I. PURPOSE OF RULES AND REGULATIONS

The purpose of these rules and regulations is to set forth policy on matters pertaining to the administration of the State Employees' and Officials' Group Insurance program.

II. AUTHORITY

Section 10-8-205(2), CRS. “The board, pursuant to the provision of Article 4 of Title 24. CRS, shall adopt such rules and regulations consistent with the provisions of this Part 2 as it deems necessary to carry out its statutory duties and responsibilities.”

III. APPLICABILITY

These rules are applicable to officers and employees of the Legislative, Executive, and Judicial branches of government, also annuitants as defined in these rules.

IV. DEFINITIONS

A S O - Administrative Services Only. A program to purchase claims paying service from a third party administrator, private insurance carrier, or other company offering this service on a fee basis.

Accidental Death and Dismemberment Plan - a voluntary group policy providing benefits for accidental loss of life, sight, hand, or foot.

Annuitant - any person who has retired while a State employee or official and who receives any retirement allowance to which the State was a contributing party; a family member receiving an allowance as the survivor of an annuitant; the survivor of a deceased employee receiving a retirement allowance as provided in Part 8 of Article 51 of Title 24, CRS.

Benefit Year-Employee Benefit Plan - the period commencing on January 1 of any calendar year and terminating at the expiration of December 31 of such calendar year.

Board of Administration - The State Employees' and Officials' Group Insurance Board of Administration, created by Part 2, of Article 8, of Title 10, CRS, and is assigned to the Department of Administration and allocated to the Division of Accounts and Control as a section thereof. 24-1-116(4)(c), CRS.

Board Members - State Employees' and Officials' Group Insurance Board of Administration, as provided by statutes, consisting of ten members who shall serve without compensation.

Carrier - a private insurance company holding a valid outstanding certificate of authority from the Commissioner of Insurance or a non-profit hospital or non-profit medical service plan incorporated as a non-profit corporation.

Coordination of Benefits - provision for coordinating with other plans under which an individual is covered so that the total benefits available will not exceed 100% of the allowable expenses.

Dependent - an employee's or annuitant's spouse; each unmarried child under the age of nineteen, including adopted children, step-children residing in the home of the employee, and foster children. Each unmarried child between the ages of nineteen and twenty-three years who is a full-time student in an educational or vocational institution and for whom the employee or annuitant is the major source of financial support; and each unmarried child over the age of nineteen who is either physically or mentally handicapped, as defined by the insurance carrier, not covered under other government programs, and for whom the employee or annuitant is the major source of financial support.

Dependent Life - the voluntary group insurance plan which provides benefits for any eligible dependent. Participation is contingent upon enrollment of the employee.

Employee - any official, or any officer, or any employee under the State Personnel System of the State of Colorado whose salary is paid by State funds, and includes officers and employees of the Legislative and Judicial branches. Also included are employees of the Department of Education, the Colorado Commission on Higher Education, and the Colorado School for the Deaf and the Blind whose salary is paid by State Funds, except otherwise specified by statute. “Employee” does not include persons employed on a temporary basis.

Group Insurance Plan - the health and life plans or other group coverages contracted for or offered by the Board.

H M O - a health maintenance organization as defined under the provisions of Title XIII of the Federal Public Services Act.

Health Insurance Plan - an employee benefit plan, a group's insurance policy or contract; or a statewide hospital and medical service plan or a hospital and medical service plan, statewide or not statewide as offered by a corporation.

Individual Stop-Loss - the dollar amount at which benefits are payable at 100% for the balance of the calendar year.

Life Insurance Plan - a group life insurance policy provided for the purpose of providing life insurance benefits. The State contributes toward the cost of the plan.

Medicare - Federal insurance or assistance provided by the provisions of Title XIX of the Federal Social Security Act.

Plan A -- Hospital insurance under Medicare. 40 quarters of social security are required for eligibility.

Plan B -- Medical Insurance under Medicare. Eligiblity for social security is not required.

Official - any elected or appointed State official who receives compensation other than expense reimbursement from State funds.

Option IV - the title designated to the faculty plans of the University of Colorado in which classified staff employees of the University participate. Under the provisions of 10-8-218, CRS, the Board continues the University faculty plan as the primary benefit plan for CU classified employees until the benefits and economic cost for such persons are comparable to the State classified employees plan.

Optional Life Insurance - a voluntary group term insurance plan. Purchase of the plan is optional. Incremental amounts are selected by the Board and rates are determined by age and salary.

