2024 CIS Benefits

Enrollment & Eligibility Guide:

- Benefit Eligibility
- Who can I cover?
- When can I make a change to my coverage?
- Special Enrollment Rights
- Medicare Eligibility & Retiree Coverage
- Leave of Absence, 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.

Notice About Request for Social Security Numbers (SSN)

The Affordable Care Act (ACA) requires providers of employer-sponsored health plans to provide SSNs for individuals covered by the plan to the IRS for tax-reporting purposes.

When an employee enrolls in a CIS plan administered through Regence or a Kaiser plan, CIS has access to the employee's SSN through the employer. When the employee covers dependents (including spouse/partner) in either of these plans, CIS — through the CIS-Connect portal — must ask the employee for the dependent SSNs. There is no penalty for the employee or the plan if the employee does not provide the information.

The IRS uses the SSNs to crosscheck that members had employer-sponsored health coverage during the plan year and that they didn't get a healthcare tax subsidy. The IRS has posted helpful information about this request: **http://tinyurl.com/HealthSSNqa** and **http://tinyurl.com/HealthMayAsk**.

When am I eligible for insurance?

You must enroll for benefits online within 60 days from your date of hire, date of becoming benefit eligible due to increase in hours, or during the annual open enrollment period. As long as you enroll within these time periods, and provide all required documentation, 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.), or on the first day of the new plan year. Supplemental Employee/Spouse Life insurance, if applicable, may be effective at a later date, depending on the date of approval by the carrier.

If new employees or newly benefit eligible employees elect to cover a disabled dependent over age 26, they can only be covered if disabled prior to age 26 and deemed disabled by a medical plan. A copy of the disability documentation from the medical plan must be provided to CIS, along with the birth certificate.

What are my options for enrollment?

Your options are based on the plans selected by your employer. These options will appear in your enrollment event and under Enrollment Materials in CIS-Connect.

If medical insurance is offered, you may opt out of coverage if you have other qualified group coverage (e.g., coverage through a spouse's plan). You may not opt out based on other individual coverage, or individual policies purchased through any state or federal sponsored exchange, Medicaid, Veteran's Administration (VA) Benefits, Medicare, TRICARE, or Tribal Benefit Programs. You must elect the "opt out" option online and you may be required to provide proof of other coverage to your employer.

There is also an option to waive coverage, which lets you decline coverage, even if you don't have other qualified group coverage. If your employer offers dental and you don't want it, you can waive dental. If your employer offers medical and you don't want it, you can waive medical. However, waiving medical automatically waives you from dental as well. 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's offered through CIS.

If offered dental insurance, you have three options:

1. Waive dental coverage
2. Enroll in employee-only coverage
3. Enroll in employee & dependent coverage.

If you (or an eligible dependent) do not enroll in dental when initially eligible, you will be subject to a late enrollment penalty. Coverage will be limited to preventive services only for the first 12 months.

Who can I cover on my insurance?
The following individuals are considered eligible dependents and can be enrolled on your coverage.

<table>
<tr><th>Dependent Type</th><th>Documentation Required</th></tr>
<tr><td><u>Legally Married Spouse</u>
An individual whom the employee is currently married to under the laws of the State of Oregon or under the laws of any other state or country.</td><td>Marriage Certificate that must include:
– Name of Employee
– Name of the Spouse
– Date of Marriage
– Certifier's Signature and Official Seal
– State, County, or Country of Issuance</td></tr>
<tr><td><u>Oregon Registered Domestic Partner</u>
An unmarried individual who has entered into the State of Oregon's "Declaration of Domestic Partnership" with the employee.
– Employees who cover a registered domestic partner will be charged an imputed value amount. Check with your employer for paycheck deduction questions.</td><td>Oregon Certificate of Registered Domestic Partnership that must include:
– Name of the Employee
– Name of the Registered Domestic Partner
– Certificate Date
– Certifier's Signature and Official Seal

