STATE EMPLOYEE BENEFITS COMMITTEE

Statutory Authority: 29 Delaware Code, Sections 5210(4) and 9602(b)(4)
(29 **Del.C.** §§5210(4) and 9602(b)(4))
19 **DE Admin. Code** 2001

FINAL

ORDER

Employees Eligible to Participate in the State Group Health Insurance Program Eligibility and Enrollment Rules

Effective on July 1, 2009, under the authority of Title 29 of the **Delaware Code**, Section 9602(b)(4), the State Employee Benefits Committee is amending the Eligibility and Enrollment Rules regarding the Employees Eligible to Participate in the State Group Health Insurance Program to read as provided below. These amended rules were prepared by the Statewide Benefits Office and have been approved by the State Employee Benefits Committee with the consent of the State Employee Benefits Advisory Council. The amended rules are effective upon publication in the *Register of Regulations* in accordance with Senate Bill 300, Section 34.

2001 Group Health Care Insurance Eligibility and Coverage Rules

1.0 Authority

Pursuant to the authority vested in the State Employee Benefits Committee (SEBC) by 29 **Del.C.** §§ 5210(4), 9602(b)(4), the SEBC adopts these eligibility and coverage rules for the State of Delaware Group Health Insurance Program ("State Plan"). In the event of a conflict between these rules and the Delaware Code, the Delaware Code takes precedence over these rules.

1.1 An Employee or pensioner must meet one of the following definitions to be eligible for coverage under the State's plan:

1.1.1 a permanent full-time employee (regularly scheduled 30 or more hours per week or 130 or more hours per month);

1.1.2 an elected or appointed official as defined by 29 **Del.C.** §5201**;**

1.1.3 a permanent part-time employee (regularly scheduled to work less than 130 hours per month);

1.1.4 a limited term employee (as defined by Merit Rule 10.1);

1.1.5 a pensioner receiving or eligible to receive a pension from the State;

1.1.6 a per diem or contractual employee of the Delaware General Assembly who has been continuously employed for 5 years.

1.1.7 a temporary employee (regularly scheduled 30 or more hours per week or 130 or more hours per month) as defined by 29 **Del.C.** §5207.

1.2 Those employees who meet the definition outlined in rule 1.1.1, 1.1.2, 1.1.4 and 1.1.5 are considered "regular officers and employees", or "eligible pensioners" as provided by 29 **Del.C.** §5202 and are to receive State Share contributions.

1.3 Short term disability beneficiaries receiving benefits under 29 **Del.C.** §5253(b) will be treated as "regular officers and employees" under these regulations. Long term disability beneficiaries receiving benefits under 29 **Del.C.** §5253(c) will be treated as "eligible pensioners" under these regulations.

1.4 Casual and seasonal and substitutes are not eligible for the State Plan.

1.5 Newly employed school teachers become eligible employees when they start employment not when they sign their contract. (Review the Eligibility Table, see Appendix "A", for coverage start date dependent upon the September hire date). Temporary teachers who are re hired in September are

eligible to elect coverage when re hired. Temporary teachers who are re hired in the next contract year are eligible to elect coverage when re hired without fulfilling another 3 month waiting period.

1.6 Employees or pensioners who are enrolled in Medicare Part D may not have prescription coverage in the State Plan.

6 DE Reg. 690 (11/1/02)

12 DE Reg. 986 (01/01/09)

2.0 Dependents Eligible to Participate

2.1 Dependents must meet one of the following definitions to be eligible for enrollment in the State plan:

2.1.1 A regular officer's or employee's or eligible pensioner's:

2.1.1.1 legal spouse (Delaware law does not recognize common law or same sex marriage). Ex spouses may not be enrolled in the State's group health insurance program - even if a divorce decree, settlement agreement or other document requires an employee to provide coverage for an ex spouse

IMPORTANT NOTE: Spousal Coordination of Benefits Policy has been in effect since 1/1/93. The policy applies to a spouse who is eligible for health coverage through his/ her own employer. Spouses who work full time and are eligible for health coverage through their employer, but do not enroll under their employer's health plan, will have a reduction in benefits under the State Plan. A new Spousal Coordination of Benefits form must be completed each year during Open Enrollment or anytime throughout the year if the spouse's employment or insurance status changes. Employees should refer to the Statewide Benefits Office's website at http://ben.omb.delaware.gov/documents/cob/index.shtm or individual benefit booklets for each plan for more detailed information.

2.1.1.2 unmarried child/ren under age 21 (age 24 if a full time student), born to or legally adopted or placed for adoption by a regular officer, or employee or eligible pensioner or a regular officer or employee's or pensioner's legal spouse, as defined in 29 **Del.C.** §5201(a);

2.1.1.3 unmarried dependent child/ren under age 21 (age 24 if a full time student), not born to or legally adopted, but residing with a regular officer or employee or eligible pensioner in a regular parent child relationship, and who is dependent upon the regular officer or employee or eligible pensioner for at least fifty (50) percent support. A statement of support form must be completed by the regular officer or employee or eligible pensioner and forwarded to the employee's Benefit Representative or Human Resources Office with the request for coverage together with a copy of the legal guardianship, permanent guardianship or custody order for the dependent child. If a natural parent resides in the same household as the insured regular officer or employee or eligible pensioner, it will be deemed that a regular parent-child relationship does not exist unless the regular officer or employee or eligible pensioner has legal guardianship documents or has legally adopted the dependent child.