Plan A -- refer to definition under Medicare.

Plan B -- refer to definition under Medicare.

Plan Administrator - the employee in the Division of Accounts and Control assigned the responsibility of carrying out the policy decisions of the Board.

Split Contract - the provision whereby a husband and wife, both State employees, must be enrolled in the same family plan and each receive State contribution.

State Share - the amount the State of Colorado contributes toward the cost of an employee's group

basic life and state group health insurance plan.

Supplemental Plan - a group insurance policy or a medical or hospital service agreement provided by a carrier for the purpose of paying for or reimbursing the cost of hospital and medical care in excess of or supplemental to Medicare which employees, officials, or annuitants and their dependents may be eligible to receive. Said supplemental coverage may consist of one, a combination of, or alternative plans as determined by the Board.

Tax Equity and Fiscal Responsibility Act (TEFRA) - a Federal law which makes Medicare benefits secondary to benefits furnished under an employer group health plan for employed individuals aged 65–69 and their dependents aged 65–69.

Usual, Customary, and Reasonable Charge (UCR) - A usual charge is the actual charge by a provider for a given service. A charge is customary when it is within a range (as determined by the carrier) of usual charges billed by most physicians or other professional providers. A charge is reasonable when it meets the usual or customary criteria, whichever is less, or it may be reasonable if, in the opinion of an appropriate medical/surgical review committee of the carrier, it merits special consideration based on the nature and extent of treatment of the particular case.

V. ENROLLMENT - HEALTH INSURANCE

Employees

1. Each new eligible employee shall have 30 days from date of employment to enroll by making proper application. Eligible dependents must be enrolled in the same plan as the employee. University of Colorado employees may enroll in Option IV.

2. Eligible employees who elect not to be enrolled during the 30 days of eligibility may enroll during the open enrollment period as specified by the Board.

3. Colorado State Patrol recruits may enroll within 30 days of the recruit's employment or may enroll within 30 days of assignment to a permanent location.

Dependents

1. Dependents may be enrolled within 30 days of eligibility with the employee making proper application and paying the appropriate premium.

2. Dependents may be enrolled during an open enrollment period as specified by the Board if the employee makes proper application and pays the appropriate premium.

3. Termination of Spouse - If both are employed by the State and enrolled in a plan, the spouse remaining in State employment may add the husband/wife to the contract without waiting for open enrollment.

4. Dependents will be allowed to enroll within 30 days without waiting for an open enrollment period provided they meet the following criteria:

    a. dependents must be terminated from previous non-State employment by reason of voluntary termination, lay-off, or dismissal;

    b. dependents must have been insured with previous employer;

    c. dependents must have suffered loss of coverage on termination;

d. conversion policy is not available through previous carrier;

e. the State employee must be insured in one of the State plans;

f. application must be approved by the State Employees' and Officials' Group Insurance Administrative Office.

Effective Date of Coverage - The effective date of coverage shall be the first day of the month following the first payroll deduction.

Active Work Requirement - An employee must be actively at work or available for work on the first day of coverage, otherwise the insurance will go into effect the first day he/she returns to work.

VI. TRANSFER PROCEDURES

1. Transfer Between Plans - an employee and dependents may transfer to another plan during the open enrollment period as specified by the Board by making proper application and paying the appropriate premium.

2. A State employee moving to an area where an HMO is available may elect to transfer to that plan if election is made within 30 days of relocation.

3. A State employee transferring out of the service area of an HMO may transfer to another State plan or HMO if available in the area where said employee now resides, if election is made within 30 days.

4. Employees on extended leave without pay or on a nine-month schedule and not working during the open enrollment period may elect to transfer to another plan upon their return to active duty.

5. Class transfers of employees previously employed at the University of Colorado or University of Colorado Health Sciences Center may continue with Option IV or may elect to enroll in a plan offered by the Board. Election must be made within 30 days of transfer.

6. An employee as defined in these rules and regulations who is covered by Option IV may transfer to another plan upon acceptance of employment at another agency. Election must be made within 30 days of transfer.

7. A member of the classified service covered by Option IV may transfer to another plan upon acceptance of employment at another agency. The pre-existing condition limitation and deductibles will be calculated as if employment has been continuous.

An employee as defined in these Rules and Regulations who is covered by Board plan may transfer to an Option IV plan upon acceptance of employment at the University of Colorado. The pre-existing condition limitation and deductibles will be calculated as if employment had been continuous.

