# CIS BENEFITS RULES

The CIS Board of Trustees adopts the following Rules regarding CIS Benefits programs. The Rules are effective ~~January~~ July 1, 2016 and supersede and replace existing CIS Benefits Rules.

## *RULE EB 1: LOSS FUND PROTECTION AND SURPLUS DISTRIBUTION*

A. CIS BENEFITS LOSS FUNDS

CIS Benefits Pooled Risk Retention Programs are funded by Contributions "to establish Loss Funds and any other necessary or prudent reserves, to purchase reinsurance and/or excess insurance in the name of the Trust, and to provide Administration." (Trust Agreement, Article 1, definition of "Contribution".) The CIS Benefits Loss Funds are established by Trust Fund (EBS and AOCIT) and by Health and Life Coverage.

B. USE OF SURPLUS

For purposes of this Rule, "Surplus" is defined as those monies remaining in a Loss Fund after the payment of the costs of administration and reinsurance or excess insurance, the payment of claims, and establishment of adequate reserves for outstanding claims.

Surplus may, in the sole discretion of the Trustees, be used in any one or more of the following ways:

1. Allocated for any purpose consistent with the Trust Agreement, including, but not limited to, Trust Program enhancements, risk management programs such as Healthy Benefits, or held as contingency reserves.

2. Allocated to offset deficits as follows:

   a. In the event of a deficit in a Loss Fund for a Coverage Year, that deficit may be offset with Surplus accrued in that Loss Fund in other Coverage Years;

   b. Within the same Trust Fund, Surplus may be transferred from a Loss Fund to a Loss Fund that is in deficit. However, such transfers shall only be made when there is a reasonable expectation that repayment can be made from future contributions and earnings of the Loss Fund that has incurred the deficit.

3. Distributed to Members as a Surplus Distribution as described in Section C of this Rule.

C. SURPLUS DISTRIBUTION

The Board, at its sole discretion, may declare a distribution of Surplus to Members through rate subsidies or other means and methods that the Board may determine.

## Rule EB2: GENERAL PROVISIONS

A. REQUEST FOR COVERAGE

Prior to initially receiving coverage, and annually during the time period specified by CIS, the Member must complete a Request for Coverage (RFC) in a form specified by CIS. Such RFC shall be approved and signed by a duly authorized employee or agent of the Member. The Member must certify that it is and will continue to be in compliance with all CIS Benefits governing documents.

Changes to RFC

Elections made on the RFC can only be changed annually except for mid-year changes resulting from collective bargaining or with CIS approval. This includes changes to plans and eligibility (waiting period, required work hours, ~~opposite sex domestic partners,~~ etc.). Members must give CIS at least 60 days advance notice for mid-year collective bargaining changes. Changes will be effective the first of the month following the 60-day notification.

B. RIGHT TO MODIFY, DISCONTINUE, OR TERMINATE

The CIS Board of Trustees retains the right to modify or discontinue any portion of the CIS Benefits Program. Except in the case of discontinuation or modification to comply with state or federal regulations, CIS will give participating entities advance written notice of at least 6 months on board actions resulting in a plan discontinuation and advance notice of at least 90 days on plan modification. CIS will not be bound by any agreements entered into by the Member that do not comply with CIS Rules or the CIS Employee Benefits Trust Plan. CIS retains the right to terminate coverage for Members that are in violation of state or federal benefits regulations or are not in compliance with CIS governing documents.

C. HIPAA COMPLIANCE

CIS programs are in compliance with the Health Insurance Portability and Accountability Act (HIPAA) privacy standards and are governed by the CIS Employee Benefits Trust Plan. As such, CIS can receive health status and claims data for participating employees. Health status and individual claims data will not be provided to participating Members without the expressed written consent of the employee. Claims data may be shared with a third party administering CIS' health risk management programs.

D. APPEALS PROCESS

1. APPEALS REGARDING COVERAGE
   An employee participating in an employee benefits Insurance Program or the Health Risk Management Program who wishes to appeal a coverage/claim decision must utilize the appeal procedure outlined in the plan booklet and/or as required by law. The determination made by the medical plan or the Independent Review Organization (IRO) is final. There are no further appeal rights.

