rights
Employees who experience either of the following events have 60 days to enroll in group coverage through their employer.

- The termination of an individual's Medicaid or SCHIP coverage due to a loss of eligibility; or
- The individual becomes eligible for a premium assistance subsidy through Medicaid or SCHIP.

Important Notice from CIS About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your employer's medical plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Regence BlueCross BlueShield (BCBS) and Kaiser have determined that the prescription drug coverage offered by your employer is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from Regence BCBS. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from Regence BCBS. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – it explains your options.

When Can You Join A Medicare Drug Plan?

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

However, if you decide to drop your current coverage with Regence BCBS, since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under Regence BCBS.

When Will You Pay a High Premium (Penalty) to Join a Medicare Drug Plan?

Since the coverage under Regence BCBS is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting

with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

If you decide to join a Medicare drug plan, you can continue your Regence BCBS medical coverage and benefits will coordinate with Part D coverage.

If you decide to join a Medicare drug plan and drop your Regence BCBS medical coverage, be aware that if you are an active employee you and your dependents **will not** be able to re-enroll until the next open enrollment period. If you are a retiree, you **will not** be able to get this coverage back.

If you are enrolled on a Kaiser medical plan, you are not eligible to enroll in Medicare Part D because of Kaiser's arrangement with Medicare. Doing so will cause your active Kaiser coverage to be terminated.

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

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

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

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: October 6, 2014

Name of Entity/Sender: CIS Benefits

Address: 1212 Court Street NE, Salem, OR 97301

Phone Number: 1-800-922-2684 (within Oregon) or 503-763-3800 (Salem)

Updated April 1, 2011

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2014. Contact your State for more information on eligibility –

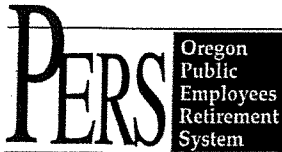
ALABAMA – Medicaid	COLORADO – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	FLORIDA – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid	MONTANA – Medicaid
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/Premiu	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml

mAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588	Phone: 1-800-694-3084
INDIANA – Medicaid	NEBRASKA – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633
IOWA – Medicaid	NEVADA – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392
MAINE – Medicaid	CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid	VERMONT – Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid	WASHINGTON – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2014, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration www.dol.gov/ebsa 1-866-444-EBSA (3272)	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov 1-877-267-2323, Menu Option 4, Ext. 61565
--	---



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
<i>Alternate beneficiary 1a</i> (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	<i>Alternate beneficiary 2a</i> (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	<i>Alternate beneficiary 3a</i> (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
<i>Alternate beneficiary 1b</i> (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	<i>Alternate beneficiary 2b</i> (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	<i>Alternate beneficiary 3b</i> (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

¹The 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.

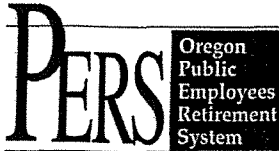
Section B: Beneficiary designation

- 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.



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.)

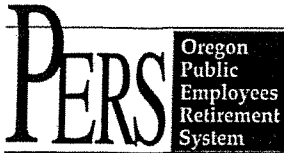
Consent box: My spouse consents to the following specific beneficiary designations. (See page 2 for complete instructions.)

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' _____ 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) _____

*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.



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) _____

*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.

Beneficiary Designation for Death Benefits Form
 Deferred Comp Plan - Certain Employees - City
 of Astoria
 #409112

The Standard®

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) _____

Name of Contingent Beneficiary (please print) _____

Relationship _____

Date of Birth _____

Relationship _____

Date of Birth _____

Current Address _____

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.

I consent to the beneficiary designation made by the participant. I understand that if the participant dies prior to retirement, any benefits under the Plan will be paid to the designated beneficiary.

I consent to the election by the participant to waive payment in the form of a QPSA. I understand that if the participant dies prior to retirement, any benefits under the Plan will be paid in the form the participant has elected above, or in another form elected by the participant or by the beneficiary.