8. An employee shall be transferred to the State plan if the employee was enrolled in an HMO and as determined by the HMO, the doctor-patient relationship cannot be maintained and proper medical care cannot be administered. The transfer must be recommended by the HMO and approved by the Administrator and/or Board designee and determined to be in the best interest of the employee.

VII. TERMINATION

1. Insurance coverage for the employee and/or dependents will terminate on the last date of coverage for which premium has been paid.

2. The insurance will terminate on the last day of the month in which the employee dies.

3. The employee may cancel the insurance by making proper application for cancellations. The termination date will be the last day of the month in which application was made.

4. The insurance will terminate for non-payment of premiums.

5. The insurance will terminate the last date of an approved leave of absence unless returned to active status and premium payment continued.

6. The insurance for the employee and/or dependents will cease if the employee transfers from an eligible to a non-eligible status.

7. Dependent's insurance may be terminated at any time by making proper application for cancellation. The termination date will be the last day of the month in which application was made.

8. A dependent's insurance will terminate when he/she is no longer an eligible dependent.

9. The dependent's insurance will terminate if premiums have not been paid.

10. The insurance may be terminated because of fraud, etc., after a hearing as authorized through the grievance procedure.

VIII. LEAVE OF ABSENCE (WITHOUT PAY)

1. An employee and/or dependent may continue coverage in the plan during the period of approved leave, provided full premium is paid monthly by the employee to the Insurance Board.

2. Employees working a nine-month schedule may continue their insurance by paying full premium during periods of leave.

3. An employee making application for retirement (regular or disability) may continue their insurance with the group until the retirement is approved by paying the full premium. If the retirement is not approved, the employee must return to active status or will be terminated from the plan.

IX. ANNUITANTS

Enrollment

1. A person retiring from State service and insured in one of the plans, and eligible to receive a PERA annuity will have their insurance transferred from the agency group to the PERA group without making further application. PERA will make the deduction of premium from the annuity (if applicable) and remit it to the SEOGI Board of Administration.

2. The survivor of a deceased annuitant may enroll in the health insurance program within thirty days of eligibility. The survivor must be receiving a PERA annuity as the survivor of an eligible annuitant.

3. The survivor of a deceased employee may enroll within thirty (30) days in the health program. The survivor must be receiving a PERA annuity as the survivor of a deceased employee who was eligible for the program.

4. Dependents of a deceased employee may enroll in the health program within 30 days if they qualify and receive PERA benefits. (Dependent is defined in Section IV of these Rules and Regulations).

Transfer procedures

1. An annuitant moving out of the service area of an HMO may transfer to another State plan including another approved HMO if election is made within 30 days of the relocation of the annuitant to the new area.

2. An annuitant or dependent attaining the age of 65 will be transferred to the Medicare supplemental program in the plan in which they are enrolled. Notification will be mailed to the most current mailing address on file with PERA 60 days prior to the annuitant reaching 65.

3. An annuitant and dependent(s) may transfer to another plan during the open enrollment period as specified by the Board making proper application and paying the appropriate premium.

X. STATE CONTRIBUTION

Active Employees and Officials

1. The State of Colorado shall contribute an amount necessary to pay the monthly contribution authorized in 10-8-211, CRS, for health or life or both for each employee and official enrolled in a plan. Such amount shall be paid for each employee or official enrolled in a plan or if the employee or official and his dependents are enrolled in a plan.

2. The State shall pay an amount which constitutes the actual premium of the plan the employee or official selects, if the total State contribution does not exceed the amount authorized in 10-8-211, CRS.

3. The board shall authorize some portion of the State contribution to purchase life insurance for employees, officials, and annuitants, as specified by statute.

4. The same life insurance contribution shall be applicable to all eligible employees, officials,

State Contribution - Annuitants

1. For annuitants who are in State service twenty years or more prior to retirement the state shall contribute the maximum amount authorized in 10-8-211(1) CRS. If the actual premium is less than the maximum state contribution the state shall pay an amount which constitutes the actual premium of the plan.

2. For annuitants who are in state service less than twenty years prior to retirement the state shall contribute five percent of the amount contributed for employees and officials for each year of state service prior to retirement. If the actual premium is less than the maximum contribution, the amount contributed shall be five percent for each year of service of the actual premium.

