



cis benefits
cisbenefits.org

2020 CIS Benefits Enrollment & Eligibility Guide:

- Benefit Eligibility
- Who can I cover?
- When can I make a change to my coverage?
- Loss of Coverage & Continuation Rights



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

Notice About Request for Social Security Numbers (SSN)

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

When an employee enrolls in either Regence or Kaiser, 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 employer - 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 care coverage during the plan year and that they didn't get a health care 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 or during the annual open enrollment period. As long as you enroll within these time periods, 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.

What are my options for enrollment?

Your options are based on the choices made by your employer. 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 must elect the "opt out" option online and you'll be required to provide proof of the 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 plus spouse, child, children, or family coverage. If enrolling dependents on dental, they must match the dependents enrolled on the medical plan (unless "opted out" of medical).
 - If opting out of medical coverage but enrolling in dental coverage and covering any dependents, all eligible dependents must be enrolled.

If you (or an eligible dependent) do not enroll in dental when initially eligible, you will 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.

1. A legally-married spouse.
2. A same-sex domestic partner included on the employee's Oregon Certificate of Registered Domestic Partnership. *Employees who cover a domestic partner will be charged an imputed value amount.*
3. Child(ren) under the age of 26 who are:
 - The natural child of the employee, spouse or domestic partner;
 - The adopted child of, or child placed for adoption with, the employee, spouse or domestic partner, provided that the child is adopted or placed for adoption prior to attaining age 18;
 - A child for whom the employee, spouse or domestic partner has obtained court-ordered legal guardianship or custody prior to attaining age 18;
 - A child for whom the employee is obligated to provide benefits pursuant to a qualified medical child support order (QMCSO).

Children don't have to reside with you, be your 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 below).

4. An unmarried child over the age of 26 who has been continuously covered and is incapable of self-support due to a physical, mental or developmental disability that occurred before the child's 26th birthday, and for whom a handicapped dependent certification form has been received and approved by the insurer or administrator.

The documentation required when adding a dependent to your coverage for the first time is included 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 (except Healthcare or Dependent Care Flexible Spending Account (FSA) changes) will be completed online at www.cisbenefits.org. Mid-year changes for the Healthcare/Dependent Care FSA must be made by completing a hard copy change form and submitting it to your employer or CIS. A description of each event, allowed changes and supporting documentation requirements are listed in the table below. Changes requiring documentation will not be approved until the appropriate documentation has been received.

IRS-Qualified Family Status Changes include:

- | | |
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| 1. Birth/Adoption | 9. Dependent Gains Other Coverage |
| 2. Court-Appointed Legal Guardianship or Custody | 10. Employee Loses Other Coverage |
| 3. Qualified Medical Child Support Order | 11. Dependent Loses Other Coverage |
| 4. New Spouse | 12. Change in Hours – Increase |
| 5. New Domestic Partner | 13. Change in Hours – Decrease |
| 6. Divorce/Legal Separation | 14. Death of a Spouse |
| 7. Dissolution/Termination of Domestic Partnership | 15. Death of a Child |
| 8. Employee Gains Other Coverage | 16. Increase/Decrease in Cost of Dependent Care |

1. Birth/Adoption

Employees have 60 days from the date of birth or adoption to enroll a new child; health care coverage is effective the date of birth/adoption.

Newborn documentation requirements: A newborn child must be enrolled within 60 days even if a birth certificate or Social Security Number (SSN) are not yet available. A birth certificate must be provided within 90 days of the date of birth, and a SSN must be provided within 6 months. If either document is not provided within the specified time period, coverage will be terminated retro to the date of birth.

The following changes can be made:

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

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; health care coverage is effective the first of the month following the date the court order was signed. The following changes can be made:

Medical/Dental/Vision	Supplemental Life	Flexible Spending	Documentation
<i>Enroll child</i>	<i>Enroll or increase coverage (subject to medical underwriting); enroll in supplemental spouse and/or dependent life</i>	<i>Enroll/increase healthcare</i>	<i>Copy of court order</i>

3. Qualified Medical Child Support Order (QMCSO)

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

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

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

²Effective the first of the month following the date the FSA Enrollment Form is signed or received by the employer, whichever is later.

4. Marriage

Employees have 60 days from the date of marriage to enroll a new spouse; health care coverage will be effective the date of marriage. The following changes can be made:

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

5. New Domestic Partner

Employees have 60 days from the date of registration to enroll a new domestic partner; health care coverage will be effective the first of the month following the date the requirements for a domestic partnership have been met. The following changes can be made:

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

6. Divorce/Legal Separation

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

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

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

²Effective the first of the month following the date the FSA Enrollment Form is signed or received by the employer, whichever is later.