Name of Spouse (please print) _____

X _____
 Signature of Plan Administrator or Notary Public

Date _____

X _____
 Spouse Signature

Date _____

Title _____

PLAN REPRESENTATIVE Complete this section if there is no Spouse signature

I, _____, state that it has been established to my satisfaction that spousal consent to this election cannot be obtained because there is no spouse, the spouse cannot be located, or other circumstances make obtaining such spousal consent impossible.

X _____
 Plan Representative Signature

Title _____

Date _____

City of Astoria
John Snyder
1095 Duane St.
Astoria, OR 97103

87545A_E_000001_RNR409112ENM0



PHONE

800.858.5420
between 5 a.m. and 5 p.m. Pacific time, 8 a.m and 8 p.m. Eastern

WEBSITE

www.standard.com/retirement

Standard Retirement Services, Inc.
1100 SW Sixth Avenue
Portland, OR 97204
800.858.5420

www.standard.com/retirement

409112 (08/11/15)

NMC-ENG-REENR



Read these instructions to enroll in your retirement plan and create your Account Access profile.

Once you complete the enrollment process, we will be ready to accept contributions on your behalf from your employer.

Express Online Enrollment

A fast, easy way to enroll in your plan! Download the ICMA-RC mobile app at <http://www.icmarc.org/mobile-app.html> and then go to "My Account." Or go to m1.icmarc.org and select the "Enroll Now" link if you are unable to download the app. After completing the steps below, you will be invested in your plan's default fund. You may then log in to Account Access to select investment options, designate beneficiaries, and make any necessary updates.

- 1:** Enter your Social Security number twice and enter your plan number. The employer plan number can be found in the enrollment kit, or can be obtained by contacting your employer, your ICMA-RC representative, or ICMA-RC at 800-669-7400.
- 2:** Enter your complete contact information and then confirm that the information you've entered is accurate.
- 3:** Check your email for a message confirming that you have been enrolled in the plan. Note: your account will register in 24 hours.
- 4:** **In order to begin contributing to your account, you will need to elect your contribution amount.** If your plan does not allow online contribution elections, please complete the Contribution Form and return it to your employer to designate your contributions.
- 5:** **After your account is registered, you will receive a welcome letter in the mail with additional information about how to manage your account.** Go to www.icmarc.org and click on the **New User - Register Now** link to create a profile in Account Access and follow the prompts to create your account.



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 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 Date Employed/Rehired Relire? Check if YES

Email Address (required for e-Delivery)

Consent with Electronic Delivery: ICMARC is committed to help reduce paper use and the environment by providing electronic delivery (e-Delivery) of all plan documents...

Job Title Department Daytime Phone Number
Evening Phone Number Gender Marital Status

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):

Table with 5 columns: NAME, DATE OF BIRTH, RELATIONSHIP TO YOU*, SOCIAL SECURITY NUMBER, % OF BENEFIT (whole %). Includes Total = 100% row.

Contingent Beneficiary(ies), if any:

Table with 5 columns: NAME, DATE OF BIRTH, RELATIONSHIP TO YOU*, SOCIAL SECURITY NUMBER, % OF BENEFIT (whole %). Includes Total = 100% row.

*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 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 Fnd. 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.

Table with 4 columns: Code, Percent, Code, Percent. Includes a TOTAL = 100% row.

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.

Participant's Signature

Month / Day / Year

Employee ID

For Employer Use Only

Authorized Employer Official's Signature

Month / Day / Year



Foresters Financial Services, Inc. offers 457(b) participation in a full line of professionally managed mutual funds. You may also save your money in a tax-advantaged stock, bond and money market fund based on your personal goals and preferences.