XI. REFUND POLICY

Any advance premium paid may be refunded in monthly increments for the following:

a. death of employee or dependent;

b. Insurance cancelled in current month and advance premiums paid for following month;

c. premium deducted in excess of enrollment authorization;

d. retirement date established retroactively, adjustment between employee share and State share required;

e. Medicare eligibility date established retroactive to date of conversion to supplemental plan;

f. refunds will only be issued with the approval of the plan Administrator;

g. refunds will only be issued for overpayments in the current contract year;

h. an employee electing to pay three months health insurance premiums upon termination and such employee converts to a group or non-group policy within the ninety-day period shall be refunded the balance of any full months premium beyond the date of conversion upon receipt of written request to the SEOGI Administrative Office.

XII. ACTIVE EMPLOYEES (AGES 65–70)

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) requires that the employee must elect either the State Group Health plan or Medicare as their primary medical coverage. The employee will be notified in writing sixty (60) days prior to their 65th birthday that a decision is required. Notification will be mailed to the employee's last known home address. Any employee who fails to notify the state as of attaining age 65 will have the State plan as the primary payor of benefits.

Options

1. State Plan as primary payor of benefits:

    a. Employee 65–70 - Dependents over 65 (if applicable):

        The State health care plan to be primary and Medicare to be secondary payor for covered services. Premium may be adjusted if necessary.

    b. Employee over 65 - Dependents under 65 (if applicable):

        The State health care plan to be primary and Medicare to be secondary payor for covered services. Premium may be adjusted if necessary.

    For this election the State is primary payor of benefits for the employee and dependent subject to the coordination of benefits exclusions in our contracts.

2. Medicare as primary payor of benefits:

    a. Employee age 65–70 - Dependents age 65–70:

        The State plan will terminate and no additional health care coverage will be provided by the State to the employee and dependents.

    b. Employee Age 65–70 - Dependents under age 65:

        The State plan will terminate and no additional health care coverage will be provided by the State to the employee and dependents.

3. Employees (65–70) not eligible for Part A (Hospital Benefits) under Medicare.

    The provisions of TEFRA do not apply. Each employee, official, or dependent not having sufficient quarters to qualify for Part A under Medicare will be converted to a supplemental plan upon attaining age 65. The supplemental plan will provide hospital benefits as if they were eligible for Part A. The supplemental plan assumes all employees and dependents to be enrolled in Medicare Part B.

4. Any employee electing the State plan as primary payor of benefits under the TEFRA election will be

converted to the Medicare supplemental plan upon retirement or age 70, whichever comes first.

5. Any employee may elect to change their option during any annual enrollment/change period.

XIII. MEDICARE (OVER 65 - RETIRED)

1. Each annuitant or dependent will be converted to a supplemental to Medicare program upon attaining the age of 65.

2. Each annuitant or dependent attaining age 65 must enroll in Medicare 90 days before or after their 65th birthday. Application must be made even though the individual is not applying for Social Security or the individual has not earned enough Social Security quarters.

3. Each annuitant or dependent not having sufficient quarters to qualify for Part A under Medicare will be converted to a supplemental plan to provide hospital benefits as if they were eligible for Part A. The Board must be notified if the annuitant or dependent is not eligible for Part A of Medicare. A premium adjustment will be required.

4. Each annuitant or dependent attaining age 65 is eligible for Part B of Medicare. The supplemental plan assumes all individuals are enrolled in Part B (Medical Benefits) of Medicare.

XIV. PAY BACK REQUIREMENTS

Paybacks will be required for the following:

1. Any premium owed for the difference in payroll deduction with-held and premium due must be paid by the employee;

2. Any pay back as determined by the board. An employee required to pay an amount that would be an economic hardship on the employee may request installment payments. Approval for the payback schedule must be approved by the Board.

XV. COORDINATION OF BENEFITS

10-8-206(7)(c), CRS requires that “The State Employees and Officials Group Health Insurance Board shall stamp on the cover page of the Board's explanation booklet the following in red ink:

> Warning: If you are insured under a separate group health insurance policy you may be subject to coordination of benefits as explained under title “Coordination of Benefits with Other Plans” in this booklet.”

1. A coordination of benefits statement in the warning stated in 10-8-206(7)(c), CRS is printed on all handbooks issued by the board.

2. A coordination of benefits statement is included on all enrollment applications.

XVI. WAIVER OF PRE-EXISTING CONDITIONS

Waiver of pre-existing conditions is authorized under the following:

a. Transfer from an HMO to the State Employee Benefit Plan during open enrollment.

b. Transfer between SEOGI plans because of relocation.

c. Transfer to another SEOGI plan because of termination of a plan.

d. Transfers between Option IV and the SEOGI group. The waiver will apply as long as both groups approve the waiver.

e. Waiver of pre-existing condition as authorized by the board; either by special board action or contractual agreement.

