

805 CMR: GROUP INSURANCE COMMISSION

805 CMR 9.00: ELIGIBILITY AND PARTICIPATION

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9.01: New Employees

(1) A new Employee's department or agency head shall determine within the first ten days of employment whether the Employee is eligible for Commission coverage. Employees whose duties are Seasonal or Emergency Employment or of a duration of not more than three months with no reasonable expectation of an extension, are not eligible for Commission coverage. Department or agency heads who are unable to determine eligibility shall send all information relating to the new Employee's work to the Commission for a final and binding eligibility determination. Persons who do not enroll in Commission coverage when they are first eligible may later enroll during the Commission's Annual Enrollment or with a qualifying event as specified in the Commonwealth's Section 125 Cafeteria Plan. Once an Employee enrolls in a health plan, the next opportunity to change plans is the GIC's next Annual Enrollment period, except as otherwise required by law.

(2) Members of the Judiciary who qualify as Employees are eligible for Commission coverage.

(3) Effective Date of Insurance Coverage. Eligible Employees who apply for coverage within ten days of the first day of employment shall be insured on the first day of the month following the earlier of 60 calendar days or two calendar months from the first day of employment. The first day of employment shall be counted when determining the effective date of Commission coverage, and one or more days of authorized leave of absence shall be counted as an equivalent number of days of employment.

(4) Retroactive Health Insurance Effective Date. Employees or dependents may request Commission Health Coverage to begin on the first day of employment or the first day of the health coverage waiting period referenced in 805 CMR 9.01(3), as applicable, if all of the following conditions are met:

- (a) the Employee or Dependent is not enrolled in other health coverage and incurs an unplanned and urgent medical expense that exceeds the Employee's full cost monthly premium;
- (b) the unplanned and urgent medical expense occurs on or after the first day of employment or waiting period but before the effective date of health coverage;

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(c) the Employee requests such coverage in writing and provides satisfactory documentation of the unplanned and urgent medical expense.

Coverage shall become effective as of State Employees' first day of active employment or Municipal Employees' first day of the waiting period, subject to their timely payment of the full-cost health insurance premium for the entire hiatus period. New Employees who begin employment on the 16th day of a month or later will not be charged premium for that month; new Employees who begin employment on or before the 15th day of a month shall be charged the full premium cost for the month. Coverage entitles the Employee only to those benefits that are otherwise available through the health plan selected, and claims may be denied in whole or in part, consistent with the health plan's covered benefits.

Employees' effective date of life insurance shall only become effective as described in 805 CMR 9.01(3) or 9.02.

(5) Employer Notification to New Employee. The Employee's department or agency head or Group Insurance Coordinator shall inform newly hired employees whether they are eligible for Commission coverage and what benefits are available to them, including Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage. The Group Insurance Coordinator shall also notify newly hired employees that premium deductions for Commission coverage are taken one month in advance of coverage.

(6) New Employees' Duty to Notify Employer. Eligible Employees who are advised by their department or agency head that they are eligible for Commission coverage shall, within ten days of beginning work or beginning the health care waiting period, inform their employer whether they intend to enroll in Commission coverage. Those enrolling in Commission coverage shall promptly select coverage and complete all necessary forms. Persons who fail to enroll in Commission coverage when first eligible may do so during the next occurring Annual Enrollment period or with satisfactory proof of loss of other coverage.

(7) Premium payment for Commission coverage must be made one month in advance of coverage in order for coverage to become effective.

(8) As a condition of employment, employees shall provide information to the Commonwealth as required by law, including but not limited to disclosures required by the Health Care Reform Act and the Affordable Care Act.

(9) If an employee is requesting a coverage effective date change to a different month, the employee's effective date of coverage shall be determined by the Commission, and is subject to receipt of premium before coverage becomes effective.

(10) Recalled Employees who do not continue their coverage with the Commission during the period when they are laid off shall be treated as re-employed persons, consistent with 805 CMR 9.19.

