

2001 Group Health Insurance Plan Eligibility and Enrollment Rules
(Effective ~~January~~ **July 1, 2026**)

1.0 Authority

- 1.1 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 Enrollment Rules for the State of Delaware Group Health Insurance Plan ("State Plan"). In the event of a conflict between these rules and the Delaware Code, the Delaware Code takes precedence over these rules.
- 1.2 An Employee, Long Term Disability (LTD) beneficiary, COBRA beneficiary, or pensioner must meet one of the following definitions to be eligible for enrollment or continued enrollment in the State Plan:
 - 1.2.1 A permanent full-time employee (regularly scheduled 30 or more hours per week or 130 or more hours per month);
 - 1.2.2 An elected or appointed official as defined by 29 **Del.C.** §5201;
 - 1.2.3 A permanent part-time employee (regularly scheduled to work less than 130 hours per month);
 - 1.2.4 A limited term employee (as defined by 19 **DE Admin. Code** 3001, subsection 11.1);
 - 1.2.5 A pensioner receiving or eligible to receive a pension from the State;
 - 1.2.6 A per diem or contractual employee of the Delaware General Assembly who has been continuously employed for 5 years.
 - 1.2.7 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;
 - 1.2.8 A current or former employee approved for LTD benefits by the Disability Insurance Program Insurance Carrier or the Administrator in response to 29 **Del.C.** §5253(c)(1);
 - 1.2.9 COBRA beneficiaries eligible for continued enrollment in the State Plan as defined by federal law.
- 1.3 Those employees who meet the definition outlined in subsections 1.2.1, 1.2.2, 1.2.4, 1.2.5, 1.2.6, and 1.2.8 are considered "regular officers and employees" or "eligible pensioners" as provided by 29 **Del.C.** §5202 and are to receive State Share contributions. State Share coverage starts on the first of the month following the date of hire.
- 1.4 Employees receiving Short Term Disability (STD) under 29 **Del.C.** §5253(b), Workers' Compensation (WC) under 19 **Del.C.** Chapter 23 or automobile Personal Injury Protection (PIP) benefits under 21 **Del.C.** §2118 will be treated as "regular officers and employees" under these rules. Long Term Disability beneficiaries receiving benefits under 29 **Del.C.** §5253(c) will be treated as "eligible pensioners" under these rules. If any time after Long Term Disability benefits begin, the beneficiary returns to work for the State and meets any of the definitions outlined in subsections 1.2.1, 1.2.2, or 1.2.4, they will be treated as "regular officers and employees" in these regulations.
- 1.5 Casual and seasonal, board members, students, and substitute teachers are not eligible for the State Plan.
- 1.6 Newly employed teachers become eligible employees when they start employment not when they sign their contract. Temporary teachers who have completed the prior year's contract period and are re-hired in September are eligible for coverage, including State Share on the first of the month following the rehire date.
- 1.7 Pensioners who are enrolled in a Medicare Advantage plan with prescription or a Medicare Part D prescription plan which is not administered by the State of Delaware cannot be enrolled in the State of Delaware's Special Medicfill Plan and Medicare Part D prescription plan for Medicare eligible retirees, per the Centers for Medicare and Medicaid Services (CMS).
- 1.8 Enrollment in State plan is not indicative of eligibility to receive State Share contributions.

6 DE Reg. 690 (11/01/02)
12 DE Reg. 986 (01/01/09)
15 DE Reg. 225 (08/01/11)
16 DE Reg. 1003 (03/01/13)
18 DE Reg. 79 (07/01/14)
24 DE Reg. 601 (12/01/20)
27 DE Reg. 532 (01/01/24)

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 or civil union partner (Delaware law does not recognize common law marriage nor domestic partnerships). Ex-spouses, ex-civil union partners, and ex-step-children may not be enrolled in the State Plan even if a divorce decree, dissolution decree, settlement agreement or other document requires an employee or pensioner to provide coverage for an ex-spouse, ex-civil union partner, or ex-step-children;
 - 2.1.1.2 ~~IMPORTANT NOTE: Spousal Coordination of Benefits Policy has been in effect since January 1, 1993 and revised January 1, 2023. The policy applies to a spouse who is eligible for health coverage through their own employer or former employer (when spouse is retired). Spouses who work full-time or who are retired and are eligible for health coverage through their current or former~~

~~employer, but do not enroll under that employer's health plan, may have a reduction in benefits under the State Plan. A new Spousal Coordination of Benefits form must be filled out upon the spouse's initial enrollment, each year during open enrollment, upon the employee's enrollment in a State Plan administered by the Pension Office as a result of retirement or employment termination due to LTD, or anytime throughout the year the spouse's employment or health insurance status changes. Information on the Spousal Coordination of Benefits Policy, Chart, online form and a Summary Plan Description (SPD) for each health care plan is available on the Statewide Benefit Office's website at de.gov/statewidebenefits.~~