2. APPEALS REGARDING ADMINISTRATIVE AND ELIGIBILITY ISSUES
   An employee participating in an employee benefits Insurance Program or the Health Risk Management Program who wishes to appeal an administrative or eligibility decision may ask for reconsideration by the Benefits Director. The request must be made in writing and received by CIS within 45 days of the date of denial. The Benefits Director will make a determination and send a written response and explanation within 15 days. If the Member representative or employee is dissatisfied with the decision of the Benefits Director, he/she may make a written request for reconsideration to the Executive Director within 45 days of the Benefits Director's denial. The Executive Director may, at his or her discretion, consult with the Board of Trustees and will respond with a notification of status of the request for consideration within 15 days. A final determination response will be sent in writing not later than 30 days from the date the request is received by the Executive Director. The Executive Director's determination is final, and there are no further appeal rights.

## Rule EB3: HEALTH INSURANCE

A. CONTINUING ELIGIBILITY

A CIS Employee Benefits Trust Plan Member as of January 1, 2010, that is an intergovernmental entity formed by a public body with another state or with a political subdivision of another state, or with an agency of the federal government, is allowed to remain a Member of the CIS Employee Benefits Trust Plan in which it is participating, provided however, if such member terminates participation in that Trust plan, it is not eligible to become a Member except as provided by the CIS Bylaws, Article 2.

B. SUBGROUP ELIGIBILITY

For Members with 100 or more eligible employees, subgroups (i.e., public works, firefighters, police, administration, SEIU, AFSCME, etc.) of less than 100 employees may be allowed to join CIS, but their rates may be based on their claims experience, if available, or subject to a surcharge.

For Members with fewer than 100 eligible employees, subgroups may join if they include all employees not eligible to be covered by an Employee Benefits Trust affiliated with their bargaining unit.

C. MEMBER PLAN SELECTION

For purposes of these Rules, Regence and ~~ODS~~Delta Dental refer to the CIS self-insured plans that are administered by Regence and ~~ODS~~Delta Dental.

1. Members may select different benefit plans for specific subgroups of employees as long as there are at least 10 employees enrolled for benefits in each subgroup.

2. Members may select riders to be added to their basic medical or dental plans as defined by CIS each year. Benefit riders can not be offered on a stand-alone basis. Riders may be added/dropped only during open enrollment, as a result of collective bargaining, or in conjunction with an eligible mid-year plan change. If a rider is dropped by a Member, it cannot be added again for two plan years. Riders include: ~~–~~Vision, Hearing Aids, Alternative Care and Orthodontic Treatment.

   Within the constraints of 3, 4 and 5 below, Members eligible to offer multiple plans to one or more subgroups must include the same riders on all plans offered.

3. Members or subgroups with 10 or more covered employees may select the following medical plan options:
   a. One Regence plan and one Kaiser plan; or
   b. Two Kaiser plans; or
   c. Two Regence plans that are within a 5% rate spread.

4. For Members or subgroups with 100 to 232 covered employees in the Regence medical plan, the following is available in addition to the options under 2, above:
   a. One additional Regence plan within 10% of the benefit value of the core plan
   b. All rates may be surcharged for potential adverse selection risk.

5. For Members or subgroups with 233 or more covered employees in the Regence medical plan, the following is available in addition to the options under 2, above:
   a. Two additional Regence plans within 15% of the benefit value of the core plan
   b. All rates may be surcharged for potential adverse selection risk.

6. CIS will accept new Members offering dental insurance only if their annual open enrollment period is offered within a month of CIS's annual open enrollment.

7. Employer contributions to a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) will be considered in determining the value of the rate spread in 3, 4, and 5 above.

8. Members or subgroups with 100 or more employees joining CIS may, with the agreement of CIS and the claims administrator or carrier for the lines of coverage sought, maintain the plan design(s) in force at the time the Member or subgroup joins CIS until the end of the applicable collective bargaining agreement(s) or two years, whichever is less. At that time, the Member or subgroup must migrate into one or more CIS plan designs, as provided above. The Member or subgroup's claims experience in the plan design(s) in force will be used in determining rates for the CIS plan design(s).

9. Members with fewer than 10 employees may only offer one medical and dental plan.

10. Members with 10 or more employees may offer a choice of a~~n ODS~~Delta Dental plan, Kaiser Dental and Willamette Dental.

11. Members may select different medical and dental plan insurers or administrators (e.g., Regence medical and Kaiser dental).