*Not all employers offer coverage to Registered Domestic Partners. Please check with your employer for Registered Domestic Partner enrollment eligibility.</td></tr>
<tr><td><u>Child Under Age 26</u>
An individual who is the child of employee, child of spouse, child of registered domestic partner, or child for whom the employee, spouse, or registered domestic partner has legal guardianship.
– Children don't have to reside with you, be tax dependent, be unmarried, or be attending college to be eligible for coverage.
– A child's coverage cannot be terminated mid-year unless the child experiences an IRS-qualified status change (see following pages).
– Child will be eligible for coverage through the end of the month they turn age 26.</td><td>One of the Following
• Government Issued Birth Certificate or Naturalization Certificate/Report of Birth Abroad for child of employee, stepchild, or child of registered domestic partner that must include:
– Name of the Employee, Spouse, or Registered Domestic Partner
– Name of the Child
– Date of Birth
o For a Stepchild or Child of Registered Domestic Partner, a Marriage Certificate or Oregon Certificate of Registered Domestic Partnership is also required in addition to a birth certificate.
• Adoption paperwork for Adopted child or child placed for adoption prior to the child turning age 18 (only needed if the Employee, Spouse, or Registered Domestic Partner is not listed as a parent on the birth certificate).
• Court Document for Legal Guardianship or custody dated prior to the child turning age 18.
• Qualified Medical Child Support Order (QMCSO) for child the employee is obligated to provide benefits.</td></tr>
</table>

Dependent Type	Documentation Required
Incapacitated Child An Incapacitated Child is 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 insurance carrier	Same documentation as stated for Child Under Age 26 and **Medical Carrier Approval**

The documentation required when adding a dependent to your coverage for the first time is outlined on the following pages. Please note that CIS has the right to conduct a dependent-audit at any time.

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 mid-year changes must be completed online at www.cisbenefits.org. A description of each event, the allowed changes, and supporting documentation requirements are listed on the following pages. 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 Guardianship or Custody
3. Qualified Medical Child Support Order (QMCSO)
4. Marriage
5. New Registered Domestic Partner
6. Divorce/Annulment/Legal Separation
7. Dissolution/Termination/Legal Separation of Registered Domestic Partnership
8. Employee Gains Other Coverage
9. Dependent Gains Other Coverage
10. Employee Loses Other Coverage
11. Dependent Loses Other Coverage
12. Change in Hours – Increase
13. Change in Hours – Decrease
14. Change in Hours – Already Benefit Eligible
15. Death of a Spouse/Registered Domestic Partner
16. Death of a Child
17. Increase/Decrease in Cost of Dependent Care

In the tables below, "Supp Life" is short for Supplemental Employee/Spouse Life through The Hartford. "Vol Plans" denotes the following voluntary plans: Dependent Life through The Hartford, Identity Theft coverage through Allstate Identity Protection, Critical Illness, Hospital Indemnity and Accident coverage through MetLife, and Trauma coverage through Lloyd's of London. Your eligibility for any of these plans is based on whether your employer elected to offer them.

1. **Birth/Adoption**
   Employees have 60 days from the date of birth or adoption to enroll a new child. Medical, dental, and vision coverages are effective as of the date of birth/adoption. Other coverages are effective the following first of the month.

   Newborn documentation requirements: A newborn child must be enrolled within 60 days even if a birth certificate or Social Security Number (SSN) is not yet available. A birth certificate must be provided within 60 days of the date of birth, and the SSN must be provided within 6 months. If either is not provided within the specified time period, coverage will be terminated retroactive to the date of birth.

   The following changes can be made:

Medical/Dental/Vision	Supp Life[1]/ Vol Plans	Flexible Spending Account[2]	Documentation
Enroll child, self and eligible dependent(s) in coverage	Enroll or increase life coverage for self (subject to medical underwriting); enroll in supplemental spouse life; enroll in voluntary plans	Enroll/increase healthcare or dependent care election	Copy of birth certificate or adoption papers

2. **Court-Appointed Legal Guardianship or Custody**
   Employees have 60 days from the date of a court-ordered Legal Guardianship or Custody to enroll a new child. 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	Supp Life[1]/ Vol Plans	Flexible Spending Account[2]	Documentation
Enroll child	Enroll or increase life coverage for self (subject to medical underwriting); enroll in supplemental spouse life; enroll in voluntary plans	Enroll/increase healthcare or dependent care election	Copy of court order

[1]Effective the first of the month following 30 days from the date of the approval.
[2]Effective the first of the month following the date the election change is made online.