9.02: Elected Officials

(1) Officials elected by popular vote are eligible for coverage on the first day of the month nearest the date that they begin their term of office, excepted as noted in 805 CMR 9.02(2). Appointed employees and officials are subject to the waiting period for coverage in 805 CMR 9.01(3).

(2) Elected officials who are Municipal Employees and who have a Regular Work Week of less than 18.75 hours are eligible for coverage only at local option, per M.G.L. c. 32B, § 2 (d), "Employee". Municipal Employers shall inform the Commission by May 1st of each year of any change in eligibility of elected officials. Notification of the local option is binding on the Municipal Employer for the fiscal year starting that July 1st.

9.03: Eligibility for Health Coverage

- (1) Municipal Insureds, Survivors, and Elderly Governmental Retirees are eligible to enroll in Health Coverage without electing any other benefit. All other Employees and Retirees, including Retired Municipal Teachers must be enrolled in Basic Life Insurance in order to be eligible for Health Coverage.
- (2) Persons who cancel their Medicare coverage will next be eligible for the Commission's Health Coverage on July 1st after they reapply for Medicare and are reinstated to Medicare coverage. Commonwealth Retirees shall be solely responsible for any Medicare penalties incurred by the cancellation.
- (3) During any of the Commission's Annual Enrollment periods, uninsured Employees, Retirees and Survivors may elect Commission health coverage, which shall become effective the next occurring July 1st.
- (4) Employees, Retirees, Survivors, and Dependents may enroll in Commission health coverage if they provide acceptable proof of loss of other coverage and are otherwise eligible for the coverage. The Commission shall determine the effective date of coverage.
- (5) Employees, Retirees, and Survivors who terminate coverage due to non-payment of premiums may re-apply during any of the Commission's Annual Enrollment periods provided they are otherwise eligible for coverage.
- (6) The Commission shall determine the effective date for all matters pertaining to Health Coverage, including but not limited to eligibility, effective dates of coverage, termination, and status changes. The Commission determines whether persons are eligible for Commission coverage according to M.G.L. c. 32A and c. 32B, and its eligibility decisions are final and binding.

9.04: Individual and Family Health Coverage

- (1) Employees who elect Individual Health Coverage at the time of hire may later elect Family Health Coverage due to a change in family status (*e.g.*, marriage or adoption, spouse's loss of other coverage), subject to verifying documentation acceptable to the Commission including, but not limited to, marriage and birth certificates. Verification that requires translation shall be at the applicant's expense. The effective date of the family status change is determined by the Commission.
- (2) Employees, Retirees, and Surviving Spouses whose dependents cease to be eligible for Commission coverage must notify the Commission within 30 days of such occurrence. The Commission shall determine the effective date of dependents' coverage termination.
- (3) Employees, Retirees or Surviving Spouses may change their Family Coverage to Individual Coverage only by providing proof of their Dependents' other coverage or a change in family circumstance as described in 805 CMR 9.04. The Commission's decisions relating to coverage termination requests are final and binding.
- (4) Where a Retiree or Surviving Spouse is enrolled in a Commission Medicare plan, any non-Medicare-eligible Dependent may enroll only in Health Coverage with the same carrier as the Retiree or Surviving Spouse, and all such Dependents must enroll in the same plan. Likewise, where a Retiree or Surviving Spouse is enrolled in a non-Medicare plan, any Medicare-eligible Dependent may enroll only in a Commission Medicare plan with the same carrier as the Retiree or Surviving Spouse, and all such Medicare-eligible Dependents must enroll in the same Medicare plan. Any Medicare-eligible Dependent of a Retiree or Survivor in a Commission Medicare plan must enroll in the same Commission Medicare plan as the Retiree or Survivor.
- (5) Divorced spouses of Employees or Retirees cannot be terminated from Commission health coverage for reasons of additional cost when their children are no longer enrolled in the coverage unless the divorced Employee or Retiree has remarried or the divorce agreement expressly defines such a scenario as constituting additional cost.