XVII. EXTENSION OF HEALTH INSURANCE

If any employee or official was enrolled in a health plan for at least 180 days prior to termination of employment the employee or official may continue coverage for a period of 90 days following the last day worked. The full cost of the plan must be paid by the employee or official no later than the date of termination or he may authorize the payment for the ninety days premium to be deducted from his terminal pay.

XVIII. CONVERSION TO NON-GROUP

An employee has thirty days beyond the termination of his insurance to convert to a non-group policy. It is the responsibility of the employee to contact the insurance company or the HMO to apply for conversion.

XIX. WAIVER OF PREMIUM - HEALTH INSURANCE

A surviving spouse and eligible children of a deceased employee or annuitant enrolled in a family contract will have 90 days free health insurance coverage on the State employee benefit plan.

XX. LIFE INSURANCE - BASIC

An eligible employee or official may enroll in the employee term life insurance plan upon acceptance of employment with the State of Colorado. The Employee Term Life Insurance Benefit amount as specified by the Board in the State Employees and official Group Insurance Employment information brochure.

Effective Date - Upon receipt of application and the agency making the advance payment of premium on the payroll, insurance shall be in force the first day of the month following the first payroll premium payment provided the employee meets the active work requirement.

Active work requirement - The employee must be actively at work or available for work on the day coverage would normally become effective. If the employee is not actively at work on the effective date of coverage, coverage will become effective on the day the employee returns to work.

Beneficiary - Any insurance under the group policy becoming payable on the death of an employee will be payable to the person designated by the employee as his/her beneficiary and on file in the State Administrative Office.

At any time the employee may, without the consent of his/her beneficiary, change the beneficiary by filing written notice of the change with the State Administrative Office. The new designation will take effect on the date the notice was signed, except that it will not apply as to any amount paid by the carrier prior to receipt of the notice. This provision does not apply to employees who have entered into an Assignment of Benefits/Right of Ownership agreement as described elsewhere in these rules and regulations.

Benefit Payment While a Covered Individual - If the employee dies while a covered individual, the amount of insurance under the basic group term life plan is payable to the named beneficiary when the carrier receives due written proof of death and meets all terms and conditions of the contract.

Death Benefits During Conversion - If the employee dies within thirty-one days after termination while entitled to a conversion, benefits will be payable whether or not the employee applied for a conversion. Contract provisions for death benefits shall apply.

Total Disability - If the employee becomes totally disabled while insured and before reaching the age of 60, and such disability continues without interruption for at least nine months, and the employee provides proof within twelve months of the total disability to the carrier the employee's life insurance will remain in force without further premium until a normal retirement age (65) is attained.

XXI. LIFE INSURANCE - OPTIONAL

An eligible employee or official may enroll in the employee optional life insurance plan upon acceptance of employment with the State of Colorado and provided he/she is enrolled in the Basic Life Plan.

Effective Date - Upon receipt of application and the agency making the advance payment of premium on the payroll, insurance shall be in force the first day of the month following the first payroll deduction provided the employee meets the active work requirement.

Annual Earnings - An employee's annual earnings shall be based on his earnings from the State, exclusive of bonus and overtime pay, for a normal work week not exceeding forty hours.

Dependent Life - amount as determined by the board.

Death Benefits During Conversion - If the employee dies within thirty-one days after termination while entitled to a conversion, benefits will be payable whether or not the employee applied for a conversion.

Total Disability - if the employee becomes totally disabled while insured and before reaching the age of 60, and such disability continues without interruption for at least nine months, and provides proof within twelve months of the total disability to the carrier, life insurance will remain in force without further premium until retirement age is attained.

Active Work Requirement - The employee must be actively at work or available for work on the day coverage would normally become effective. If the employee is not actively at work on the effective date of coverage, coverage will become effective on the day the employee returns to work.

Beneficiary - Any insurance under the group policy becoming payable on the death of an employee will be payable to the person designated by the employee as his/her beneficiary and is on file in the State Administrative Office.

At any time the employee may, without the consent of his/her beneficiary, change the beneficiary by filing written notice of the change through the State Administrative Office. The new designation will take effect on the date the notice was signed, except that it will not apply as to any amount paid by the carrier before receipt of the notice. This provision does not apply to employees who have entered into an Assignment of Benefits/Right of Ownership agreement as described elsewhere in these rules and regulations.