## Rule EB4: HEALTH INSURANCE - MEMBER PAYMENTS

A. If a Member does not contribute toward the cost of dependent coverage, then the Member must pay 75% of the employee rate. If the Member contributes toward the cost for dependent coverage, then the Member must pay at least 50% for any coverage level. The Member's payment may vary by subgroup.

B. If rates are subsidized by CIS Benefits trust reserves, there is a 24-month wait before the subsidized rates are available to Members or subgroups entering or re-entering the program.

C. A Member or subgroup that leaves CIS coverage cannot return for at least 18 months. If the Member or subgroup returns to medical or dental coverage within three (3) years, they will also pay a 15% rate penalty for 12 months. This will be imposed in addition to the provisions of Rule 4(B), if applicable.

1. Members that leave CIS medical coverage for enrollment in a state or federal exchange ~~Cover Oregon~~ plan option may return to CIS medical coverage without penalty one time within the following three (3) years, as long as they have maintained other continuous coverage with CIS Benefits.

D. Members with less than 100 covered employees will receive the pooled group's rates, except as outlined in Rule EB3B.

E. Members with 100 or more covered employees in the Regence medical or ~~ODS~~ Delta dental plans will have their rates adjusted based on their own experience. These Members will also receive claims utilization reports specific to their group.

F. Only experience-rated groups can receive a composite rate.

G. Commissions for agents of record will be added to the CIS medical/dental rates. Commissions are negotiable between the Member and the agent. Commissions must be applied as a percentage of the premium; flat dollar amounts per employee per month are not acceptable. Commissions are only applicable to Regence medical, ~~ODS~~ Delta Dental and VSP vision plans. CIS must be notified of any applicable commissions at least 30 days before the start of coverage.

## Rule EB5: HEALTH INSURANCE - ENROLLMENT ELIGIBILITY

A. To qualify for health insurance, employees must work at least: (1) half of the full-time schedule stated by the Member (but no less than 17.5 hours per week) or (2) the minimum number of hours specified by the Member, whichever is greater. Employees may qualify for medical and vision (if applicable) coverage only if they don't meet the full-time schedule defined by the employer but meet the minimum number of hours (30) defined by the Patient Protection and Affordable Care Act.

B. No seasonal, temporary, or limited duration employees can be covered unless eligible under the Patient Protection and Affordable Care Act. Contract employees (through a temporary employment agency or personal services contract) and volunteers are not eligible for coverage.

C. Domestic partner coverage is available only to same-sex partners who file a Certificate of Registered Domestic Partnership with the applicable county. Same and opposite-sex domestic partners covered prior to January 1, 2016 due to completion of an Affidavit of Domestic Partnership remain eligible to be covered until the employee voluntarily terminates the coverage or the partnership dissolves.

   The Member agrees to charge employees covering a domestic partner and his/her eligible children, the applicable imputed value amount.

D. Employees adding a spouse or domestic partner to health coverage are required to provide documentation. Acceptable documentation is a marriage license/certificate or a copy of the Certificate of Registered Domestic Partnership.

E. Health insurance may be made available for elected officials who do not qualify as employees as long as coverage is authorized by the governing body, the Member pays at least 50% of the rate, and the group or subgroup meets the participation requirements outlined in Rule EB6(C). Elected officials do not qualify as a unique subgroup.

F. A Member may waive its stated waiting period for new employees under the following conditions:

   - The employee comes from another CIS Benefits-covered Member;
   - There is no break in CIS coverage;
   - The waiver must apply to all CIS coverages offered by the employer, as long as the employee was enrolled in them at the previous employer; and
   - If the employee was not previously enrolled in a specific type of coverage such as LTD, the waiting period cannot be waived for that coverage.

G. The following are considered eligible dependents:

   1. A legally married spouse.
   2. Domestic Partners who meet the criteria listed in Rule 5C.

3. Child(ren) under the age of 26 who are :
   - The natural child of the employee, spouse or domestic partner;
   - The adopted child, or a child placed for adoption, of 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 or custody.
   - 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 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. The child must have been enrolled in a CIS plan at the time he/she turned 26. A new hire may add a disabled child over age 26 if the child was disabled prior to his/her 26th birthday.

H. Ineligible dependents will be deleted retroactive to the last day of the month in which they became ineligible. Claims paid for ineligible dependents, whether or not they have been removed from coverage, will be the responsibility of the employee.