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(6) For an Employee, Retiree, or Surviving Spouse with Family Health Coverage to enroll in a plan with a defined geographical enrollment area, all enrolled family members, including all covered Dependents, must reside in the plan's service area. For the purposes of 805 CMR 9.04(7), Children younger than 19 years old and Students are deemed to reside with the Employee, Retiree, or Surviving Spouse on whose plan they are Dependents, unless that Employee, Retiree, or Surviving Spouse is not the Child's or Student's custodial parent. In that case, Children younger than 19 years old and Students are deemed to reside with their custodial parent. In the event that an enrolled family member no longer resides in the plan's service area, the Employee, Retiree, or Surviving Spouse must either:

(a) disenroll the Dependent who no longer resides in the plan's service area, subject to other applicable requirements as outlined in 805 CMR 9.04(7); or

(b) enroll in a plan with an appropriate service area, or with no geographical restrictions.

If the latter course is elected, the Employee, Retiree, or Surviving Spouse must change plans concurrently with the change in residence, outside of the Annual Enrollment period if necessary.

9.05: Duplicate Coverage Prohibited

(1) In the event that a person is eligible for Commission benefits as an Employee or Retiree of more than one Employer, or as more than one of the following categories: Employee, Retiree, and Dependent; the person must elect a single such status for the purposes of enrolling in Commission benefits. For example, a person who qualifies both as a State Retiree and as a Municipal Employee may elect to be treated as either one, but not both.

(2) If both members of a married couple are Employees or Retirees and both are enrolled in Commission coverage, they may either:

(a) each have Individual Health Coverage; or

(b) have Family Health Coverage covering both spouses and all other eligible Dependents.

If a couple elects Family Health Coverage, only one spouse of the couple may be the named Insured for the Family Coverage. Both Employee spouses may each enroll in Basic Life Insurance coverage.

(3) If both members of a divorced couple are Employees or Retirees and both are enrolled in Commission coverage, they may have Family Health Coverage covering both former spouses and all other eligible Dependents. Alternatively, each may independently elect Individual or Family Health Coverage. In that case, a Dependent may not be covered on more than one plan.

9.06: Leaves of Absence

(1) Employees may continue their Commission coverage while on an authorized leave of absence without pay for reasons other than personal illness or injury. Such Employees are responsible for the entire premium cost; no Employer contribution shall be made, except as otherwise provided in 805 CMR 9.06.

(2) Employees on leave of absence without pay for six or more continuous months will only be eligible for coverage if the Commission approves. Such Employees must pay the entire premium and must apply to renew their application with the Commission every six months.

(3) Employees who are absent from work due to personal illness or injury, for which they are receiving Workers' Compensation benefits pursuant to M.G.L. c. 152 or any similar law or regulation, and whose salary ceases due to lack of sick leave credits, must be given written notice from the Employer and an accompanying application that they may be eligible to continue their coverage by paying the employee's share of the premium cost. The Commission shall make a determination as to applicants' eligibility when it receives their completed applications. Employees approved for coverage shall re-certify their continued eligibility for coverage with the Commission at six month intervals.

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(4) Employees who are not entitled to receive salary or wages while awaiting a determination of eligibility for Workers' Compensation benefits shall be deemed to have been granted a leave of absence without pay, and may continue their existing coverage by paying the entire monthly premium cost with no contribution made by the Employer. Employees approved for Worker's Compensation may apply for a reduction of premium, which the Commission will review and may refund the amount for which the employer is properly responsible.

(5) Entitlement to Workers' Compensation benefits does not entitle a terminated Employee to continue Commission life or health coverage.

(6) Employees on a leave of absence for one year who pay the Employee's share of premium may thereafter continue to receive their Health Coverage if they continue to pay the Employee's share of the premium cost and the Employee's agency pays the Commonwealth's share of the premium cost.