This information is general in nature and should not be construed as advice. Please consult a tax or legal advisor relative 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 forestersfinancial.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 your hard-earned 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, the Fraternal Benefit Society, 289 Don Mills Road, Toronto, Canada, M3C 1J9 and its subsidiaries, including Foresters Financial Services, Inc. Foresters 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

forestersfinancial.com

Foresters
Financial

Find Foresters Financial on Social Media



15-002600-457 BRO (9/11/15)

RETIREMENT



457(b)

Foresters
Financial

Jason Tei
Investment Advisory Representative

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

T: 503-296-7676, ext. 21
F: 503-296-9071
C: 503-314-8679

jason.tei@foresters.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 for state and local government employees, such as public school employees, police officers and firefighters. These accounts encourage individuals to prepare for their own retirement.

Why establish a 457(b) account?

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

Did you know that...

The average American, age 65, will spend 18 years in retirement—a long period of time which living expenses will continue and likely increase with inflation.

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

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

How much can I contribute?

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

Employee contribution	
General Limit	Age 50 and Over
\$18,000	\$24,000
Indexed for inflation after	Add \$6,000 to general limit

Special rules allow employees in their last years before normal retirement to make significantly larger contributions. Your Representative can assist you in increasing your maximum contribution amount.

Can 457(b) accounts be consolidated?

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

What if I change jobs or retire?

When you change jobs or retire, you will need to evaluate your options. You may be eligible to roll your 457(b) account into a Traditional IRA or other type of plan, or treat it as a 457(b) account. In such cases, earnings on your account continue to be tax-deferred. Distributions from a 457(b) retirement plan must be directly rolled over to a Traditional IRA or other type of plan in order to maintain tax-deferred status, and avoid 20 percent withholding.

Are there any penalties for early withdrawals?

A major advantage of your 457(b) account is that distributions, due to retirement or termination, even before age 59½, are not subject to a 10 percent early withdrawal penalty. Regular income taxes will apply, however.

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.

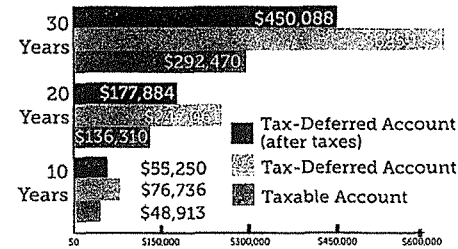
Tax-deferred growth. Your 457(b) account grows on a tax-deferred basis, meaning that any appreciation, earnings, interest, capital gains and dividends are not taxed until the funds are withdrawn. This allows assets to accumulate at a faster pace, a major advantage when saving for the long term. Also, 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 59½ 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

CITY OF ASTORIA
BLOODBORNE PATHOGENS & SEXUAL HARASSMENT
ORIENTATION

Name: _____

Date: _____

Bloodborne Pathogens

I have received and read a copy of the City of Astoria Bloodborne Pathogens Policy. I have been certified through Ellis and Associates Life Guard Training or watched the "Bloodborne Pathogens" DVD.

Sexual Harassment

I have received the Sexual Harassment Policy and have watched the related DVD.

I have read and understand the above.

Signature

Date

CITY OF ASTORIA SEXUAL HARASSMENT POLICY

Harassment on the basis of sex is a violation of Section 703 of Title VII of the 1964 Civil Rights Act as issued by the U.S. Equal Employment Opportunity Commission (AWAKE). Sexual harassment is defined as follows:

Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitutes sexual harassment when (1) submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment, (2) submission to or condition of an individual's employment, (f2) submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individuals, or (3) such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

The City of Astoria prohibits sexual harassment of its employees or any citizen in any form. Such conduct may result in disciplinary action up to and including dismissal.

Conduct specifically prohibited:

1. No supervisor shall threaten or insinuate either explicitly or implicitly, that an employee's refusal to submit to sexual advances will adversely affect the employee's employment, evaluation, wages, advancement, assigned duties, shifts, or any other condition of employment.
2. Other sexually harassing conduct in the work place, whether committed by supervisors or non-supervisory personnel is also prohibited. It may include:
 - Verbal harassment or abuse
 - Offensive sexual flirtations, advances, propositions
 - Graphic verbal remarks about an individual's body
 - Display in the work place of sexually suggestive objects or pictures
 - Physical assault
 - Forced sexual relations

Any employee who feels her or himself to be a victim of sexual harassment should report the concern to the Supervisor, Department Head, Human Resources Director, or City Manager. The concern will be thoroughly investigated in a prompt, fair manner. The support for this policy from all employees is mandatory to maintain a work environment free of harassment.

