CIS BENEFITS RULES

The CIS Board of Trustees adopts the following Rules regarding CIS Benefits programs. The Rules are effective January 1, 2014~~3~~ 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 Line of 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 30 days advance notice for mid-year collective bargaining changes. Changes will be effective the first of the month following the 30-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 ~~over~~ 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. ~~based on evaluation of 24 months of claims experience.~~

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 Dental refer to the CIS self-insured plans that are administered by Regence and ODS 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 cannot 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 ~~the visiona~~ 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:

O One Regence ~~indemnity~~ plan and one Kaiser ~~managed care~~ plan; or
O Two Kaiser plans; or
O Two Regence plans ~~for medical. As an alternative, two plan options~~ that are within a 5% rate spread. ~~may be offered.~~

4. For Members or subgroups with 100 to 232 covered employees in the ~~indemnity~~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 ~~may be offered~~
   b. All rates may be surcharged for potential adverse selection risk.

5. For Members or subgroups with 233 or more covered employees in the indemnity 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 ~~may be offered~~
   b. All rates may be surcharged for potential adverse selection risk.

6. 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.

7. 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).

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

9~~8~~. Members with 10 or more employees may offer a choice of ~~the~~ an ODS Dental ~~self-insured dental~~ plan and Kaiser and Willamette Dental. ~~one or both of the managed care options.~~

10~~9~~. Members may select different medical and dental plan insurers or administrators.

Rule EB4: HEALTH INSURANCE - MEMBER PAYMENTS

A. If a Member does not contribute toward the cost of dependent coverage, then the Member must pay ~~100%~~ 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 ~~health~~ 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 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 ~~self-insured medical or~~ Regence medical or ODS d~~D~~ental 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-~~adjusted~~ rated groups can receive a composite rate.

G. Commissions for agents of record will be added to the CIS medical/dental rates. Commissions are a flat 2% of eligible contributions/premiums for pooled Members (under 100 employees) and negotiable between the Member and the agent for experience-rated Members (100 or more ~~over 100~~ employees). ~~Eligible contributions for c~~Commissions are only applicable to Regence medical, ODS Dental, and VSP vision plans.~~based on contributions for the self-insured medical and dental 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. Employees (including part-time employees) must be in a regular position and 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 health insurance coverage.

B. No seasonal, temporary, or limited duration ~~(less than four months)~~ employees can be covered unless eligible under the Patient Protection and Affordable Care Act. ~~working less than 30 hours can be insured.~~ Contract employees (through a temporary employment agency or personal services contract) and volunteers are not eligible for coverage.

C. Same-sex domestic partners, and their eligible children, are eligible for coverage, as required by law. A Member may choose to extend coverage to opposite-sex domestic partners, and their eligible children, by vote of the governing body. A Certificate of Registered Domestic Partnership ~~*or a CIS Affidavit of Domestic Partnership*~~ *is required.* The Member agrees to charge the covered employee the applicable imputed value amount.

D. Employees adding a spouse to the health coverage are required to ~~must~~ provide documentation. ~~a copy of their marriage license or certificate for coverage to be continued.~~ Acceptable documentation is a marriage license or certificate.~~*or a CIS Affidavit of Marriage.*~~

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's 75% participation requirement (see Rule 6(A)) is met. Elected officials do not qualify as a unique subgroup.

F. A Member may waive its stated waiting period for new employees who come from another CIS-Benefits-covered Member as long as there is no break in CIS 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.
   - 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. For Members with 10 or more employees, at least ~~75%~~ 90% of the eligible employees of the Member or the subgroup who have not opted out under Section E below must be enrolled in each of the coverages that the Member offers. For Members with fewer than 10 employees, at least 50% of the eligible employees must be enrolled. 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.

B. If the Member offers medical and dental coverage, an employee need not enroll in both; however, the individuals enrolled in dental must match the individuals enrolled in the medical plan. Employees or dependents enrolled in an ODS Dental plan after their initial eligibility period will be subject to a waiting period for certain dental services.

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

D. Members may offer dependent coverage on an optional basis but may not provide incentives to employees for not enrolling their eligible dependents on medical and/or dental coverage.

E. Members may choose to offer an employee "opt out for cash" arrangement when completing their annual RFC, with the following parameters:

1. Employees accepting this option must provide proof of other group medical coverage. Individual policies purchased through Cover Oregon or any other state or federal Insurance Exchange program do not qualify as group coverage.
2. Employees accepting this option can do so only for medical (including any riders).
3. The cash back allowance cannot exceed $50 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 $100.

F. Employees waiving medical and/or dental coverage must complete a Waiver of Coverage form and provide proof of other group coverage. Employees must still be enrolled in all employer-paid life/disability plans through CIS.

G. Members cannot 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 may require completion of the medical plan's health assessment in order to be eligible to participate.~~ 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 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 ($5k) 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. Same-sex domestic partners are eligible for Spouse Life or Long Term Care coverage, 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 EB10: 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 covered as an active employee under a CIS health benefits program 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 ~~their~~ his/her eligible dependent, becomes Medicare eligible.

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 ~~must~~may continue that plan at retirement.

2. Employees offered a choice of plans with multiple insurers/administrators 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 can change to a different option within the same carrier 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 ~~statewide~~ Regence plan, or an ODS 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. Dependents can only be covered on the dental plan if they are also covered on the medical plan. If dental insurance is discontinued, the retiree cannot re-enroll at a later date. ~~must retain both coverages as a retiree unless the Member elected not to offer dental coverage to any retirees.~~

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, it will contribute toward the cost of retiree coverage.

~~Rule EB12: LONG TERM CARE INSURANCE~~

~~A. This Rule will be deleted effective April 1, 2013, after which time new enrollment in Long Term Care insurance will not be offered.~~

~~B.~~

~~C. MEMBER/EMPLOYEE ELIGIBILITY~~

~~D.~~

~~1. Members that offer CIS medical, dental, Basic Life, or Long Term Disability insurance may offer long term care insurance.~~

~~2. Long term care insurance must be offered to all employees. It cannot be offered to a subgroup only.~~

3. ~~Employees of a Member or subgroup must be eligible to participate in a CIS medical, dental, Basic Life or Long Term Disability plan to participate in CIS' Long Term Care insurance.~~

Rule EB132: PRE-TAX PROGRAMS

A. MEMBER PLAN SELECTION

Members must offer a CIS medical plan to offer a CIS pre-tax plan. 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), Health Reimbursement Arrangements (HRA) or Voluntary Employees Beneficiary Association (VEBA) plans may be selected. The Member is responsible for providing the data for testing and any applicable required filings outlined in Internal Revenue Code.

High Deductible Health Plans 1 and 2 can only be offered with an HSA.

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 ~~will be equal to~~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, ~~Member contributions to an HRA or VEBA~~ 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 COLA), the Member can determine the contribution amount.~~or less than the previous out-of-pocket maximum cost (deductible & coinsurance) for medical insurance (or dental insurance if that is the only coverage offered).~~ 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 ~~eligible to participate in a CIS medical or dental plan~~ to be eligible to participate in a CIS pre-tax plan.