3. **Qualified Medical Child Support Order (QMCSO)**
   Employers will be notified when an employee is required to provide coverage due to a court order. Coverage is effective the first of the month following the date the order was signed. The following changes can be made:

Medical/Dental/Vision	Supp Life/ Vol Plans	Flexible Spending Account[2]	Documentation
Enroll child	No changes allowed	If ordered to pay for medical expenses not paid by insurance, enroll/increase healthcare FSA. If the order requires another person to pay for expenses not paid by insurance, may decrease/terminate healthcare FSA election.	Copy of QMCSO

4. **Marriage**
   Employees have 60 days from the date of marriage to enroll a new spouse. Coverage is effective the first of the month following the date of marriage. The following changes can be made:

Medical/Dental/Vision	Supp Life[1]/ Vol Plans	Flexible Spending Account[2]	Documentation
Enroll spouse, self and eligible dependent(s) in coverage	Enroll or increase life coverage for self (subject to medical underwriting); enroll in supplemental spouse life; enroll in voluntary plans	Enroll/increase healthcare or dependent care election	Copy of marriage certificate

[1]Effective the first of the month following 30 days from the date of the approval.
[2]Effective the first of the month following the date the election change is made online.

5. **Newly Registered Domestic Partner**
Domestic Partners are only eligible for coverage when an Oregon Certificate of Registered Domestic Partnership has been filed. Employees have 60 days from the date of filing to enroll a new domestic partner. Coverage is effective the first of the month following the date of filing. The following changes can be made:

Medical/Dental/Vision	Supp Life[1]/ Vol Plans	Flexible Spending Account[2]	Documentation
Enroll registered domestic partner, self, and eligible dependent (s) in coverage	Enroll or increase life coverage for self (subject to medical underwriting); enroll in supplemental spouse life; enroll in voluntary plans	No changes allowed; medical expenses for domestic partners are not eligible for reimbursement	Oregon Certificate of Registered Domestic Partnership

6. **Divorce/Legal Separation/Annulment**
Employees have 60 days from the date of a final divorce/legal separation/annulment to report the event. Coverage terminates the end of the month following the date of divorce. Failure to report this event in a timely manner will result in the loss of COBRA continuation rights. *For legal separation only - if the employee does not want to remove the spouse from enrollment, no action is needed as the spouse is still an eligible dependent*. The following changes can be made:

Medical/Dental/Vision	Supp Life[1]/ Vol Plans	Flexible Spending Account[2]	Documentation
Drop spouse and stepchild(ren)	Increase (subject to medical underwriting) or decrease coverage for self; supplemental spouse life is terminated; voluntary plans should be updated to remove spouse	Enroll/increase healthcare election due to loss of coverage; decrease election (cannot decrease if annual election has been reimbursed)	Copy of divorce decree (first page and last page) or other legal documentation showing date of divorce and judge's signature

[1]Effective the first of the month following 30 days from the date of the approval.
[2]Effective the first of the month following the date the election change is made online.