(7) Employees on a medical leave of absence (excluding worker's compensation, industrial accident or maternity leave) may continue to receive their Health Coverage by paying the Employees' share of the premium cost only after they have exhausted their accrued sick and vacation time.

(8) Employed and Re-employed Members of the Uniformed Services are subject to the requirements of the Uniformed Services Employment and Re-employment Rights Act (USERRA).

(a) Employed and re-employed members of the uniformed services who are absent from employment by reason of service may elect to continue their Commission coverage up to the lesser of either 24 months from the date their absence begins or the day after the date on which they fail to apply for or return to their employment positions. Members who elect to continue their Commission coverage are required to pay the full premium cost; however, members who perform service for fewer than 31 days are not required to pay more than the Employee's share, if any, for such coverage.

(b) Members who do not elect to continue Commission coverage or do not pay for it in a timely manner may, upon the members' departure for service, have their coverage terminated unless their failure to elect was excused because continued payment was impossible, unreasonable or precluded by military necessity. The Commission shall reinstate such members' health coverage retroactively if they elect to continue coverage and pay all unpaid amounts due.

(c) Re-employed members, except in the case of those who elect continuing coverage, will not have a waiting period if such a waiting period would not have been imposed for reasons other than uniformed service.

(9) Employees who are absent from work for 30 days or more are considered to be on leave of absence for the purpose of Commission coverage.

(10) Employees resuming employment following an approved leave of absence, who terminated coverage during said leave, may resume coverage in accordance with the Commission's Section 125 Cafeteria Plan or at Annual Enrollment.

(11) When an employee terminates state or municipal employment, coverage will continue to the end of the next month following the effective date of the termination.

9.07: Subsequent Determination of Ineligibility

If premiums have been paid and accepted on behalf of a person enrolled in Commission coverage and the Commission later determines that the person was not eligible, Commission coverage shall cease as of the end of the period for which the Commission last received premium payment. The ineligible person shall not be entitled to continuation coverage except as required by federal law.

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If an employee initially is eligible and insured under the Commission's programs but thereafter becomes ineligible due to a change in employment or status in the service of the Commonwealth or of one of its participating municipalities, his or her Commission coverage shall terminate at the end of the month following the month in which the change that caused the Employee's ineligibility occurs or a later date as determined by the Commission. Such employees shall be entitled to Continuation Coverage, unless the ineligibility is due to termination for gross misconduct.

If an employee or covered person becomes ineligible by operation of law, coverage shall terminate on the date they become ineligible. The ineligible person shall be entitled to continuation coverage only as required by state or federal law.

9.08: Employees not Entitled to Receive a Pension or Retirement Allowance

Except for Elected Officials, Employees who are not entitled to receive a pension or a retirement allowance when they terminate employment or who subsequently lose or withdraw their pension after retirement are not eligible to continue Commission Coverage. However, Employees other than Municipal Employees may be entitled to Commission life insurance portability or conversion and health insurance Continuation Coverage as set forth in 805 CMR 9.13 and 9.14; Municipal Employees and their Dependents may be eligible for health insurance Continuation Coverage as set forth in 805 CMR 9.13 and 9.14.

9.09: Surviving Spouses

Surviving Spouses may elect to remain insured only for Health coverage until their remarriage or death. They must apply for Surviving Spouse coverage within six months of the Employee's or Retiree's death. Additional time to apply may be granted for delays due to the applicant's medical condition or the existence of other coverage that has since terminated.

(1) Surviving Spouses of deceased Employees or Retirees who were enrolled in Commission Coverage at the time of the Insureds' death may elect only Health Coverage until their remarriage or death. Surviving Spouses must apply for Surviving Spouse Health Coverage.