2.1.1.4 unmarried dependent child/ren who meet the criteria of sections 2.1.1.2 or 2.1.1.3 above, but who is over age 21 and incapable of self-support because of a mental or physical disability which existed before the child reached age 21. The child/ren must have been covered under employee's contract immediately preceding age 21, or age 24 if a full time student.

IMPORTANT NOTE: Dependent Coordination of Benefits (child/ren) form must be completed for each enrolled dependent upon enrollment, any time coverage changes, or upon request by the Statewide Benefits Office.

2.2 Eligible dependent child/ren covered under the health insurance plans of both parents will be primary to the parent's plan whose birthday is the first to occur during the calendar year. In the event the birth dates are the same, the dependent child will be primary to the parent with the longest employment service. In the event birth dates and length of service are the same, the dependent child will be primary to the male parent's plan.

2.3 Adult Dependent Program - Provides a period of health care coverage up to age 24, if an adult dependent's coverage was terminated or will terminate due to his/her age; i.e., dependent was terminated from coverage effective December 31 in the year he/she turned 21 and is not a full-time student, or the end of the month in which he/she graduated from college and is not yet 24.

2.3.1 Eligibility Requirements. An Adult Dependent eligible to be covered under this program is a covered person's (employee's or pensioner's) child by blood or by law who meets all of the following:

2.3.1.1 Is less than 24 years of age;

2.3.1.2 Is unmarried;

2.3.1.3 Has no dependents of his/her own;

2.3.1.4 Is either a resident of the State of Delaware or is enrolled as a full-time student at an accredited institution of higher learning; and

2.3.1.5 Is not actually provided coverage as a named subscriber, insured, enrollee, or covered person under any other group or individual health benefits plan, group health plan, or church plan, or entitled to benefits under a state's Medical Assistance program.

2.3.2 If an Adult Dependent is no longer eligible to be covered under the health plan of the parent or legal guardian (referred to as covered person) because of his/her age, he/she is eligible to enroll in this program provided the covered person continues to have health care coverage through the State of Delaware. The Adult Dependent must contact the health care carrier within 30 days of their loss of coverage to enroll or may enroll during an Open Enrollment period. If an Adult Dependent is between the ages of 21 and 24 and is enrolled as a full-time student at an accredited institution of higher learning he/she is eligible to be covered under the health care coverage of the covered person and does not need to enroll in this program.

2.3.3 Program Requirements

2.3.3.1 Employee or pensioner must remain actively enrolled in a State of Delaware Group Health Insurance plan provided by one of the State designated health care providers.

2.3.3.2 Adult Dependent must enroll in the same health care plan, which provides coverage to their parent or legal guardian who is an employee or pensioner with Group Health Insurance through the State of Delaware.

2.3.3.3 Health care premiums must be paid directly to one of the State designated health care providers.

2.3.3.4 Payroll deductions from the paycheck of the parent or legal guardian with group health insurance through the State are not an option.

2.3.4 End of Coverage. Coverage of an eligible Adult Dependent who enrolls in this Adult Dependent Program is provided until the earlier of the following:

2.3.4.1 Adult Dependent child no longer meets the definition of an Adult Dependent because he/she:

2.3.4.1.1 Reaches 24 years of age;

2.3.4.1.2 Marries;

2.3.4.1.3 Has his/her own dependents;

2.3.4.1.4 Is not a resident of the State of Delaware or is not enrolled as a full-time student at an accredited institution of higher learning; or

2.3.4.1.5 Has his/her own coverage as a named subscriber, insured, enrollee, or covered person under another group or individual health benefits plan, group health plan, or church plan, or entitled to benefits under a state's Medical Assistance plan;

2.3.4.2 Date on which coverage ceases under the contract by reason of failure to make a timely payment of premium required under the contract. Payment of any premium is considered to be timely if made within 30 days after the due date; or

2.3.4.3 Date upon which coverage under the State Plan is terminated for the covered person (parent or legal guardian) of the eligible Adult Dependent.

6 DE Reg. 690 (11/1/02)
12 DE Reg. 986 (01/01/09)

3.0 Coverage

3.1 Coverage of an eligible regular officer or employee and his/her eligible dependents will become effective on the first of the month following date of hire provided the employee submits a signed application within 30 days of the employee's date of hire or within 30 days of the employee becoming eligible for the State Share. Refer to Eligibility Table for specific coverage date options for employees who elect coverage when eligible for State Share.

3.1.1 Coverage may become effective on date of hire provided the employee submits a signed application within 30 days of the employee's date of hire. Premiums are not pro-rated.

IMPORTANT NOTE: Spousal Coordination of Benefits Policy became effective 1/1/93 for a spouse who is eligible for health coverage through his or her own employer. Spouses who work full time and are eligible for health coverage through their employer, but do not enroll under their employer's health plan, will have a reduction in benefits under the State Plan. Employees should refer to the individual benefit booklets for each plan for more detailed information or see http://ben.omb.delaware.gov/documents/cob/index.shtml.

3.2 Employees of the State of Delaware who are enrolled in a health insurance benefit plan must re-enroll in a plan of their choice during the Open Enrollment period as determined by the SEBC. Should such employee(s) neglect to re-enroll in the allotted time, said employee/s and any spouse or dependents shall be automatically re-enrolled in their previous plan as long as verification of employment is provided by the employee and the Statewide Benefits Office.

3.3 Employees or pensioners who cover their spouse on the State Plan must complete a Spousal Coordination of Benefits Policy Form during each annual Open Enrollment period as well as anytime there is a change in the spouse's employment or an insurance status change. Failure to supply the Spousal Coordination of Benefits form shall result in the spouse's medical claims being reduced to 20 percent and inability to have prescriptions filled.