7. **Dissolution/Termination/Legal Separation of Oregon Registered Domestic Partnership**
Employees have 60 days from the date of the event to report a final dissolution of registered domestic partnership. Coverage terminates at the end of the month following the date of dissolution. Failure to report this event in a timely manner will result in the loss of COBRA continuation rights. <u>*For legal separation only*</u> - *if the employee does not want to remove the registered domestic partner from enrollment, no action is needed as the registered domestic partner is still an eligible dependent*. The following changes can be made:

Medical/Dental/Vision	Supp Life[1]/ Vol Plans	Flexible Spending Account	Documentation
Drop registered domestic partner and child(ren) of registered domestic partner	Increase (subject to medical underwriting) or decrease coverage for self; supplemental spouse life is terminated; voluntary plans should be updated to remove registered domestic partner	No changes allowed	Copy of dissolution/termination

8. **Employee Gains Other Coverage**
Employees have 60 days to report a gain of other coverage and provide proof of that coverage for themselves. Coverage terminates at the end of the previous month if new coverage begins on the 1st of the current month or the end of the current month if coverage begins any day other than the 1st. "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	Supp Life/ Vol Plans	Flexible Spending Account[2]	Documentation
Drop self and any dependents	No changes allowed	Decrease/terminate healthcare election	Documentation showing effective date of other coverage and name of covered individual(s)

[1]Effective the first of the month following 30 days from the date of the approval.
[2]Effective the first of the month following the date the election change is made online.

9. Dependent Gains Other Coverage

Employees have 60 days to report a gain of other dependent coverage and provide proof of that coverage for dependent(s). Coverage terminates at the end of the previous month if new coverage begins on the 1st of the current month or the end of the current month if coverage begins any day other than the 1st. "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	Supp Life/ Vol Plans	Flexible Spending Account[2]	Documentation
Drop dependent(s) who gained coverage	No changes allowed	Decrease/terminate healthcare election	Documentation showing effective date of other coverage and name of covered individual(s)

10. Employee Loses Other Coverage

Employees have 60 days to report and submit appropriate documentation of a loss of other employer group coverage for themselves. 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	Supp Life/ Vol Plans	Flexible Spending Account[2]	Documentation
Enroll self and any dependents	No changes allowed	Enroll/increase healthcare election	Documentation showing date of loss of other coverage and name of covered individual(s)

11. Dependent Loses Other Coverage

Employees have 60 days to report and submit appropriate documentation of a loss of other employer group coverage for their dependents. Coverage is effective the first of the month following the date of loss. "Coverage" only includes other employer group coverage or termination of federal or state assistance programs. The following changes can be made:

Medical/Dental/Vision	Supp Life/ Vol Plans	Flexible Spending Account[2]	Documentation
Enroll dependent(s)	No changes allowed	Enroll/increase healthcare election	Documentation showing date of loss of other coverage and name of covered individual(s)

[2]Effective the first of the month following the date the election change is made online.

12. Change in Hours – Increase Resulting in New Benefit Eligibility

Employees have 60 days to enroll in benefits from the date their work hours increase resulting in becoming benefit eligible. If waiting period has already been met, coverage is effective the first of the month following the date of the hours change. The following changes can be made:

Medical/Dental/Vision	Supp Life[1]/ Vol Plans	Flexible Spending Account[2]	Documentation
Enroll self and eligible dependent(s) in coverage	Enroll in coverage	Enroll in healthcare and/or dependent care	Employer updates hours in Connect and date of change

13. Change in Hours – Decrease Resulting in Loss of Eligibility for Benefits

All coverages terminate at the end of the month the hours change.

14. Change in Hours (Already Benefit Eligible) – Significant Bmployee Cost Change Due to Increase/Decrease in Hours

Employees have 60 days to enroll or disenroll in benefits from the date their work hours increase/decrease. Coverage change is effective the first of the month following the date the hours change. Please contact the CIS Benefits Helpline at 855-763-3829 to discuss coverage options.

15. Death of a Spouse/Registered Domestic Partner

Upon notification of a spouse/registered domestic partner's death, coverage for the deceased individual terminates the end of the month following the death. Coverage change is effective the first of the month following. The following changes can be made:

Medical/Dental/Vision	Supp Life[1]/ Vol Plans	Flexible Spending Account[2]	Documentation
Drop dependent	Increase (subject to medical underwriting) or decrease coverage for self; supplemental spouse life is terminated; voluntary plans should be updated to remove spouse/registered domestic partner	Enroll/increase/ decrease healthcare election (cannot decrease if annual election has been reimbursed)	No documentation is required

[1]Effective the first of the month following 30 days from the date of the approval.
[2]Effective the first of the month following the date the election change is made online.