(2) Surviving Spouses who are eligible for coverage as Employees are not eligible for survivor coverage unless they terminate employment. Enrollees who are eligible for coverage as Retirees are not eligible for survivor coverage.

(3) Divorced or legally Separated Spouses are not Surviving Spouses and are not eligible for Surviving Spouse coverage.

(4) Surviving Spouses who receive a retirement allowance must have their Health Coverage premium deducted from their retirement allowance.

(5) Widows and widowers of deceased Insureds are only eligible for Surviving Spouse coverage if the deceased was enrolled in Commission coverage at the time of death.

9.10: Surviving Dependents

Surviving Dependents may elect Health Coverage until the Surviving Dependent becomes eligible to enroll in other group health coverage or becomes 26 years of age, whichever occurs first. Surviving Dependents must apply for Health Coverage within six months of the employee's or Retiree's death. For good cause shown, the Commission may grant additional time to apply.

9.13: Conversion of Health Coverage: Continuation Coverage Options

(1) Insured Employees in good premium standing who terminate their employment and whose Dependents become ineligible for Commission Health Coverage may convert their Health Coverage to non-group conversion or continuation Health Coverage, including Federal "COBRA" coverage, and Massachusetts Health Connector Authority coverage, provided that they apply for health coverage 31 days following the later of:

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- (a) termination of Family Health Coverage; or
- (b) the date that the former health plan or the Commission notifies the former Employee of his or her right to obtain non-group coverage, provided that the Employee is in good premium payment standing on the date of his or her group Health Coverage termination.

(2) Surviving Spouses or Surviving Dependents who are no longer eligible for Health Coverage and who decline Health Coverage as survivors may enroll in a non-group plan of health coverage, provided that they make timely application to the health plan. The effective date of non-group health coverage shall be determined by the health plan.

(3) Insured Employees, Retirees, or Surviving Spouses or Dependents who remain eligible for Commission coverage but who voluntarily withdraw from or decline to enroll in Commission coverage, or are terminated for nonpayment of premium, are not eligible for non-group conversion coverage.

9.14: Conversion of Life Insurance: Continuation Coverage Options

Insured Employees who leave employment or become ineligible for Commission coverage due to a reduction in hours may either apply for portable group term life insurance similar to their Commission life insurance or may convert their life insurance to a non-group life insurance plan with the carrier providing Commission life insurance coverage when the Commission coverage ends without having to provide medical evidence of insurability. Employees must apply to the group life insurance carrier for portable life insurance coverage within 31 days of terminating Commission coverage and pay the first month's premium within 31 days of the date of the carrier's premium bill or within 15 days of the date the notice of conversion right is sent to the employee. Employees applying for non-group conversion coverage must do so within 90 days of the Commission's coverage termination. Only applicants in good premium standing when terminating their employment can be considered for continued coverage.

9.15: Misstatement of Information and Misuse of Benefit Plans

(1) An Insured's coverage may be terminated, in addition to other civil or criminal penalties, if the Commission determines that the Insured provided incorrect information in submitting a medical evidence of insurability or other such form that resulted in approval of the Insured's coverage request. The Commission shall establish the extent and duration of the termination.

(2) Any Insured who procures services fraudulently or submits false claims for himself or herself, or otherwise enables a person who is not eligible for Commission coverage to fraudulently enroll, procure services for, or submit claims for Commission coverage shall, upon determination by the Commission and in addition to other civil or criminal penalties that may be imposed, forfeit his or her eligibility for Commission coverage. The Commission shall establish the extent and duration of the forfeiture.

(3) Personal reimbursement of out-of-country health care claims will only be provided to Insureds who produce all related records requested by the plan and, as necessary, their translation; an itemized bill for health care claimed and, as necessary, its translation; and satisfactory proof of personal payment of the claims by cancelled check or credit card statement. Reimbursement is subject to the reasonable and customary payment as determined by the health plan, based on the locality where services were rendered.