IMPORTANT NOTE: Dependent Coordination of Benefits (child/ren) form must be completed for each enrolled dependent upon enrollment, any time coverage changes, or upon request by the Statewide Benefits Office.

3.4 If an employee elects not to enroll in the State Plan, the employee must complete and sign an application/enrollment form acknowledging the desire not to enroll by noting "waive" on the appropriate form.

3.5 Eligible employees who fail to submit a completed and signed application/enrollment form within 30 days of their date of hire or their date of eligibility for State Share may not join the State Plan until the next open enrollment period (usually May), unless the employee meets the requirements of Eligibility and Enrollment Rule 3.6.

3.6 Pursuant to a federal law, Health Insurance Portability and Accountability Act (HIPAA), if an employee declines enrollment for him or herself or their dependent/s (including the spouse) because of other health insurance coverage and later involuntarily loses the coverage, the State employee and/or spouse may be eligible to join the State Plan, without waiting for the next Open Enrollment period, as long as the request to enroll is made within 30 days of the loss of coverage. Necessary forms must be completed within 30 days of the request to enroll. If such a change is not made in the time period specified, the eligible employee/and or spouse must wait until the next Open Enrollment period.

3.6.1 The following list includes examples of loss of coverage or loss of eligibility for coverage rules under which an employee may request enrollment for him/her-self and for dependent/s:

- Loss of eligibility for coverage as a result of legal separation, divorce, death, termination of employment or reduction in the hours of employment;
- Loss of eligibility for coverage provided through a Health Maintenance Organization (HMO) because the individual no longer resides, lives, or works in an HMO service area (regardless

of whether the choice of the individual) and no other benefit package is available to the individual;

- Loss of eligibility for coverage due to the cessation of dependent status;
- Loss of coverage because an individual incurs a claim that meets or exceeds a lifetime limit on all benefits under the plan;
- A plan discontinues a benefit package option and no other option is offered;
- If the employer ceases making contributions toward the employee's or dependent's coverage, the employee or dependent will be deemed to have lost coverage and does not need to drop coverage to have special enrollment rights;
- Exhaustion of Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, except that an employee/dependent losing coverage under another plan is not required to elect COBRA under that plan before using their special enrollment rights to enroll with the State.

3.6.2 An increase in employee contribution, change of benefits or change of carrier of the spouse's plan shall not constitute loss of coverage, except where the other plan terminates employer contributions. Employees should contact their Benefit Representative or Human Resources Office and pensioners should contact Pension Office to ask specific questions about eligibility.

3.7 If an employee declines enrollment for him/her-self or his/her dependents (including the spouse) and later has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may be able to enroll him/her-self and his/her dependents provided that he/she request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Necessary forms must be completed within 30 days of the request to enroll.

3.8 The eligible employee who is currently enrolled in a group health plan, may change his/her benefit plan upon the dependent's involuntary loss of coverage, pursuant to Eligibility and Enrollment Rule 3.06, and addition to the State's Plan, provided the request for enrollment is made within 30 days of the loss of dependent's coverage and necessary form must be completed within 30 days of the request. In addition, if the employee has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may change his/her benefit plan upon the addition of the dependent to the State Plan provided the request for enrollment is made within 30 days after the marriage, birth, adoption, or placement for adoption and the necessary paperwork is completed within 30 days of the request.

3.9 When husband and wife are eligible State employees, the two employees, or each eligible pensioner, and all eligible dependents may elect to enroll under one family contract. When the employees are both active, and an employee and spouse or family contract is chosen, the spouse whose birthday occurs earlier in the calendar year shall sign an application for coverage form requesting coverage. A change of agency is considered re-enrollment. (In the event the birth dates are the same, length of service and/or gender will be applied as described in Eligibility and Enrollment Rule 2.2.) Beginning with the effective date of these rules, State Share contributions for all new enrollments will be charged to the agency or organization whose employee enrolls for employee, employee and spouse, employee and child/ren or family coverage. Enrollments prior to February 1990 shall continue to be charged to the agency or organization as was previously determined.

3.9.1 Each regular officer or employee or each eligible pensioner may elect to enroll under a separate contract. Eligible dependent/s may be enrolled under either contract, but no dependent shall be enrolled more than once under the State Plan.

3.9.2 The increment of cost of the options selected by the two regular officers or employees or eligible pensioners, which exceeds the cost of two First State Basic family plans, shall be deducted by the Director of the Office of Management and Budget (OMB) from salary, pension or disability payments or checks.

3.10 When the spouse of an eligible regular officer or employee is a retired State of Delaware employee receiving a pension, and enrolled under separate individual contracts, the employing agency and the Pension Office will carry the coverage for their respective employee/pensioner. If an Employee & Spouse, or a Family contract is chosen, the coverage will continue to be carried through the active employee's agency until such time that the Pensioner turns 65. The over age 65 spouse may continue to have the State Plan as primary payor of benefits with the contract to continue under the active

employee's agency, or the spouse may choose Medicare as the primary payor through the Pension Office. Also see Eligibility and Enrollment Rules 4.8 and 4.12.

6 DE Reg. 690 (11/1/02)

12 DE Reg. 986 (01/01/09)

4.0 Changes In Coverage

4.1 An eligible employee who elects to be covered on his/her EMPLOYMENT COVERAGE DATE may change coverage when the employee first becomes eligible for the State Share payment. (Examples: (1) An employee who at hire enrolls in the "First State Basic" plan may change to "Comprehensive PPO" (or another optional coverage) when beginning State Share contribution, without waiting for the next open enrollment period. (2) An employee who at hire enrolls for "Employee" coverage may change to "Employee and Child/ren", "Employee and Spouse", or "Family" coverage when he/she begins to receive State Share, without waiting for the next open enrollment period.