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 injuries. Needles shall not be bent or re-capped. Sharp instruments shall be placed in a specially designated puncture-resistant 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:

<u>AREA</u>	<u>SCHEDULE</u>	<u>CLEANER</u>
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 tied. 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 resistant, 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

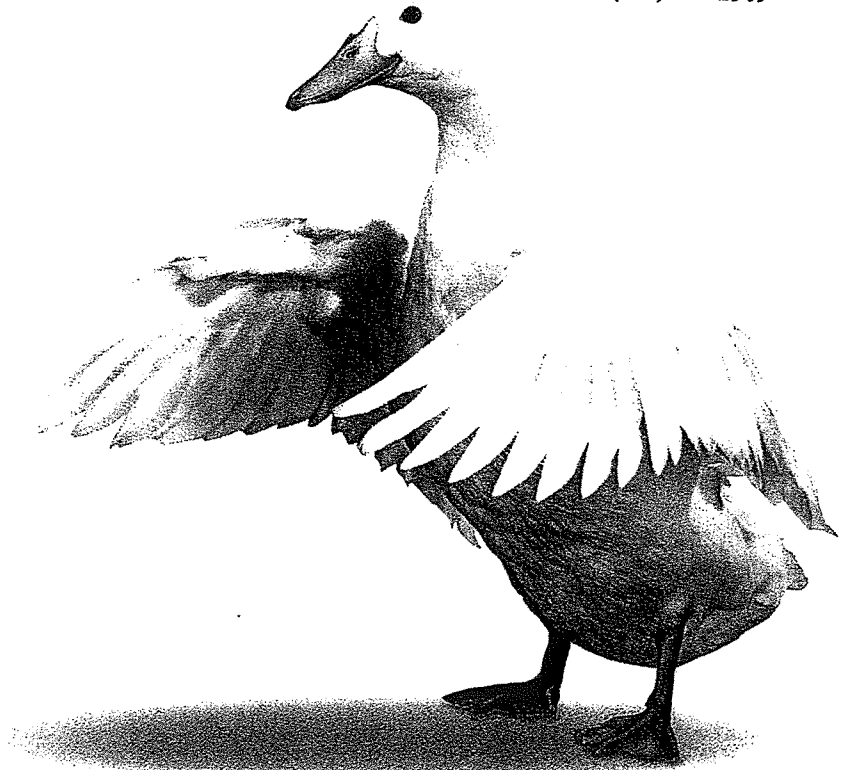
The Public Works Director is responsible for annually reviewing this program, and its effectiveness, and for updating as needed.

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

Reviewed <u>(2/7/95)</u>	Reviewed _____
Reviewed <u>(8/97)</u>	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.®

Solutions to Simplify Life.

FREE. EASY.
CONFIDENTIAL.

866.750.1327

MyRBH.com

CALL THE EAP.

If you are struggling with a personal problem, call your Employee Assistance Program (EAP). The EAP can help you solve personal and professional issues so you can regain balance in your life, at work and at home.

866-750-1327

Call the EAP



Scan to call

www.MyRBH.com

Visit Online



Scan to visit

RBH
Reliant Behavioral Health

Your EAP is provided by your employer or health plan and is delivered by RBH RBH EAP Poster (2013) Letter.