9.16: Retired National Guard Technicians

(1) National Guard Technicians retired after January 1, 1969 who receive a pension from the State Retirement System may become insured as Retirees, notwithstanding the period of time from January 1, 1969 to their retirement when they were Federal employees, provided that they were insured on the date of transfer from the state employment to federal employment.

- (a) Such National Guard Technicians must complete an application for Commission coverage.

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(b) The application for coverage must be received by the Commission within 31 days following the date of retirement. Persons who fail to submit a timely application may reapply at the Commission's next occurring Annual Enrollment.

(2) National Guard Technicians retired after January 1, 1969 who receive a pension from the State Retirement System but who have never been insured through the Commission may be insured as Retirees only after compliance with the retirement pre-conditions described in 805 CMR 9.16.

(3) National Guard Technicians who have no right to receive a pension from the State Retirement System are not eligible to be insured as Retirees.

9.17: Surviving Spouses of National Guard Technicians

(1) Surviving spouses of insured Retired National Guard Technicians may be insured for health insurance only.

(2) Surviving spouses of Retired National Guard Technicians who were federal employees at the time of death may be insured for health insurance only, provided that such National Guard Technicians were insured by the Commission on the date of their transfer from state employment to federal employment.

9.18: Retired Employees' Return to Active Employment

Retirees who subsequently are hired for a position with benefits by the Commonwealth or a Municipal Employer may either continue their Commission coverage as active employees if they waive their monthly retirement allowance, or may continue to have their retiree premium deducted from their retirement allowance.

9.19: Re-employed Persons

(1) Insured Employees who terminate employment while in good premium payment standing, who are re-hired as Employees in a position with benefits and begin employment before Commission coverage ends under their prior public employment, shall continue to be insured without a break in existing coverage, provided that they submit a timely application for Commission coverage.

(2) Insured Employees who terminate employment while in good premium payment standing and are re-hired as State Employees after their Commission coverage ends shall be insured as new Employees and will be subject to the New Employee waiting period for Commission coverage.

(3) Notwithstanding 805 CMR 9.19(2), Insured State Employees who terminate employment while in good premium payment standing and are re-hired as State Employees in a position with benefits within two years of the date of termination of their employment shall be considered to have been hired on their original hire date for the purposes of computing the Commonwealth's share of their premiums.

(4) In the event that an Insured Employee is reinstated in a prior position as the outcome of a labor arbitration or other statutory labor proceeding, a Massachusetts Commission Against Discrimination (MCAD) proceeding, operation of M.G.L. c. 30, § 59, or court order, such employee shall be considered to have been hired on his or her original hire date for the purposes of computing the Commonwealth's share of premiums. Benefits as an active State Employee will be reinstated prospectively as soon as is administratively feasible, without waiting for the next Annual Enrollment period.

9.20: Retirement - General

- (1) Retirees entitled to a pension or retirement allowance may continue Basic Life and Health Insurance coverage, and Additional Life Insurance by applying to continue the coverage and continue paying the required premium. State Retirees, Retired Municipal Teachers, and eligible Municipal Retirees may also enroll in the Commission's retiree dental coverage by submitting an enrollment application in a timeframe as determined by the Commission.
- (2) State Retirees who never have been insured through the Commission and initially apply for Commission coverage as State Retirees are eligible to apply for the Commission's Retiree Basic Life, Health Coverage and Retiree Dental coverage.
- (3) Retirees who are re-hired as employees under the applicable provisions of M.G.L. c. 32 and are receiving adjusted salary or wages are not eligible to be insured as active employees. Retirees who waive and renounce their rights to all pension or retirement allowance payable to them for a period of time in accordance with M.G.L. c. 32, and are not rehired as full-time employees for a period of time that does not constitute Emergency Employment, may be insured as Employees subject to payment of the Employee's share of the premium.
- (4) Eligible Retirees who voluntarily withdraw from Basic Life or Basic Life and Health Coverage may apply to re-enroll in Commission coverage either during the next Annual Enrollment or if they provide acceptable proof of loss of other coverage.
- (5) Deferred retirees are considered to be employees on leaves of absence without pay for as long as they retain the right to receive a retirement allowance from a participating retirement system and do not withdraw their pension monies from the retirement system. Persons receiving a retirement allowance cease to be Deferred Retirees.
- (6) Once a Retiree enrolls in a health plan, the next opportunity to change plans is the GIC's next Annual Enrollment period, except as otherwise required by law.