4.2 When a covered regular officer or employee or eligible pensioner marries, coverage for the spouse will become effective on the date of marriage, or first of the month following the date of marriage provided the regular officer or employee or eligible pensioner requests enrollment of the new spouse within 30 days of the date of the marriage and provides the necessary paperwork within 30 days of the request to enroll. A copy of valid marriage license must be provided. (Delaware law does not recognize common law or same sex marriage). Premiums are paid on a monthly basis and not pro rated; therefore, if a regular officer or employee or eligible pensioner adds the new spouse effective the date of the marriage, the regular officer or employee or eligible pensioner must remit the difference in employee contribution for the entire month. The regular officer or employee or eligible pensioner may submit a signed application within thirty (30) days prior to the date of marriage. If a request to enroll is not made within 30 days after the marriage, a covered regular officer or employee or eligible pensioner must wait until the next open enrollment period to add the spouse. A Spousal Coordination of Benefits Policy form must be completed when adding spouse to coverage.

4.3 Coverage for a child/ren born to a regular officer or employee or eligible pensioner or legal spouse who is covered under the State Plan will begin on the date of birth provided a request to enroll the child is made within 30 days of the date of birth and provided the necessary paperwork is received within 30 days of the request to enroll. A copy of a valid birth certificate must be provided. Premiums are paid on a monthly basis and not pro rated. If such a change is not made in the time period specified, a covered employee must wait until the next Open Enrollment period to add the child/ren. For an employee who has an existing Employee and Child, or Family type contract, the 30 day time period does not apply. However, the application to add the newborn child/ren must be made within a reasonable time period and copy of valid birth certificate provided.

IMPORTANT NOTE: Dependent Coordination of Benefits (child/ren) form must be completed for each enrolled dependent upon enrollment, any time coverage changes, or upon request by the Statewide Benefits Office.

4.4 Coverage for a child/ren legally adopted or placed for adoption with a regular officer or employee or eligible pensioner or legal spouse who is covered under the State Plan will begin on the date of adoption or placement for adoption provided a request to enroll for the child/ren is made within 30 days of the date of adoption or placement for adoption and provides the necessary paperwork within 30 days of the request to enroll.

4.4.1 A copy of a valid legal document attesting to the adoption or placement for adoption must be provided. Premiums are paid on a monthly basis and not pro rated. If such a change is not made in the time period specified, a covered employee must wait until the next Open Enrollment period to add the child. For an employee who has an existing Employee and Child/ren, or Family type contract, the 30 day time period does not apply. However, the application to add the newly adopted child must be made within a reasonable time period.

4.5 Coverage for an eligible dependent, other than a newborn child/ren, who becomes an eligible dependent after the employee has been enrolled, becomes covered on the first day of the month following eligibility provided the regular officer or employee or eligible pensioner requests enrollment

within 30 days of eligible status. The necessary paperwork must be completed within 30 days of the request for enrollment. A copy of valid documentation of dependent status must be provided, i.e. legal guardianship, permanent guardianship, custody order. Applicable premiums must be paid.

4.6 An employee who transfers to another agency or school district may change his/her plan and coverage without waiting until the next Open Enrollment period if the transfer impacts the employee contribution to health benefits provided the employee makes the required change within 30 days of the transfer.

4.7 Changes in coverage can only be made at the annual Open Enrollment period, except:

4.7.1 A regular officer or employee or eligible pensioner is making a change due a qualifying event or Special Enrollment Right as previously outlined in Eligibility and Enrollment Rules 3.6 through 3.8;

4.7.2 In the case of divorce, if there is a "qualifying event" under Eligibility and Enrollment Rules 3.6 through 3.8, the regular officer or employee or eligible pensioner's coverage status may change, but the plan cannot unless Double State Share (DSS) is applicable;

4.7.3 The spouse of a regular officer or employee or eligible pensioner has become a State of Delaware employee entitled to State Share in which case the plan may be changed if an Employee and Spouse or Family contract is chosen;

4.7.4 A regular officer or employee or eligible pensioner may change coverage and/or plan if no longer entitled to DSS, provided application is made within 30 calendar days of the qualifying event; or

4.7.5 A regular officer or employee or eligible pensioner electing to drop health coverage or drop one or more dependents (including the spouse of such regular officer, employee, or eligible pensioner) from health coverage may drop coverage of dependents, under the following limited circumstances as per Section 125 of the Internal Revenue Service Code:

"1. Change in status.

(i) Due to death of spouse.

(ii) Due to changes in employment status of the employee, the employee's spouse or dependent (e.g., commencement of employment, change of worksite or return from an unpaid leave of absence).

(iii) Change in the eligibility conditions for coverage under the spouse's or dependent's employer's plan.

(iv) Events that cause the employee's dependent to cease to satisfy the plan's eligibility requirements. (e.g. age, student status or similar circumstance).

(v) Change in the place of residence of the employee, spouse or dependent provided that in each of the circumstances described in subparagraphs (i) through (v), inclusive, the cessation of coverage for the dependent is on account of and corresponds with a change in status that affects eligibility for coverage under the plan.

2. Judicial Order, Decree, or Judgment. Health coverage for one or more of dependent children may be dropped if a judicial order, decree, or judgment permits the cancellation of dependent child coverage, provided that the spouse, former spouse or another individual is required to cover such child and such coverage is in fact provided.