- 2.1.1.~~23~~ A child or children under age 26 born to or legally adopted or lawfully placed for adoption by a regular officer's, or employee or eligible pensioner or a regular officer or employee's or pensioner's legal spouse;
- 2.1.1.~~34~~ A child or children who do not meet the requirements of subsection 2.1.1.~~32~~ of this regulation, who is unmarried, under age 19 (age 24 if a full-time student), 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 50% support, and who would be considered the regular officer's or employee's or pensioner's "dependent" under Section 105(b) of the Internal Revenue Code. A statement of support form must be filled out 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 the guardianship or custody order has ended due to the child reaching legal adult age, a statement of support will be required. 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.~~45~~ An unmarried dependent child or children who meet the criteria of subsection 2.1.1.~~32~~ of this regulation, but who is age 26 or older and ~~determined~~ incapable of self-support because of a mental or physical disability which existed before the child reached age 26. The child or children must have been covered under employee's contract immediately preceding age 26.
- 2.1.1.~~56~~ An unmarried dependent child or children who meet the criteria of subsection 2.1.1.~~43~~ of this regulation, but who is age 19 (age 24 if full-time student) or older and ~~determined~~ incapable of self-support because of a mental or physical disability which existed before the child reached age 19 (age 24 if full-time student). The child or children must have been covered under employee's contract immediately preceding age 19 (age 24 if full-time student).
- ~~2.1.1.7~~ **IMPORTANT NOTE:** ~~A Dependent Coordination of Benefits form must be filled out for each enrolled dependent regardless of age, upon enrollment in other health coverage, any time other health coverage changes, or upon request by the Statewide Benefits Office or the State Plan administrator.~~
- 2.2 An eligible dependent child or children covered under the health insurance plans of both parents (one of whom must be employed by a group not participating in the State Plan) will be primary to the parent's plan whose birthday is the first to occur during the calendar year or in response to applicable Court Order. In the event the parents' birth dates are the same, the dependent child will be primary to the parent with the plan that has covered that parent longest. In the event birth dates and length of service are the same, the dependent child will be primary to the mutual choice of the parents.
- 2.3 ~~In the event a dependent child is eligible to be enrolled under more than one State of Delaware Group Health Insurance Plan (GHIP), the primary plan as described below shall be the only plan the child is permitted to be enrolled in as outlined under s~~Subsection 3.10.2 of this regulation. An eligible dependent child or children whose parents are divorced or not living together and not married will be primary to the plan of the parent with custody or primary to the plan of the spouse of the parent with custody unless a Court or Administrative Order defines one parent as responsible for the child's or children's health care expenses or health care coverage and if so, that parent's plan will be primary. If a Court or Administrative Order states that both parents are responsible for the child's or children's health care expenses or health care coverage or that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child or children the provisions in subsection 2.2 of this regulation shall apply. If there is no Court or Administrative Order allocating custody or responsibility for the child's or children's health care expenses or health care coverage the provisions of subsection 2.2 of this regulation shall apply. Also see subsection 4.9 of this regulation.
- 2.4 Employing agencies and the Office of Pensions shall maintain files that include such documents as SEBC determines appropriate to administer the State Plan; files shall be subject to audit by the SEBC.
- 2.5 In accordance with 29 **Del.C.** §5202(h) any spouse receiving a survivor's pension benefit from the State Employee Pension Plan, the State Police Pension Plans or the Judiciary Pension Plan may not include a new spouse in the State's pension group health insurance plan effective June 1, 2012.
- 2.6 Enrollment of a dependent as defined in subsection 2.1 of this regulation is contingent upon enrollment of a regular officer, employee, or eligible pensioner.

- 6 DE Reg. 690 (11/01/02)
- 12 DE Reg. 986 (01/01/09)
- 15 DE Reg. 225 (08/01/11)
- 15 DE Reg. 1071 (01/01/12)
- 16 DE Reg. 1003 (03/01/13)
- 17 DE Reg. 91 (07/01/13)
- 18 DE Reg. 79 (07/01/14)
- 24 DE Reg. 601 (12/01/20)
- 27 DE Reg. 532 (01/01/24)