7. Dissolution of Domestic Partnership

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

Medical/Dental/Vision	Supplemental Life ¹	Flexible Spending Account	Documentation
<i>Drop domestic partner and child(ren) of domestic partner</i>	<i>Increase or decrease coverage for self; supplemental spouse life and/or dependent life</i>	<i>No changes allowed</i>	<i>Copy of dissolution</i>

8. Employee Gains Other Coverage

Employees have 60 days to report a gain of other coverage and provide proof of that coverage for themselves; health care 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	Supplemental Life	Flexible Spending Account	Documentation
<i>Drop self and any dependents</i>	<i>No changes allowed</i>	<i>No changes allowed</i>	<i>Documentation showing effective date of other coverage and name of covered individual(s)</i>

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); health care 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	Supplemental Life	Flexible Spending Account	Documentation
<i>Drop dependent(s) who gained coverage</i>	<i>No changes allowed</i>	<i>No changes allowed</i>	<i>Documentation showing effective date of other coverage and name of covered individual(s)</i>

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

10. Employee Loses Other Coverage

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

Medical/Dental/Vision	Supplemental Life	Flexible Spending Account	Documentation
<i>Enroll self and any dependents</i>	<i>No changes allowed</i>	<i>No changes allowed</i>	<i>Documentation showing date of loss of other coverage and name of covered individual(s)</i>

11. Dependent Loses Other Coverage

Employees have 60 days to report and submit appropriate documentation of an involuntary loss of other employer group coverage for their dependents; if appropriate documentation is submitted within the 60-day period, health care 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	Supplemental Life	Flexible Spending Account	Documentation
<i>Enroll dependent(s)</i>	<i>No changes allowed</i>	<i>No changes allowed</i>	<i>Documentation showing date of loss of other coverage and name of covered individual(s)</i>

12. Change in Hours - Increase

Employees have 60 days to enroll in benefits from the date their work hours increase resulting in becoming benefit eligible. Coverage is effective the first of the month following the date of the hours change. The following changes can be made:

Medical/Dental/Vision	Supplemental Life ¹	Flexible Spending Account	Documentation
<i>Enroll self and eligible dependent(s) in coverage</i>	<i>Enroll in coverage; enroll in supplemental spouse or dependent life</i>	<i>Enroll</i>	<i>None</i>

13. Change in Hours - Decrease

Employees whose work hours decrease, resulting in loss of eligibility for benefits, will have all coverages terminate the first of the month following the date of the hours change.

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

²Effective the first of the month following the date the FSA Enrollment Form is signed or received by the employer, whichever is later.

14. Death of a Spouse

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

Medical/Dental/Vision	Supplemental Life ¹	Flexible Spending Account	Documentation
<i>Drop dependent</i>	<i>Increase or decrease coverage for self; supplemental spouse life and/or dependent life is terminated</i>	<i>Enroll/increase/decrease health care election (cannot decrease if annual election has been reimbursed)</i>	<i>No documentation is required</i>

15. Death of a Child

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

Medical/Dental/Vision	Supplemental Life ¹	Flexible Spending Account	Documentation
<i>Drop dependent</i>	<i>Decrease coverage for self; dependent life is terminated</i>	<i>Decrease health care election (cannot decrease if annual election has been reimbursed)</i>	<i>No documentation is required</i>

16. 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 has to be consistent with the event. The following changes can be made:

Medical/Dental/Vision	Supplemental Life	Flexible Spending Account	Documentation
<i>No changes allowed</i>	<i>No changes allowed</i>	<i>Increase/decrease dependent care due to cost change</i>	<i>Completed FSA Enrollment Change form</i>

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

²Effective the first of the month following the date the FSA Enrollment Form is signed or received by the employer, whichever is later.

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:

- 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; or
 - Exhaustion of federal COBRA or any state continuation.
- 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:

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

Coverage will be effective the first of the month following the event, as long as required documentation is provided within 60 days of the event.

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

Leave 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 coverage for a limited period of time, but specific timelines must be followed. If coverage is terminated during a leave, employees may have the option to continue their coverage on a self-pay basis, such as medical and/or dental continuation through COBRA. Employees planning on a leave of absence, or are returning from a leave, need to discuss their options with their employer.

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 details.

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.

If your employer will be providing a premium subsidy, you **MUST** still complete and return an application to CIS within the enrollment timeline.

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

Alternatives to COBRA Continuation Coverage

Under the Affordable Care Act (ACA), individuals who lose employer health insurance coverage 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 take retiree coverage because it can be continued until

Medicare eligibility, whereas COBRA can only be continued for a limited period of time. If retiree or COBRA continuation coverage is voluntarily terminated, you cannot re-enroll at a future date.

Life/Disability Coverage

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

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 officers and 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.

If your employer will be providing a premium subsidy, you **MUST** still complete and return an application to CIS within the enrollment timeline.

Eligibility for medical/vision/dental insurance ends for you, your spouse or any dependent children when they become eligible for Medicare due to age or disability. 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 18.

For questions regarding coverage options upon retirement, contact Melinda Lund (CIS' Retiree/COBRA Coordinator) at mlund@cisoregon.org or 800-922-2684, x3823.

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 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.