3. Medicare or Medicaid Eligibility. If an employee, spouse, or dependent who is enrolled in an accident or health plan of the employer becomes entitled to coverage (i.e., becomes enrolled) under Part A or Part B of Title XVII of the Social Security Act (Medicare) (Public Law 89-97 (79 Stat. 291) or Title XIX of the Social Security Act (Medicaid) (Public Law 89-97 (79 Stat. 343), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the regular officer, employee or eligible pensioner may for themselves or for their dependents make a prospective election change to cancel or reduce coverage of that employee or dependent under the health plan.

4. Change in Costs or Coverage. If the cost charged to an employee for health coverage significantly increases during a period of coverage, the regular officer, employee or eligible pensioner may make a corresponding change in election under the plan, including commencing participation in an option with a decrease in cost, or, in the

case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving on a prospective basis coverage under another benefit package option providing similar coverage or dropping coverage if no other health plan option providing similar coverage is available. (For purposes of this paragraph, a cost increase or decrease refers to an increase or decrease in the amount of the elective contributions under the cafeteria plan, whether that increase or decrease results from an action taken by the employee (such as switching between full-time and part-time status) or from an action taken by an employer (such as reducing the amount of employer contributions for a class of employees)."

4.8 An eligible regular officer or employee or a legal spouse (eligible to receive State Share) who reaches age 65 and becomes eligible for Medicare shall continue to be covered under the State Plan as the primary payor of benefits.

4.8.1 Regular officers or employees ~~or eligible pensioners~~ and dependents eligible for Medicare, by reason of age or disability, must apply for Medicare Part A when first eligible regardless of their coverage under the State Plan. Also see Eligibility and Enrollment Rule 3.10.

4.8.2 If an employee or dependent covered under the State Plan becomes eligible for Medicare Parts A and B due to End Stage Renal Disease (ESRD), the covered individual must enroll in Medicare Parts A and B and these plans will be primary to the State Plan for the period of time as outlined in the Medicare guidelines. Employees with ESRD should contact their State Plan insurance carrier to discuss coverage options.

4.9 An employee who becomes eligible for pension or Long-Term Disability (LTD) may change their plan at the onset of receiving pension or LTD.

4.10 A regular officer or employee or eligible pensioner who is required by Court or Administrative Order to provide health insurance coverage for a child/ren shall be permitted to enroll under family or employee and child/ren coverage, any child/ren who is eligible for such coverage (without regard to any Open Enrollment restriction). If the employee is enrolled, but fails to make application to obtain coverage of the child/ren, the child/ren shall be enrolled under such family or employee and child/ren coverage upon application by the child/ren's other parent, the Division of Child Support Enforcement or Division of Social Services. The employee shall not disenroll (or eliminate coverage of) any child/ren unless the employer is provided satisfactory written evidence that:

4.10.1 The Court or Administrative Order is no longer in effect, or

4.10.2 The child/ren is or will be enrolled in comparable health coverage, which will take effect no later than the effective date of such disenrollment.

4.11 When a covered regular officer or employee or eligible pensioner divorces, coverage for the ex spouse will terminate on the day following the date of divorce. Premiums are paid on a monthly basis and not prorated. The regular officer or employee or eligible pensioner must remit the employee contribution for the plan, which included the spouse for the entire month. The regular officer or employee or eligible pensioner must submit a signed application within 30 days prior to or 30 days following the date of divorce. If DSS terminates as a result of the divorce, the regular officer or employee or eligible pensioner must pay the employee contribution for the entire month that the divorce occurred.

4.12 Pensioners and dependents eligible for Medicare, by reason of age or disability, must also enroll in Medicare Part A and B when first eligible for these plans and may enroll in the Medicare Supplement plan provided by the State Group Health Plan through the Pension Office. Also see Eligibility and Enrollment Rule 3.10.

6 DE Reg. 690 (11/1/02)

12 DE Reg. 986 (01/01/09)

5.0 Cost Of Coverage

(Used to determine the amount of State Share contributed toward an employee's coverage and the amount of employee contributions required, if any.)

5.1 "Regular officers and employees" begin earning State Share contributions on the first of the month following three full months of employment. See Eligibility Table for specific information regarding State Share payments and employee payroll deductions for employees who elect coverage when eligible for State Share.

5.2 Permanent part-time, temporary per diem and contractual employees of the General Assembly as described in Eligibility and Enrollment Rule 1.01 are eligible to participate in the State Plan, but are not eligible for State Share. Therefore, any such employee joining the State Plan must pay the full cost of the health plan selected. Payment must be collected by the organization and forwarded to the Statewide Benefits Office by the first day of the month for which the employee's coverage becomes effective.

5.2.1 If an existing full time state employee takes a limited term position, State Share shall continue.

5.2.2 Casual and seasonal employees and substitutes are not eligible to participate in the State Plan, nor are they eligible for State Share.

5.3 When a husband and wife are both permanent full time active employees, they shall earn State Share contributions in accordance with the following:

5.3.1 If they elect to enroll in two individual contracts, the increment of cost of the options selected by the two employees which exceeds the cost of two First State Basic family plans, shall be deducted by OMB from salary, pension or disability payments.

5.3.2 If they elect to enroll in one employee and spouse or family contract, the increment of cost of the option selected by the employee that exceeds the cost of two First State Basic family plans, shall be deducted by OMB from salary, pension or disability payments.