## Rule EB6: HEALTH INSURANCE - ENROLLMENT/UNDERWRITING REQUIREMENTS

A. The following definitions apply to this section:

1. Group Medical Coverage. Employer-sponsored coverage. Does not include individual coverage or individual policies purchased through any state or federal sponsored exchange, Medicaid (such as Oregon Health Plan), TRICARE or Medicare.
2. Opt Out. Employees choosing not to enroll because they are enrolled in other Group Medical coverage. Proof of other coverage is required.
3. Waive. Employees without other Group Medical coverage choosing not to enroll. Those waiving are required to waive medical and/or dental, as offered by the Member.

B. Employees who opt out or waive must still be enrolled in all employer-paid life and disability plans offered through CIS.

C. For Members with 10 or more employees, at least 90% of the eligible employees, excluding opt outs, must be enrolled in medical coverage. For Members with fewer than 10 employees, at least 50% of the eligible employees must be enrolled in medical coverage. If the Member offers an employee choice of CIS and non-CIS coverage, at least 51% of eligible employees must be enrolled in the CIS coverage.

D. If the Member offers dental coverage, employees have the following options with regard to dental:
- Waive coverage
- Enroll for employee-only coverage
- Enroll for employee & dependent coverage.
  - If the employee's medical coverage is through CIS, dependents enrolled in dental must match those enrolled in medical.
  - If the employee's medical coverage is not through CIS or if the employee opts out of CIS medical coverage, the employee must enroll all eligible dependents in the dental coverage.

Employees or dependents enrolling in an ODS Dental plan after their initial eligibility period will be subject to a waiting period for certain dental services.

E. For groups that offer vision coverage, the individuals enrolled in vision must match the individuals enrolled in the medical plan.

F. Members, when completing their annual RFC, may choose to offer a cash payment to employees who opt out of medical. The cash option cannot exceed $100 per employee per month. If the employee and spouse both work for the same CIS employer and are both covered by a CIS-sponsored medical plan, one can opt out and receive up to $200. The cash option is not available to any employee who

waives medical coverage (i.e., who does not have other Group Medical Coverage) or who is eligible for Medicare coverage.

G. An opt out or waiver election is subject to IRS Code Section 125 election restrictions. Accordingly, an election made for a year may not be revoked or modified, except in the case of a qualified Change in Status Event.

H. Except as outlined in Section F above, Members may not provide cash or other financial incentives to employees for not enrolling themselves or their eligible dependents on the medical and/or dental plans.

I. Members may not directly reimburse employees for any medical expenses incurred including, but not limited to, payment of all or part of the deductible, copayments or coinsurance amounts.

## Rule EB7: GROUPS/SUBGROUPS LEAVING THE HEALTH INSURANCE PROGRAM

A. A Member or subgroup leaving the CIS health program or dropping coverage must provide written notice of termination received by CIS at least 60 days prior to the effective date of termination.

B. Members with fewer than 100 benefit-eligible employees that remove a subgroup from CIS Benefits may continue participation for the remaining employees only if all of the following conditions are met:

1. The group being removed is a represented bargaining group;
2. The plan they are moving to is a health insurance trust program sponsored by the union representing the bargaining unit and available to all bargaining units of that union; and
3. All remaining employees are insured through CIS.

C. Members with more than 100 benefit-eligible employees that remove a subgroup, leaving fewer than 100 employees on health benefits with CIS, can continue participation for the remaining employees only if all of the following conditions are met:

1. The group being removed is a represented bargaining group;
2. The plan they are moving to is a health insurance trust program sponsored by the union representing the bargaining unit and available to all bargaining units of that union; and
3. All remaining employees are insured through CIS.

The rate adjustment factor previously applied to this group will continue for the remaining employees for up to three years.

D. Members with more than 100 benefit-eligible employees that remove a subgroup, leaving more than 100 employees on health benefits with CIS, can continue participation for the remaining employees.

E. Members that remove all of their employees, or a subgroup of its employees, must also remove the retirees and COBRA participants associated with the Member or its subgroup.

## Rule EB8: HEALTH RISK MANAGEMENT PROGRAM

Employees, retirees and spouses enrolled in a CIS medical plan are eligible to participate in Healthy Benefits programs. Some programs or services may have specific eligibility requirements.

## Rule EB9: LIFE/DISABILITY INSURANCE

A. SUBGROUP ELIGIBILITY

If a Member has 25 or more eligible employees, subgroups of the Member may only join CIS for Life and Long Term Disability if the subgroups have at least 25 covered employees.