Employee Assistance Program

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

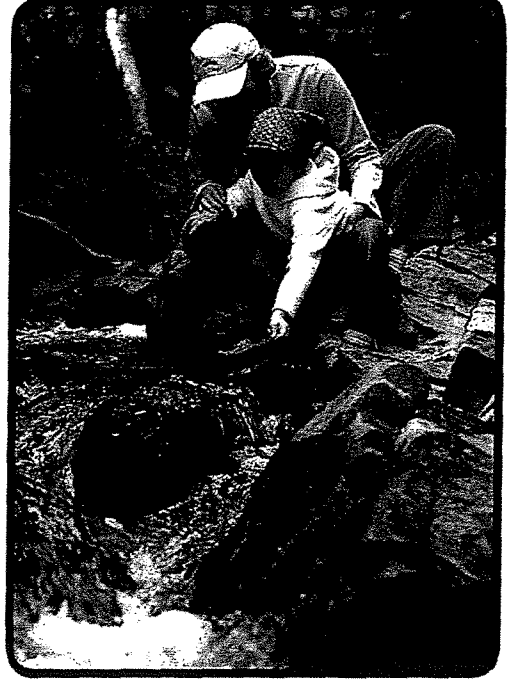
The EAP is provided for **FREE** (no out of pocket cost), and confidential services cover employees and their dependents, living at or away from home, and all household members, related or not.

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.



★ **Wellness Resources** – now MyRBH.com includes helpful wellness resources! The first time you visit MyRBH, you must activate your personal wellness account. During the simple activation process, you will need your Access Code (found on the right of this sheet), and you will select a private username and password for logging in whenever you visit the site. You will also need to provide an email address, and we recommend using your employee-provided email if possible.



**City Of Astoria
Employee Responsibilities
Regarding On-The-Job Injuries/Illnesses**

1. If a work-related injury or illness occurs that requires professional medical assistance, a workers' compensation claim form 801 and an "Employee Accident/Incident Report" must be completed and returned as soon as possible (preferably within 24 hours) to your immediate supervisor.
2. You must cooperate and assist your supervisor, other city personnel and Risk Management in any investigation of your injury/illness.
3. You must inform your medical provider that there are temporary transitional jobs available, and provide them with either the enclosed "Release To Return To Work" form or obtain another suitable release form signed by your medical provider. This form must be updated each time you see your medical provider. If there is no change in work restrictions from visit to visit your doctor can indicate such by either updating the form or communicating such on their official letterhead.
4. Once your medical provider releases you to return to work (temporary, part time, temporary transitional duties or regular duties), you must report to work immediately. If you leave the provider's office near the end of your shift for that day, you must then report to work no later than your next scheduled shift. Upon returning to work, give the work release to your supervisor and make sure that they are informed of any physical restrictions or conditions. Please note that modified duty may be provided for a period of 90 days.
5. If you are released to temporary transitional work, you are responsible for working within those limitations/restrictions set forth by your physician.
6. As a Return-To-Work Program participant, you are encouraged to schedule physical therapy and medical provider appointments at times when you are not expected to be at work. If you must leave your assignment, all appointments requiring time away from work must be approved/recorded by your supervisor and verified by your provider.
7. It is **YOUR RESPONSIBILITY** to perform your Temporary Alternative Work Assignment in a responsible and professional manner, as you would your own regular job. Failure to do so, for example, non-performance of assigned duties, tardiness, not calling in when absent, etc., will result in the same corrective action as would have occurred if you had been working in your regular job. Your supervisor will handle any problems requiring corrective action.
8. If you have been released for a Temporary Alternative Work Assignment, and an assignment is available that meets the restrictions set forth by your attending physician, and you refuse the assignment, your time-loss benefits will be terminated.
9. If you are unable to report for any kind of work, you must call in weekly to your supervisor and to Risk Management (unless otherwise arranged) to report your status. While you are off work, it is your responsibility to supply your supervisor and Risk Management with your current telephone number (unlisted or not) and a street address where you can be reached.

I understand my responsibilities as an employee in the City of Astoria's Return-To-Work Program and I agree to observe and follow these procedures as they have been explained to me by my employer and my medical provider.

Printed Name

Signature

Date

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