5.4 When the spouse of an eligible employee is a retired State of Delaware employee receiving a monthly pension or a Disability Insurance Program (DIP) LTD beneficiary receiving an LTD check, each may enroll as two individual contracts, employee and spouse contract or a family contract. The increment of cost of the option selected by the employee that exceeds the cost of two First State Basic family plans, shall be deducted by OMB from salary, pension or disability payments. (A notation should be made in the employee's file that the spouse is a State of Delaware Pensioner or DIP LTD beneficiary). The Pension Office should be notified when the active employee terminates State Service.

5.5 An eligible employee who elects to be covered prior to becoming eligible for State Share must pay the full cost of coverage, State Share and employee share, until State Share begins.

5.6 If a regular officer, employee, eligible pensioner, or beneficiary selects coverage under any plan other than the First State Basic Plan, the employee is responsible for paying the additional cost, if any, over and above the cost of the same coverage class (individual, employee & child, employee & spouse, or family) under the First State Basic plan.

5.7 A regular officer or employee or eligible pensioner who is eligible for the State Share contribution may not receive the cash equivalent in lieu of the coverage itself.

5.8 Health coverage premiums are collected on a lag basis. (Example: January coverage is paid by deduction in the second pay of January plus deduction in the first pay of February). Each agency/ school district/sub group is responsible for reconciling premiums to ensure that proper payment has been remitted. Payments, other than those made through OMB's automated payroll system, and all adjustments must be submitted in a timely manner to the Statewide Benefits Office. The State Plan will not be responsible for payment of premiums and/or claims if a signed enrollment form/confirmation statement/waiver is not in the employee file.

5.9 An eligible employee who returns from an authorized unpaid leave of absence is entitled to State Share payments upon return without fulfilling another three month waiting period. The employee must request enrollment by contacting their Human Resources Office within 30 days of return from leave of absence. State Share and coverage (if it has lapsed) begin on the date of return from leave of absence.

5.10 Any regular officer or employee or eligible pensioner who fails to make payment for his/her share of the cost of health coverage when he/she is eligible to continue coverage and does not have sufficient salary from which payment can be deducted will have coverage canceled on the first day of the month

~~following any month~~ that a regular officer or employee or eligible pensioner fails to pay the required share for the coverage selected.

5.10.1 Family and Medical Leave Act (FMLA) regulations provide that employees have a 30 day grace period for late premium payments. The employer's obligation to maintain health coverage ceases if an employee's premium payment is more than 30 days late. Benefit Representative or Human Resources Offices should continue the employee's health coverage for the 30 day period provided under FMLA. The Benefit Representative or Human Resources Offices can then do a retroactive cancellation if the required employee contribution was not paid by the end of the 30 day grace period.

5.11 An employee who has a break in active employment due to authorized leave of absence, suspension, termination or unauthorized leave of absence without pay for a full calendar month, shall not be eligible for State Share for that calendar month and any subsequent calendar month that the employee is in a non pay status for the entire calendar month. In the case of an authorized leave of absence, an intermittent return to work or use of paid leave of less than five full days in one month, the employee shall not be entitled to State Share contributions. Full payment must be made for the month in order to retain coverage. Upon return, the employee is eligible for State Share without fulfilling another three month waiting period, provided the break was the result of any of the following:

5.11.1 an authorized leave of absence;

5.11.2 a suspension without pay;

5.11.3 termination or unauthorized leave of absence for a period less than 30 calendar days.

Coverage begins on the date of employee's return to work.

5.12 State Share will be paid for employees drawing Workers' Compensation, provided the employee is not eligible for coverage from a subsequent employer. Such an employee must submit payment for the share of the coverage that would normally be deducted from his/her salary.

5.13 State Share will be paid for employees who are approved for Short Term and/or Long Term Disability through the State's DIP.

5.13.1 Employee's share of premium shall be deducted by OMB from employee's salary or DIP LTD check.

5.13.2 Employees whose STD claims are in a pending status are entitled to receive State Share.

5.13.3. Employees who are appealing a STD termination and/or benefit denial are eligible to receive State Share. If the appeal results in a denial, the employee is responsible for the State Share paid on his/her behalf while the claim was in a pending appeal status.

5.14 Any refund of State Share or employee share is subject to the following requirements:

5.14.1 An employee who has paid the State Share in order to insure continuation of health coverage and then later is found to have been eligible for receipt of State Share, is to be refunded the amount that was not paid by the State. The employee must make application for the refund within one calendar year of the date the employee paid the State Share to be refunded;

5.14.2 An employee who has paid the employee share then later is found to have been eligible for receipt of DSS is to be refunded the amount paid for employee share for a period not to exceed one calendar year. The employee seeking a refund must make application for the refund within one year of the date the employee paid the employee share to be refunded;

5.14.3 An employee who has paid the employee share for an ineligible dependent (for example following a divorce, death or exceeding the dependent age limits) is to be refunded the amount paid for employee share for a period not to exceed 60 days, provided that the employee seeking a refund must make application for the refund within 60 days of the date the employee paid the employee share to be refunded and further that the employee shall be liable for any amounts paid by the State Plan on behalf of the ineligible dependent until the employee provides notice to the Statewide Benefits Office of the dependent's ineligibility;

<u>5.14.4 If an employee is terminated from employment and does not pay the employee share for the second half of the month in which terminated, coverage under the Plan is terminated as of the first</u>

of the month, any claims paid for that month will be reversed and a refund will be given, if employee makes request for refund within 60 days.

5.14.~~4~~5 In any event, refunds of less than $1.00 will not be made.

5.15 Teachers who are granted a sabbatical leave of absence are eligible for State Share while they are on such leave. Also see Eligibility and Enrollment Rule 6.3.