For Members with less than 25 eligible employees, subgroups are only eligible if they include all employees not eligible for an Employee Benefits Trust affiliated with their bargaining unit.

B. MEMBER PLAN SELECTION

1. Accidental Death & Dismemberment (AD&D) may only be offered in conjunction with Basic Life options and only in amounts equal to the Basic Life insurance coverage selected.

2. Dependent Life insurance is only available in conjunction with Basic Life options.

3. Supplemental Employee and Spouse Life are only available in conjunction with Basic Life options.

4. Statutory Life coverage is for firefighters, volunteer firefighters, and police officers. Coverage for police reserves is optional. EMTs, unless also a firefighter or police officer, are not eligible. This coverage is mandated by Oregon statute.

5. A Member may select different plan options for subgroups as long as there are at least 10 eligible employees enrolled for benefits in each subgroup.

6. Members or subgroups with 25 or more eligible employees may choose from the Basic Life plan options or tailor-make their own plan (with approval from carrier).

   Members with less than 25 eligible employees may select only from the Basic Life plan options.

C. MEMBER RATE

1. Members or subgroups with 25 or more eligible employees will have their rates based on a census of their employee group.

2. Members with fewer than 25 eligible employees will receive the pooled group’s rates.

3. For Members with over 25 eligible employees, commissions for agents of record will be added to the Basic Life and LTD rates. Commissions are based on the standard commission schedule from the carrier. Supplemental Life, Statutory Life, Dependent Life (Voluntary/Member paid), AD&D and Basic Life/LTD rates for pooled Members are not subject to a commission. CIS must be notified at least ~~30~~60 days before the start of coverage of any applicable commissions.

D. MEMBER PAYMENTS

1. The Member must pay at least 50% of the Basic Life, AD&D, Dependent Life, and Long Term Disability rates for its eligible employees. The Member's payments may vary by subgroup.

2. Statutory coverage for police officers, firefighters, and volunteer firefighters/police reserves shall be 100% Member paid, and all eligible individuals must be insured.

3. Voluntary ($10k) Dependent Life and Supplemental Life may be 100% employee paid.

E. EMPLOYEE ELIGIBILITY

1. Employees ~~(including part-time employees)~~ must ~~be in a regular position and must~~ work at least (1) half of the full-time schedule stated by the Member (but no less than 17.5 hours per week), or (2) the minimum number of hours specified by the Member, whichever is greater, to qualify for insurance coverage.

2. No seasonal, temporary or limited duration (less than six months) employees or volunteer individuals may be insured, except volunteer firefighters or volunteer/reserve police officers. Contract employees (through a temporary employment agency or personal services contract) are not eligible for coverage.

3. Domestic partner coverage is available only to same-sex partners who file a Certificate of Registered Domestic Partnership with the applicable county. Same and opposite-sex domestic partners covered prior to January 1, 2016 due to completion of an Affidavit of Domestic Partnership remain eligible to be covered until the employee voluntarily terminates the coverage or the partnership dissolves. ~~Same-sex domestic partners are eligible for Spouse Life as required by law. A Member may choose to extend coverage to opposite-sex domestic partners by vote of the governing body. A Certificate of Registered Domestic Partnership or a CIS Certificate of Domestic Partnership is required.~~

4. For elected officials who do not qualify as employees, the same amount of Basic Life coverage offered to employees, or a lesser amount, may be made

available as long as all elected officials are enrolled.  If the Basic Life benefit is tied to amount of salary, the maximum amount that may be offered is $50,000. The Member must pay at least 50% of the rate.

## Rule EB 10: LIFE/DISABILITY INSURANCE - ENROLLMENT/UNDERWRITING REQUIREMENTS

A. All eligible employees must be enrolled in Basic Life, AD&D and Long Term Disability upon initial eligibility and thereafter as long as eligibility continues. Employees cannot opt out of coverage.

B. Employees not enrolled when initially eligible will be enrolled retroactive to their original effective date.

C. Members/Subgroups Leaving the Life/Disability Program

A Member or subgroup leaving the CIS life/disability program or dropping coverage must provide written notice of termination received by CIS at least 60 days prior to the effective date of the termination.