3.0 Coverage

- 3.1 Health Plan Coverage of an eligible regular officer or employee (eligible for State Share) and their eligible dependents will become effective on the first of the month following the date of hire provided the employee submits a signed application within 30 days of their hire date. Also see subsection 10.1 of this regulation regarding dental and vision plan coverage.
 - 3.1.1 State Troopers who retire from the State of Delaware and return to active State employment in a position covered by the Delaware State Employees' Pension Plan, must enroll in coverage through their State employer.
 - 3.1.2 Pensioners who return to active State employment in a position covered by the Delaware State Employees' Pensions Plan must enroll in coverage through their State employer. Coverage will be effective on the first of the month following ~~the date of rehire~~[termination from 29 Del.-C. §55](#).
 - 3.1.3 Participating Organizations pursuant to 29 Del.-C. §5209, have flexibility in determining the coverage start date for their eligible regular officers or employees and eligible dependents, if different from subsection 3.1 of this regulation, given that Participating Organizations are not subject to the State of Delaware Section 125 Cafeteria Plan.
 - 3.1.4 Premiums are not pro-rated for employees whose coverage effective date is not the first day of the calendar month. Examples include family status changes and return from leave (without benefits). [Also see subsection 5.8 of this regulation](#).
 - 3.1.5 Health Plan coverage for LTD beneficiaries who are totally disabled will be administered by the Office of Pensions and will become effective on the first of the month following the effective date of LTD. Health care coverage for LTD beneficiaries who are working part-time in a benefit eligible position for the State of Delaware in accordance with subsection 1.2.8 of this regulation will have their benefits administered by the employing organization.
 - 3.1.6 [Pursuant to the authority vested in the State Employee Benefits Committee \(SEBC\) by 29 Del.-C. §5210\(4\), the SEBC has adopted a Spousal Coordination of Benefits Policy. The policy applies to all eligible spouses enrolled under the State of Delaware Group Health Insurance Plan and is used to determine if a spouse is eligible for coverage through their own employer or former employer. If a spouse is eligible to be covered by a health care plan through their current or former employer, but does not enroll under that plan, the State will pay 20% of allowable charges for services covered under the State's health plan and services covered under the State's prescription plan will be charged at the full allowable amount at the pharmacy. Additional information on the Spousal Coordination of Benefits Policy is available on the Statewide Benefits Office's website at de.gov/statewidebenefits.](#) ~~IMPORTANT NOTES: Spousal Coordination of Benefits Policy became effective January 1, 1993 and revised January 1, 2023 for a spouse who is eligible for health coverage through their own employer or former employer (when spouse is retired). Spouses who work full time or who are retired and are eligible for health coverage through their current employer or former employer and are not required to pay more than 50% of the premium for the lowest individual only health plan option but do not enroll under their current or former employer's health plan, will have a reduction in benefits under the State Plan. Information on the Spousal Coordination of Benefits Policy, Chart, online form and a Summary Plan Description (SPD) for each health care plan is available on the Statewide Benefit Office's website at de.gov/statewidebenefits.~~
- 3.1.7 ~~7~~ A Dependent Coordination of Benefits form must be filled out for each enrolled dependent regardless of age, upon enrollment in other health coverage, any time other health coverage changes, or upon request by the Statewide Benefits Office or the State Plan administrator.
- 3.2 Health Plan coverage for a permanent, part-time employee (not eligible for State Share) will become effective on the first of the month following date of hire.
- 3.3 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 the employees neglect to re-enroll in the allotted time, the employee's or employees' and any spouse's or eligible dependents' coverage shall be determined by the SEBC.
- 3.4 Employees, LTD beneficiaries, or pensioners who cover their spouse on a State health plan must fill out a Spousal Coordination of Benefits Policy form upon the spouse's initial enrollment, each year during open enrollment upon the employee's enrollment in a State Plan administered by the Office of Pensions as a result of retirement or employment termination due to LTD, or anytime throughout the year that the spouse's

employment or health insurance status changes. Failure to supply the Spousal Coordination of Benefits form shall result in the spouse's medical claims being sanctioned, which reduces health care claims to be processed at 20% of the in-network allowable charges for services covered under the State health care plan with the remainder becoming the responsibility of the employee, LTD beneficiaries, or pensioner; prescriptions must be paid in full at the pharmacy and a claim submitted to the State's pharmacy benefit manager to be reimbursed at the allowable charge (20% minus the applicable copay).