5.16 All employees whose positions are involuntarily terminated after they have been employed for a full calendar year who return to full time State employment within 24 months of their termination will be eligible for State Share without fulfilling another three month qualification period.

5.17 A temporary, casual, seasonal employee, or substitute who becomes a "Regular Officer or Employee" shall have his/her unbroken temporary, casual, seasonal, or limited term, provisional or permanent part time "Aggregate State Service" applied toward the three month qualification period for State Share contributions. The "Aggregate State Service" must immediately precede becoming a "Regular Officer or Employee". The temporary, casual, seasonal employee, or substitute must have worked each pay cycle for the three months prior to hire eligibility for state share - or last three full months of the school year prior to September hire.

5.18 State Share shall continue for a "Regular Officer or Employee" who is temporarily appointed to a position that results in a dual incumbency.

5.19 Any active employee who is also receiving a survivor's pension through the State of Delaware shall receive DSS. The increment of cost, which exceeds the cost of two First State Basic family plans, shall be deducted from employee's salary.

5.20 A regular officer or employee called to active duty with the National Guard or Reserve for other than training purposes shall continue to receive state share toward health insurance coverage for a period of up to two years. Employee's share must be remitted to Benefit Representative or Human Resources Office for further processing.

6 DE Reg. 690 (11/1/02)

12 DE Reg. 986 (01/01/09)

6.0 Continuation Of Coverage

6.1 To continue coverage other than the First State Basic Plan, a covered employee must pay the difference between the State Share contribution and the cost of the coverage selected. Coverage will be terminated on the first day of the month employee did not make required payment.

6.2 An employee granted an unpaid authorized leave of absence can maintain membership in the group health plan by paying the full cost of coverage (State Share plus employee share) during the period of the leave as long as that leave of absence does not exceed two years. An employee who returns from an authorized leave of absence, whether he/she maintains coverage or not while on leave of absence, is authorized to receive State Share immediately upon return. (Eligibility for State Share begins upon return without fulfilling another three month qualification period). An employee on FMLA leave is entitled to have pre existing health insurance benefits (including the State Share) maintained while on an FMLA leave. If an employee was paying State Share and/or employee share of the premium payments prior to leave, the employee would continue to pay the same share during the leave period. Failure to make such payment within 30 days of the due date will result in termination of coverage.

6.3 Coverage other than the First State Basic Plan continues for teachers who are granted sabbatical leave provided they make the required payments for their share of the cost of their coverage; otherwise, their coverage reverts to the First State Basic Plan. (State Share continues while employee is on sabbatical leave.) Also see Eligibility and Enrollment Rule 5.15.

6.4 Employees leaving State employment, except for termination due to gross misconduct or whose application for LTD benefits under the DIP has been approved, are eligible for continuation under COBRA. Employees should contact their Benefits Representative or Human Resources Office for details of this continuation option.

6.5 An eligible employee or eligible dependent that loses coverage under the State Plan may continue coverage under COBRA. If a COBRA qualifying event occurs, the employee or the employee's

dependent(s) must notify the employee's Benefit Representative or Human Resources Office or the State's COBRA Administrator to provide notice of the qualifying event within 60 days of its occurrence.

6.6 Upon expiration of the covered individual's COBRA eligibility, the individual may apply directly to the insurance company for a direct billed health insurance contract.

12 DE Reg. 986 (01/01/09)

7.0 Termination Of Coverage

7.1 Coverage ends on the last day of the month in which the employee terminates employment. A public school or higher education employee (less than 12 month employee) whose employment during a school year continues through the last scheduled work day of that school year shall retain coverage through August 31 of the same year so long as the required employee share has been paid. In the event an employee fails to make the required payment for any optional coverage selected, coverage will be terminated. If an employee works one day in the month in which he/she terminates, he/she shall earn State Share for the entire month. Coverage will be terminated on the first day of the month employee did not make required payment.

7.2 Coverage (and dependent coverage, if applicable) ends as of the end of the month in which the employee ceases to be an eligible employee for coverage (due to some change such as a reduction in the number of hours the employee works).

7.3 Coverage of dependents, except for dependents of pensioners and dependents eligible for a survivor's pension, ends as of the last day of the month of the employee's death. Dependents who lose coverage as a result of the employee's death are eligible for continuation under COBRA. Contact the State's COBRA administrator for details of this continuation option.

7.4 Ex spouses not employed by the State of Delaware are not eligible for coverage under the State Plan - even if a divorce decree, settlement agreement or other document requires an employee to provide coverage for an ex spouse. Coverage for the ex spouse will terminate on the day after the date of divorce. Premiums are paid on a monthly basis and not prorated. The regular officer or employee or eligible pensioner must remit the employee share for the plan which included the spouse for the entire month. The regular officer or employee or eligible pensioner must submit a signed application within 30 days prior to or 30 days following the date of divorce. If DSS terminates as a result of the divorce, each regular officer, employee or eligible pensioner must pay the employee contribution for the entire month that the divorce occurred. The State Plan will not be responsible for payment of claims when a dependent is no longer eligible for coverage.

7.5 Coverage for a dependent child/ren will end the earlier of the following:

7.5.1 December 31st of the year in which he/she reaches age 21. If a full time student, coverage will end on the earlier of the following: (1) the end of the month in which the dependent child is no longer a full time student, or (2) the end of the month in which the dependent child/ren attains age 24. Student certification must be updated each year between ages 21 and 24.