Benefit Payment While a Covered Individual - If the employee dies while a covered individual, the amount of insurance under the optional group term life plan is payable to the named beneficiary when the carrier receives due written proof of death and meets all terms and conditions of the contract.

XXII. ASSIGNMENT OF BENEFITS - OPTIONAL AND BASIC LIFE INSURANCE

An employee of the State of Colorado insured in the optional and/or basic life insurance plans may assign the policy and relinquish all rights to the policy. Under the terms of the assignment the following conditions apply:

1. Payroll deductions for the optional and/or basic life insurance plan premiums will no longer be under the control of the employee. They expressly waive their right to modify, rescind or otherwise abrogate such deductions and payments.

2. The assignee will reimburse the employee for the cost of the optional life premium on an annual basis or periodically at a time in compliance with regulations of the IRS.

3. In the event of the death of the assignee, the policy becomes the property of the estate of the assignee and cannot be transferred by the employee.

4. The assignment of this policy becomes irrevocable. Cancellation may only be made by termination, death, or cancellation of the group contract by the State of Colorado.

XXIII. GRIEVANCE PROCEDURE

Appeals from Claim Denials (other than denials under the second opinion surgery program)

First Level Appeals: SEOGI Plan Administrator

Initially all appeals from claims denials shall be in the form of a letter addressed to the Administrator of the SEOGI plan.

A. Contractual Review

1. Upon receipt of the letter of appeal from a claimant, the plan administrator shall review the appeal and make a determination whether the claim being appealed is within the contractual language of the policy.

2. If the plan administrator determines that the claim does not come within the language of the policy, the administrator shall so notify the claimant.

3. If the plan administrator determines that the claim does come within the language of policy, the administrator shall request the claims administrator to pay the claim.

B. Medical Review

1. If, after reviewing the initial letter of appeal the Plan Administrator determines that further medical review is necessary, the administrator shall forward the letter of appeal along with all pertinent documents to the carrier for submission to the carrier's medical review committee.

2. For this purpose, claimant shall provide the Plan Administrator and/or the carrier with all documents and medical releases requested.

3. The carrier shall submit the letter of appeal along with all pertinent documents to the medical review staff.

4. The results of the review by the carrier's medical staff shall be transmitted to the Plan Administrator who shall notify the claimant. A summary of the results of the review shall be made available to the claimant upon request in writing.

Second Level Appeals: SEOGI Board

All claimants wishing to appeal claim denials beyond the first Level may do so by addressing a letter of further appeal to the Plan Administrator.

A. Board Review

1. Upon receipt of the letter of appeal, the Plan Administrator shall prepare copies of the letter and all pertinent documents for the individual members of the Board. Such copies shall be distributed to

Board members prior to the next scheduled meeting.

2. At the next scheduled meeting after receipt of the notice of further appeal, the Board shall review the appeal and take action thereon.

3. If the Board determines that the appeal lacks merit because the disputed claim is for services not covered under the SEOGI plan, it shall dismiss the appeal. If the Board dismisses the appeal, such action shall constitute final agency action.

4. If the Board determines that the appeal merits further medical review, it shall refer the claim to an independent review authority. For this purpose, claimant shall provide the Plan Administrator and/or the independent authority with all documents and medical releases requested. The recommendation from the independent review authority shall be forwarded to the board for action.

Appeals of Claims Submitted for Non-Emergency Surgery

Appeals Denied

Requests for reconsideration and reversal of a reduction in benefits for failure to get a second opinion prior to non-emergency surgery will be automatically denied unless the appeal falls within the special provisions set forth in II., below. No waivers or hardships will be considered.

Special Provisions for Appeals on the Grounds that the Surgery Was An Emergency

Requests for reconsideration and reversal of the reduction in benefits for failure to get a second opinion prior to non-emergency surgery will be granted only if the medical experts of the carrier determine that the particular surgery was an emergency. For this purpose, all such appeals shall be resubmitted to the carrier for review by their medical consultants. The recommendation of the carrier's medical consultant shall be forwarded to the board for action.

Appeals other than claims on second opinion surgery program:

First Level Appeals: SEOGI Plan Administrator

All appeals from employees shall be in the form of a letter addressed to the Administrator of the SEOGI plan.

A. Review-Plan Administration

1. Upon receipt of the letter of appeal, the Plan Administrator shall review the appeal and make a determination whether the complaint is within the statutory responsibility of the board.

2. If the Plan Administrator determines that the appeal is not within the statutory responsibility of the board, the administrator shall so notify the complainant.