9.21: Additional Life Insurance

- (1) All eligible Employees enrolled in Basic Life Insurance may apply for Additional Life Insurance consisting of group term life insurance and accidental death and dismemberment insurance. New Employees who enroll when first eligible are eligible for Additional Life Insurance in an amount up to eight times their salary without providing medical evidence of insurability.
- (2) Evidence of insurability shall be required when an Employee:
 - (a) applies for initial coverage after the deadline for applying has passed, unless certain life events occur that qualify under the policy for coverage without providing such evidence; or
 - (b) seeks to increase the amount of his or her Additional Life Insurance; or
 - (c) seeks to be reinstated after losing coverage for failing to pay the required premium.
- (3) If a physical examination is required to determine eligibility for Additional Life Insurance, the life insurance carrier shall review the medical evidence and determine eligibility for the additional coverage based upon its underwriting standards. Such standards shall be consistent with the life insurance underwriting standards in general use by the insurance industry. In addition, the life insurance carrier's underwriting criteria shall not consider the applicant's age, gender, occupation or amount of life insurance requested. Consideration shall be given only to the applicant's medical evidence of insurability, recognizing the size of the group and volume of insurance administered by the Commission in determining standards of acceptability and insurance risk.
- (4) Upon retirement, Retirees may continue or reduce the amount of their Additional Life Insurance in effect at that time, upon full and timely premium payment. Retirees who cancel or reduce their Additional Life Insurance are eligible to continue their coverage directly with the carrier. Persons who have not previously had Additional Life Insurance are not eligible for the coverage upon or after retirement.

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(5) Pensioned justices who are recalled to judicial duties on full-time assignment are eligible for Additional Life insurance without providing medical evidence of insurability if they waive their pension for the duration of the full time recall period.

(6) The effective date of an Employee's life insurance beneficiary designation is the date that the Commission receives the completed beneficiary designation form.

(7) Employees who are enrolled in Basic Life Insurance but do not enroll in Additional (Optional) Life Insurance when first hired may later elect the coverage due to a change in family status without having to provide proof of good health. Applicants must apply for the Additional Life Insurance and provide evidence of the family status change within 31 days of the event causing the status change.

9.22: Dental and Vision Benefits

The Commission and the vendor(s) providing Dental and Vision benefits shall determine the conditions for participation, the amount of benefits and their duration, premium rates and all effective dates of coverage.

Certain State Employees who are not covered by collective bargaining are eligible for Dental and Vision benefits that are offered primarily to managers, legislators, legislative staff, and certain Executive Office staff. All Employees of higher education, the Trial Court system, and authorities other than the Massachusetts Bay Transportation Authority are ineligible for Commission Dental and Vision coverage. Certain Massachusetts Bay Transportation Authority employees who are not covered by collective bargaining are eligible for Commission Dental and Vision coverage, as are certain confidential Employees. Employees may only change plans during Annual Enrollment, even if their dentist leaves the plan.

9.23: Pre-tax Options for Commission Benefits

Employees' share of basic life and health insurance premiums may be deducted from their paychecks on a pre-tax basis, and may change the tax status of their premium deductions during Annual Enrollment or upon a qualifying event.