7.5.2 The last day of the month in which the child/ren marries;

7.5.3 The date the child/ren ceases to be dependent on you or your spouse for at least 50% support per Sections 2.1.1.3 and 2.1.1.4.

7.5.4 Adult Dependent Program coverage is as provided in Section 2.3.

6 DE Reg. 690 (11/1/02)

6 DE Reg. 1515 (5/1/03)

12 DE Reg. 986 (01/01/09)

8.0 Reinstatement of Coverage

8.1 Once a regular officer or employee or eligible pensioner has requested that his/ her coverage be canceled, he/she cannot rejoin the State Plan until the next annual Open Enrollment period unless such regular officer or employee or eligible pensioner qualifies for re-enrollment under the applicable exceptions to these Eligibility and Enrollment Rules.

8.2 An employee who returns from an authorized leave of absence not exceeding 24 months in duration who does not maintain coverage while on leave of absence, is permitted to enroll immediately upon return without waiting for the next Open Enrollment period, provided the employee requests enrollment within 30 days of return and completes the necessary paperwork required to enroll within 30 days of the request. Coverage will begin as of the date the employee returns from leave following completion of the necessary paperwork and payment of any required employee share. Premiums are paid on a monthly basis and are not prorated.

8.3 Employees whose positions are involuntarily terminated after they have been employed for a full year (or full school year) will be eligible for State Share immediately if they return to full time State employment within 24 months of termination.

6 DE Reg. 690 (11/1/02)

12 DE Reg. 986 (01/01/09)

9.0 Miscellaneous

9.1 It is the responsibility of the regular officer, employee or eligible pensioner to keep his/her Benefit Representative or Human Resources Office informed of any change of address or change in status which results in the adding or dropping of dependent/s (marriage, divorce, birth, death, adoption, etc.) that affects his/her health care coverage. In turn, it is the responsibility of the Benefit Representative or Human Resources Office to make ~~the make~~ the necessary changes in the appropriate payroll system, or to notify the Statewide Benefits Office of these changes. Failure to do so may affect eligibility of coverage or extent of coverage for any participant and could impose an extreme hardship on a regular officer or employee or eligible pensioner. The State Plan will not be responsible for payment of premiums and/or claims in the event of ineligibility and/or the absence of a signed enrollment form/ confirmation statement in the regular officer or employee or eligible pensioner's file.

9.2 If any provision of these Rules and Regulations or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or application of the Rules and Regulations which can be given effect without the invalid provision or application, to that end the provisions of these Rules and Regulations are declared to be severable

6 DE Reg. 690 (11/1/02)

12 DE Reg. 986 (01/01/09)

10.0 Dental Plan

10.1 Employees electing to pay for and receive coverage under one of the Dental Plans should be aware of the following terms:

10.1.1 Dental is not affected by Double State Share (DSS) and dental insurance plans cannot be changed upon eligibility for DSS;

10.1.2 Employees may enroll in a dental plan during the first of month after being hired, becoming eligible, or 90 days after the first of the following month after being hired;

10.1.3 The Dental Plan's effective date is always the first of the month and not on event date as for the health plan;

10.1.4 Dental Plan refund rules are limited to 60 days or less because the Dental Plan is fully insured;

10.1.5 Dental Plan term dates are limited to 60 days or less;

10.1.6 Dental Plan will be terminated in the event that employee is 60 days delinquent in payment of Dental Plan premium and any paid claims in the same period will be reversed;

10.1.7 If an employee is terminated from employment and does not pay the Dental Plan premium for the second half of the month in which terminated, coverage under the Dental Plan is terminated as of the first of the month, any claims paid for that month will be reversed and a refund will be given, if employee makes request for refund within 60 days;

10.1.8 School district employees (except those of Delaware Technical and Community College) who are offered school district dental coverage are not eligible for coverage under the State Dental Plans;

10.1.9. Terminations in dental coverage can only be made during the annual Open Enrollment period, except that a regular officer or employee or eligible pensioner may elect to drop dental coverage for one or more dependents within the plan year due to same circumstances as noted in Section 4.75.

10.1.10 The employee's election of a dental insurance plan is binding for the plan year.

10.1.11 An employee on approved leave of absence without pay may waive participation in Dental Plan. Employee must notify his/her Benefit Representative or Human Resources Office of request as waive must be designated in the appropriate enrollment system. When employee returns to work, participation must be reinstated in the appropriate enrollment system to be effective the first of the month following employee's return to work.

10.1.12 An employee on approved leave of absence without pay may continue to participate in Dental Plan by making full payment of premium by end of each month or coverage will be terminated. Employee must make payment to Benefit Representative or Human Resources Office for further processing.

12 DE Reg. 986 (01/01/09)

13 DE Reg. 126 (07/01/09) (Final)

STATE OF DELAWARE GROUP HEALTH INSURANCE PROGRAM ELIGIBILITY TABLE

Employee Start Date	Coverage Start Date (Employee pays the full cost)	Eligible for State Share
January 2nd through February 1st	February 1st	May 1st
February 2nd through March 1st	March 1st	June 1st
March 2nd through April 1st	April 1st	July 1st
April 2nd through May 1st	May 1st	August 1st
May 2nd through June 1st	June 1st	September 1st
June 2nd through July 1st	July 1st	October 1st
July 2nd through August 1st	August 1st	November 1st
August 2nd through September 1st	September 1st	December 1st
September 2nd though October 1st	October 1st	January 1st
October 2nd through November 1st	November 1st	February 1st
November 2nd through December 1st	December 1st	March 1st
December 2nd through January 1st	January 1st	April 1st