16. Death of a Child

Upon notification of a child's death, coverage for the child terminates the end of the month following the death. Coverage change is effective the first of the month following. The following changes can be made:

Medical/Dental/Vision	Supp Life[1]/ Vol Plans	Flexible Spending Account[2]	Documentation
Drop dependent	Decrease coverage for self; voluntary plans should be updated to remove child	Decrease healthcare election (cannot decrease if annual election amount has been reimbursed)	No documentation is required

17. Increase/Decrease in Cost of Dependent Care

Employees have 60 days to request a change in their dependent care FSA elections due to increase/decrease in cost. The election change must be consistent with the event. The following changes can be made:

Medical/Dental/Vision	Supp Life/Vol Plans	Flexible Spending Account [2]	Documentation
No changes allowed	No changes allowed	Increase/decrease dependent care due to cost change	No documentation is required

[1]Effective the first of the month following 30 days from the date of the approval.
[2]Effective the first of the month following the date the election change is made online.

Special Enrollment Rights (Medical/Vision & Dental)
There are certain situations when you may enroll yourself and/or your eligible dependents, even though you didn't do so when first eligible, and you do not have to wait for an annual enrollment period.

The following events may allow enrollment within 60 days of the date of the qualifying event and coverage will be effective the first of the month following the coverage end date:

- You and/or your eligible dependents lose coverage under another group or individual Health Benefit Plan due to one of the following:
  - An employer's contributions to that other plan are terminated;
  - Exhaustion of federal COBRA or any state continuation; or
  - Loss of eligibility, for instance, due to legal separation, divorce, termination of domestic partnership, death, termination of employment or reduction in hours.
- You involuntarily lose coverage under Medicare, CHAMPUS/Tricare, Indian Health Service or a publicly sponsored or subsidized health plan (other than the Children's Health Insurance Program (CHIP)).

The following event may allow enrollment within 60 days of the date of the event and coverage will be effective the first of the month following the date of the qualifying event:

- You and/or your dependent(s) become eligible for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP).

Please contact the CIS Benefits Helpline (855-763-3829) if any of these events happen so we can assist in determining eligibility for enrollment.

Medicare Eligibility for Active Employees
If you or a dependent becomes Medicare-eligible while still working and eligible for benefits, the group coverage through CIS is primary and Medicare is secondary. You, or your dependent, can enroll in Medicare Part A (usually available at no cost) and defer Medicare Part B and Part D (prescription drug coverage) until no longer an active employee or no longer covered by an active plan.

Leaves of Absence
Employees are entitled to many different types of leaves of absence, including family medical leave (state and federal), 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 leaves will allow employees to maintain their existing medical/dental and life/disability coverage for a limited period of time, but specific timelines must be followed. Employees planning on a leave of absence, or returning from a leave, need to discuss their options with their employer.

<u>Medical/Dental Coverage</u>
If coverage terminates due to loss of eligibility, employees may have the option to continue coverage on a self-pay basis through COBRA (see below).

Healthcare Flexible Spending Account (FSA)
For participants enrolled in the Healthcare FSA, deductions continue if the leave is with pay and no changes are allowed. For leave without pay, deductions are discontinued unless the employee elects to continue the account through COBRA. The account is reinstated upon return to work and while election changes may be allowed, they must be consistent with returning from leave.

Dependent Care Flexible Spending Account (FSA)
For participants enrolled in a Dependent Care FSA, dependent care expenses are not eligible for reimbursement while on leave with or without pay. Deductions will be reinstated upon return to work, but election changes can be made.

Hartford Life/Long-Term Disability Coverage
Depending on the type of leave, coverage may be continued for a limited period of time. Check with CIS for your continuation options.

Voluntary Plans: Short-Term Disability, Identity Protection, Critical Illness, Hospital Indemnity, Accident, Trauma
Check with the applicable company for your continuation rights.