## Rule EB11: RETIREES

A. RETIREE ELIGIBILITY

1. A retiree is a former officer or employee of a local government participating in the CIS Benefits program who is retired for service or disability, and who received, is receiving, or is eligible to receive retirement benefits under the Oregon Public Employees Retirement System or any other retirement system or plan applicable to officers and employees of the local government.

2. The retiree must be enrolled as an active employee in a CIS medical or dental plan at the time of retirement to qualify for continued coverage.

3. The retiree must enroll in retiree coverage within 60 days of their date of retirement. The retiree has the option of enrolling an eligible spouse/domestic partner and/or dependents for coverage at retirement, provided they are covered through CIS at the time of the employee's retirement. Dependents not enrolled in retiree coverage at the time of retirement may not be added at a later date; however, a new spouse or qualified domestic partner, or new dependent child(ren) acquired after retirement will be eligible to enroll within 31 days of the event. Dependents become ineligible if the retiree leaves the CIS plan, unless the retiree's loss of eligibility is due to Medicare eligibility or death. If incapacitated, the child can remain on coverage until both the Employee/Spouse become Medicare eligible or the incapacitated child becomes Medicare eligible, whichever is earlier.

4. Eligibility ceases when the retiree, or his/her eligible dependent, becomes Medicare eligible due to age or disability.

5. Retirees who return to work for a Member in the CIS health benefits program and who become eligible for benefits as an active employee, may temporarily drop the retiree plan for the active plan and later return to the current Member's retiree plan as long as CIS coverage is continuous.

B. PLANS AVAILABLE

1. Employees offered only one plan option while active may continue only that plan at retirement.

2. Employees offered a choice of plans with multiple insurers/administrators while active will be given a one-time opportunity to change plans at the time of retirement.

3. Employees offered a choice of plans with the same insurer/administrator while active can change to a different option offered with the same insurer/administrator at the time of retirement, or during open enrollment.

4. If a Kaiser member moves out of the Kaiser service area, he/she may make a

one-time change to a Regence plan, or an DeltaODS or Willamette Dental plan, if available.

5. If the retiree is enrolled in both medical and dental coverage as an active employee, he/she may choose to continue only medical in retirement. If medical is offered by the Member, retirees cannot continue dental only unless they opted out of medical as an active employee. Dependents can only be covered on the dental plan if they arewere also covered on the medical plan. If dental insurance is discontinued, the retiree cannot re-enroll at a later date.

6. Retirees continue at the rates specified by CIS or as specified by law.

7. If the active group or subgroup from which the employee retired leaves CIS, the retiree must move with them and is no longer eligible to continue CIS retiree coverage.

C. MEMBER PAYMENTS

The Member determines the amount, if any, they will contribute toward the cost of retiree coverage.

## Rule EB12: PRE-TAX PROGRAMS

A. MEMBER PLAN SELECTION

Members must offer a CIS medical plan to offer a CIS pre-tax plan. Subgroups can participate only if they also are covered by at least one line of CIS coverage (e.g., medical, dental, Basic Life or LTD). Members may select one or more of the options available: Premium Only Plan, Healthcare Flexible Spending Account, or Dependent Care Flexible Spending Account.

Other partial funding options such as Health Savings Accounts (HSA) or Health Reimbursement Arrangements (HRA) funded through a Voluntary Employees Beneficiary Association (VEBA) plan may be selected. The Member is responsible for providing the data for testing and any applicable required filings outlined in Internal Revenue Code.

An HSA can only be offered with High Deductible Health Plans 1, 2, 3 and 4.

B. MEMBER PAYMENTS

There are no required Member payments to these programs.

C. MEMBER CONTRIBUTIONS – HSAs or HRAs/VEBAs

Member contributions to an eligible employees' HSA may not exceed an amount equal to the annual deductible for the category of coverage applicable to the Participant under the HDHP for the Plan Year.

If a Member is implementing an HRA (with or without funding through a VEBA) as the result of a medical plan change, contributions for the HRA may not exceed an amount equal to the annual deductible for the category of coverage applicable to the Participant under the medical plan. If implementing an HRA without any change or relationship to the medical plan (e.g., in lieu of a COLA), the Member can determine the contribution amount.

Member premiums may be surcharged based on the employer contribution amount into the employees' HSA, HRA or VEBA.

D. EMPLOYEE ELIGIBILITY

Employees of a Member or subgroup must be covered by a CIS medical, dental, life or disability plan to be eligible to participate in a CIS pre-tax plan.