3. If the Plan Administrator determines that the appeal is within the jurisdiction of the board a review of the appeal shall be made by the Administrator for solution within guidelines of the Rules and Regulations of the State Employee and Officials Group Insurance Board.

4. If the Plan Administrator determines that the grievance cannot be resolved within the rules of administration, the Administrator shall notify the appellant in writing that the person has the right to appeal to the second level (SEOGI Board).

Second Level Appeal: SEOGI Board

All persons wishing to appeal a grievance beyond the first level, may do so by addressing a letter of further appeal to the Plan Administrator.

1. Upon receipt of the letter of appeal, the Plan Administrator shall prepare copies of the letter and all pertinent documents for the individual members of the Board. Such copies shall be distributed to Board members prior to the next scheduled meeting.

2. At the next scheduled meeting after receipt of the notice of further appeal, the Board shall review the appeal and take action thereon.

3. If the Board denies the appeal, such action shall become the final decision of the Board.

4. The Board may overrule the Administrator.

XXIV. EMPLOYEE RESPONSIBILITY

A. It is the responsibility of each employee to verify enrollment by payroll deduction for correct plan and dependent coverage, if applicable.

B. It is the employee's responsibility to provide the Administrative Office with changes of address on the other demographic data.

C. It is the employee's responsibility to follow the guidelines provided in the plan selected.

XXV. AGENCY RESPONSIBILITY

A. Each agency shall distribute all information received on the SEOGI program to each employee in a timely manner.

B. Each agency shall advise new hires of the benefits available to them through the State Employees and Officials Group Insurance Program.

C. Each agency shall advise employees of the rules and regulations adopted by the State Employees and Officials Group Insurance Board.

XXVI. BENEFITS

Employee Benefit Plan

The Board shall determine the benefits under the Medical and Life Plans (Group) by competitive bidding and/or annual review of the program.

A. Benefit changes shall be sent to agencies for distribution to all employees in the annual State Employees and Officials Group Insurance Open Enrollment Information Brochure.

B. It is the responsibility of each employee to verify coverage and benefits under the plan selected.

C. The State Plan will provide an ID card and certificate outlining benefits and limitations on the program.

Health Maintenance Organization

A. The Board shall determine the HMO's to be offered to State employees and select optional benefits to be offered to State employees.

B. Benefit changes for each HMO will be printed in the annual State Employees and Officials Group

Insurance Open Enrollment Information Brochure.

C. It is the responsibility of each employee to verify benefit changes.

D. Each HMO will furnish to each employee enrolled, a booklet of all benefits including modification and instructions for using the plan and identification cards.

E. Each employee must notify the HMO that he has moved out of the service area. This must be done within 30 days of the transfer.

XXVII. BOARD RESPONSIBILITIES

Powers and Duties of the Board

A. The board shall administer and manage the State Employees' and Officials' Group Insurance Programs and, has the following powers and duties:

1. The preparation of specifications for the health insurance plan and a supplemental plan, the life insurance plan, and any other group insurance plan contracted for by the board;

2. The authority to enter into contracts with carriers to underwrite group or supplemental insurance plans;

3. The determination of the methods of claims administration under group insurance or supplemental plans, whether by the State or by the carrier or by both;

4. The determination of the eligibility of employees and annuitants and their dependents to participate in group insurance and supplemental plans;

5. The determination of the amount of employee payroll deductions and the responsibility for such deductions being made;

6. The establishment of a grievance procedure by which the board shall act as an appeals body for complaints by insured employees and annuitants regarding the allowance and payment of claims, eligibility, and other matters;

7. The administration of the state group insurance reserve fund;

8. The continuing study of the operation of group insurance and supplemental plans, including such matters as gross and net costs, administrative costs, benefits, utilization of benefits and claims administration;

9. The authority to enter into a contract with a carrier to underwrite the supplemental plan and to negotiate and enter into amendments to existing health insurance contracts, from time to time as may be appropriate, to provide a supplemental plan following to the extent possible the procedures set forth in Section 10-8-206, CRS, and in case of an amendment, the authority to determine an effective date of a supplemental plan;

10. The authority to determine that officers, employees, annuitants, and their dependents who are eligible for Medicare or Medicaid, or both, shall be eligible for a supplemental plan and, upon the effective date of the supplemental plan as to such officers, employees, annuitants, and their dependents presently covered by the health insurance plan, the authority to transfer them from such plan to the supplemental plan;