(1) Health Care Spending Account Program. Active State Employees who work at least 18.75 hours in a 37.5 hour work week or 20 hours in a 40-hour work week and are eligible for Health Coverage may arrange to pay for their out-of-pocket health care expenses on a pre-tax basis through the Commission's Health Care Spending Account program. State Employees pay a specified sum determined by the Commission by payroll deduction for non-covered health-related expenses. The Commission and the vendor(s) administering pre-tax options for Commission Employees establish the procedures, terms and conditions consistent with Internal Revenue Code rules. Such rules require that any unused funds in a participant's account at the plan's year end be forfeited.

(2) Dependent Care Assistance Program. Active State Employees who have employment-related dependent care expenses for Dependent children who are younger than 13 years old or are younger disabled adult dependents may pay for certain dependent care expenses through the Commission's Dependent Care Assistance Program. Participants elect an annual dollar amount per family to be taken as a payroll deduction, up to a maximum set by the Commission, to pay for qualified child and elder day care, after school programs, and day camp dependent care expenses.

9.25: Appeals

(1) Any person who is aggrieved by a decision of the Commission, or by a final decision of one of the Commission's self-insured plan administrators about benefits may appeal in writing to the Commission's Executive Director. Benefits that are explicitly excluded from coverage in the plan of benefits are not appealable. The Executive Director shall consult with the Commission's General Counsel to determine whether the matter warrants presentment to the Commission's Appeals Committee. If presentment is warranted, the Executive Director shall enter the matter

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on the Commission's Appeals Docket for resolution via the Commission's appeals procedures. The Appeals Committee's decisions are final and binding, and may only be re-considered if new information that was unknowable at the time of the initial appeal to the Appeals Committee would alter the outcome of the appeal. Appellants may pend their appeals to the Commission up to a maximum of 120 days after their initial filing in order to obtain additional information. Appeals that exceed the 120 day period will be closed without prejudice to the appellant.

(2) Notwithstanding 805 CMR 9.25(1), the Executive Director may modify appeals procedures in order to achieve compliance with requirements of federal law, including but not limited to 42 U.S.C. § 300gg-19. To that end, Commission's Executive Director may delegate external appeals procedures to the Commission's self-insured plan administrators. If the Executive Director has delegated appeals procedures to one or more plan administrators, any person who is aggrieved by a decision of the Commission, or by a final decision of one of the Commission's self-insured plan administrators about benefits, may appeal in writing to the plan administrator.

(3) Notwithstanding 805 CMR 9.25(1) and (2), eligibility decisions by the Commission are final and not subject to appeal procedures under 805 CMR 9.25.

9.26: Health Insurance Buy-out Option

Insured State Employees and Insured State Retirees may buy out their Commission health coverage during Annual Enrollment or at a time designated by the Commission in the fall if they have other non-state health insurance coverage that is comparable to Commission health coverage and is verified by documentation acceptable to the Commission and must maintain Basic Life Insurance. Eligible Employees and Retirees receive 25% of the full-cost monthly premium in lieu of health insurance benefits for a maximum of one 12-month period starting either July 1st or January 1st. Full cost monthly premium is determined based on the Employee's last Commission health plan and coverage type (individual vs. family), and is subject to applicable taxes.

9.27: Long-term Disability Insurance

All active full-time and half-time State Employees who work at least 18.75 hours in a 37.5-hour work week or 20 hours in a 40-hour work week are eligible for Long-term Disability benefits. Active State Employees who are eligible for Basic Life Insurance coverage are eligible for the Commission's Long-term disability insurance program sponsored by the Commission. The conditions for participation, the amount of benefits and their duration, and the premium rates shall be jointly determined by the Commission and the Long-term Disability insurance carrier providing the Long-term Disability Insurance plan.

New State Employees may enroll in the Long-term Disability program within 31 days of hire without providing acceptable evidence of good health and thereafter may enroll in the program at any time by providing acceptable proof of good health to the Long-term Disability carrier.

REGULATORY AUTHORITY

805 CMR 9.00: M.G.L. c. 32A, § 3.