Workers' Compensation Claims
If you are not working the minimum hours required by your employer for coverage due to an injury or illness for which you have filed a workers' compensation claim, you may be eligible for continued medical and dental coverage for up to 12 months after your eligibility ends, depending on your employer's policies/procedures. Continuation periods for life and disability coverage are different, based on the insurance policies' provisions. Check with your employer for eligibility on medical/dental continuation options and CIS for life/disability continuation options.

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

Oregon state law allows surviving or divorced spouses between the ages of 55-65 and their dependent(s) to extend continuation coverage in their Oregon-based insured health plans once the Federal continuation has been exhausted. The extended coverage can be continued until they become eligible for Medicare or covered under another health benefit plan, as long as the employer continues to sponsor the group health plan.

The premium for continuation coverage is more expensive than the amount you paid as an active employee for group health coverage. This is because your employer paid all or part of your active premium. With COBRA continuation coverage, the full cost, along with a 2% administrative fee, is typically passed on to the individual(s) electing coverage.

Important Note: If your employer will be providing a premium subsidy, you MUST still complete and return the COBRA Enrollment Form to CIS or enroll online within the enrollment timeline. If enrollment is not completed, your coverage will not be continued.

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 at any time during the continuation period. The administrator, however, will terminate coverage due to non-payment of premium on a timely basis, when the participant has gained other coverage, or at the end of the continuation period.

Alternatives to COBRA Continuation Coverage

Under the Affordable Care Act (ACA), individuals who lose employer health insurance coverage 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.

Notice Procedures

Upon notification of a termination by your employer, CIS will send a COBRA notice to you using the address on file. If you are moving to a new location, you will need to notify your employer or contact CIS. You 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 elect retiree coverage because it can be continued until Medicare eligibility, whereas COBRA can only be continued for a limited period of time. Retiree coverage also does not include the 2% administrative fee. If retiree or COBRA continuation coverage is voluntarily terminated or terminated for non-payment, you cannot re-enroll at a later 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. The Hartford will mail, to your address in CIS-Connect, a letter which will outline your continuation options. You can also contact The Hartford directly at 888-563-1124.

Retiree Coverage

You may be eligible to continue coverage as a retiree if:

- You are not Medicare eligible and
- You are receiving, or are eligible to receive, retirement benefits under the Oregon Public Employees Retirement System or any other retirement system or plan applicable to employees of the local government that employs you.

You must have been enrolled as an active employee in a CIS medical and/or dental plan at the time of retirement to qualify for continued coverage as a retiree. You must enroll within 60 days of your date of retirement. If you had dependents covered when you retired, coverage may also be continued for them.

Eligibility for medical/vision/dental insurance ends for you, your spouse, and any dependent children the last day of the month prior to becoming eligible for Medicare due to age or disability. Even if CIS is not timely notified of Medicare eligibility, coverage will be terminated retroactive to the date you or your dependent became Medicare eligible. Eligibility for dependent children ends when the employee and spouse, if applicable, both become Medicare eligible unless the child(ren) has not yet reached the age of majority (18). Children under 18 can continue coverage until the end of the month in which they turn 26.

For questions regarding coverage options upon retirement, contact the CIS COBRA/Retiree Team at cobraretiree@cisoregon.org or by calling the CIS Benefits Helpline at 855-763-3829.

Administrative and Eligibility Appeals

Administrative appeals relate to decisions made by your employer. Eligibility appeals relate to employees who miss enrollment timelines. Employees may appeal an administrative or eligibility decision by appealing in writing to the CIS Benefits Director 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 employee is dissatisfied with the decision, he/she may make a written request for reconsideration to the CIS Executive Director within 45 days of the CIS Benefits Director's denial. The CIS Executive Director may, at their discretion, consult with the Board of Trustees and will respond with notification of status of the request for consideration within 15 days. A final determination response will be sent in writing no later than 30 days from the date the request is received by the CIS Executive Director. The CIS Executive Director’s determination is final, and there are no further appeal rights.