11. The authority to negotiate and enter into amendments to existing contracts providing group

insurance and supplemental plans to provide appropriate coverage for employees, officials, and annuitants who may become eligible for coverage after the effective date of said contracts and to provide for the enrollment thereof;

12. The authority and responsibility to enter into contract with carriers to underwrite optional group insurance plans which may be additions to or supplemental to those plans contracted pursuant to paragraph (b) of this subsection and which are paid for entirely by state employees and officials, entirely by the State, or by both the State and State employees and officials, in such a manner as to provide the fullest benefits at the lowest cost including, if necessary, contracting with the same carriers for the optional group insurance plans as for the plans contracted for under paragraph (b) of this subsection. Payments will be contingent upon authorization pursuant to section 10-8-211, CRS.

13. The authority to contract with persons, firms or associations for the furnishing of actuarial services, the preparations of specifications for group insurance plans, and other specialized services which cannot be performed by the board or by state employees.

14. Financial Responsibility - The Board shall request the Commissioner of Insurance to certify to the Board the financial condition of each firm the Board considers to offer benefits to State employees.

B. The board, pursuant to the provisions of Article 4, Title 24, C.R.S., shall adopt such rules and regulations consistent with the provisions of this part 2 as it deems necessary to carry out its statutory duties and responsibilities.

Board Meetings

A. The Board shall normally meet the second Tuesday of January, March, May, July, September, and November. Other meetings may be scheduled as deemed necessary by the chairman or a majority of its members. Six members shall constitute a quorum. All Board meetings shall be open to the public.

B. All interested parties shall be notified ten days prior to the date of the board meeting. The notice shall contain date, time, location and agenda items.

C. Any board meeting held for the purpose of rule making shall conform to the requirements of Article 4, Title 24, Section 105 CRS.

Board Actions

A. Any person (employee or representative of a program or firm) desiring to address the Board must give 10 days notice of intent in writing to the chairman of the Board stating name, address, phone number, purpose, comments, and conclusion or request. This will be reviewed as to appropriateness, time schedule of the Board, other alternatives available prior to schedule on the agenda.

B. Any person attending the board meeting may address the board on any current agenda item if such person signs in with the chairman.

C. All grievances to be reviewed by the Board must first comply with procedures for grievances of these rules and regulations.

D. The Board may adopt under emergency procedures any issue that requires immediate attention for the health, welfare, and public interest of any employee, official, annuitant, or for the entire program.

XXVIII. ELECTION PROCEDURES

Purpose - The five state officials designated as Board members shall establish the procedures for the election of five members to be elected by the employees to represent the employees of the State.

Date - Elections shall be held between May 1 and May 31 in odd-numbered years.

Nomination procedures

A. Submit the name of the eligible employee you wish to nominate to the SEOGI Plan Administrator.

B. Nominations must be received by 10:00 a.m. of the second Monday in April in odd-numered years.

C. Each nomination must be supported by 125 signatures of eligible employees.

D. Attach a letter from the nominee stating his or her willingness to serve and a brief biographical sketch, including department, agency, and position of the nominees.

E. The biographical sketch shall not exceed 150 words in length. Any lengthy biographical sketch will be abbreviated.

F. All individuals nominated in accordance with the nomination procedure shall have the opportunity to be voted upon by the employees.

G. The five nominees with the highest number of votes will be declared elected. No more than two employees shall be elected from any one department to serve on the Board.

H. The name of the department will be printed by the candidate's name on the face of the ballot. Also appearing on the face of the ballot will be the statement: “No more than two employees shall be elected from any one department to serve on the Board.” The name of the department will be printed on the biographical sketch of each candidate.

I. Petition procedure for write-in candidate must file written notice of intent with the Board by the last working day of April in the election year.

Election procedures

A. Ballots with return envelopes will be delivered to all state agencies the last week in April in odd-numbered years.

B. Agencies are to distribute all ballots to eligible state employees by the first week in May.

C. All ballots are to be returned or mailed (post-marked) by May 31, to the Division of Accounts and Control.

D. All ballots received by the deadline will be sent to the Division of ADP for tabulation.

E. Ballots with five (5) or less candidates being voted for will be accepted.

F. Ballots with votes for more than five nominees will be rejected.

G. Election results will be announced by the Chairman as soon as the tabulation is available.

Vacancy procedures

The five state official Board members shall fill the vacancy of an elected Board member selecting the next eligible, available employee from the list of candidates from the proceding election if such person is not from a department already represented by two employees on the Board.