- 3.5 Any employee, LTD beneficiary, or pensioner who chooses not to enroll in the State Plan must fill out and sign an application/enrollment form acknowledging the desire not to enroll by noting "waive" on the appropriate form. A pensioner who becomes Medicare eligible due to age and who chooses not to enroll in the Medicare Supplement Plan must submit a waive form to the Office of Pensions.
- 3.6 Eligible employees or pensioners who fail to submit a completed and signed application/enrollment form within 30 days of their date of hire, LTD benefit effective date or their date of retirement may not join the State Plan until the next open enrollment period (usually May), unless the employee or pensioner meets the requirements of subsections 3.7 and 3.8 of this regulation. Also see subsection 10.1 of this regulation regarding dental and vision plan coverage.
- 3.7 Pursuant to a federal law, Health Insurance Portability and Accountability Act (HIPAA), if an employee declines enrollment for themselves, their spouse, or their dependents because of other health insurance coverage and later involuntarily loses the coverage, the State employee, spouse, or dependents 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 and must be tied to the qualifying event. Necessary forms must be filled out within 30 days of the request to enroll. If such a change is not made in the time period specified, the eligible employee, spouse, and dependents must wait until the next open enrollment period.
- 3.7.1 The following list includes examples of loss of coverage or loss of eligibility for coverage rules under which an employee may request enrollment for themselves, their spouse, and for their dependents:
- Loss of eligibility for coverage as a result of legal separation, divorce, death, termination of employment or reduction in the hours of employment;
 - Involuntary loss of eligibility for a dependent child (under the age of 26) under the dependent's spouse's employer health plan coverage due to legal separation, divorce, death or employment termination;
 - Loss of Medicaid eligibility/CHIP eligibility;
 - 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 certain 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 choose COBRA under that plan before using their special enrollment rights to enroll with the State; or
 - Loss of individual market health insurance coverage, including coverage purchased through a Marketplace. This rule does not apply if the individual lost eligibility for the coverage due to a failure to pay premiums or on a timely basis or termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact.
- 3.7.2 An increase in employee or pensioner 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 and LTD beneficiaries should contact the Office of Pensions to ask specific questions about eligibility.
- 3.7.3 See subsections 3.8, 3.9, and 4.6 of this regulation for other instances when changes in coverage are permissible outside of annual open enrollment.
- 3.8 If an employee declines enrollment for themselves, their spouse, or their dependents and later has a new dependent as a result of marriage, civil union partnerships, birth, adoption, or placement for adoption, the employee may be able to enroll themselves, their spouse, and any eligible dependents in the State Plan provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Necessary forms must be filled out within 30 days of the request to enroll. The enrollment of the spouse or dependent must be tied to the qualifying event. Please see subsection 2.5 of this regulation for exception for new spouses of surviving pensioners.
- 3.9 The eligible employee who is currently enrolled in a group health plan, may change their benefit plan upon the dependent's involuntary loss of coverage, in response to subsection 3.7 of this regulation, and addition to the State Plan, provided the request for enrollment is made within 30 days of the loss of dependent's coverage and necessary form must be filled out within 30 days of the request. The enrollment of the dependent must be tied to the qualifying event. In addition, if the employee has a new dependent as a result of marriage, civil union

partnership, birth, adoption, or placement for adoption, the employee may change their 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 filled out within 30 days of the request. For loss of Medicaid/CHIP coverage, the employee or pensioner should request enrollment in the State Plan within 60 days of loss of coverage.

- 3.10 When 2 active eligible regular officers, employees, LTD beneficiaries, or pensioners and their eligible spouse and dependents choose to be covered under “employee and spouse” or 1 “family” contract then the spouse whose birthday occurs earlier in the calendar year shall sign an application for coverage form requesting coverage. Exceptions are permitted upon mutual agreement by both the State agency or organization and the Office of Pensions. (In the event the birth dates are the same, length of service, and mutual choice of parents will be applied as described in subsection 2.2 of this regulation). State Share contributions for all new enrollment will be charged to the agency or organization whose employee enrolls for employee, employee and spouse, employee and children or family coverage.
- 3.10.1 An eligible employee of a State Plan Participating Group (with the exception of ~~the University of Delaware, Delaware Transit Corporation, Delaware Solid Waste Authority and the Delaware State Housing Authority~~) who is married ~~into or in~~ a civil union partnership to a State of Delaware employee enrolled in the State Plan must choose health coverage through the Participating Group. Each employee must enroll under a separate contract with their own employer. Eligible dependents may not be enrolled more than once under the State Plan and can be enrolled under either parent unless the parents cannot agree in which case enrollment shall meet the requirements of subsections 2.2 and 2.3 of this regulation.
- 3.10.2 An eligible retiree of a State Plan Participating Group (with the exception of Delaware Transit Corporation, Delaware Solid Waste Authority and the Delaware State Housing Authority) who is married, or in a civil union partnership, to a State of Delaware employee or pensioner enrolled in the State Plan will be subject to the State Spousal Coordination of Benefits Policy.
- 3.10.32 Each eligible regular officer, employee, LTD beneficiary, or pensioner may choose to enroll under a separate contract, but no regular officer or employee, LTD beneficiary, or eligible pensioner may be enrolled more than once under the State Plan. Eligible dependents may not be enrolled more than once under the State Plan and can be enrolled under either parent unless the parents cannot agree in which case enrollment shall meet the requirements of subsections 2.2 and 2.3 of this regulation.
- 3.11 When the spouse of an eligible regular officer or employee is a retired State of Delaware employee receiving a pension, or LTD benefits, and enrolled under separate State Plan health contracts, the employing agency and the Office of Pensions will carry the coverage for their respective employee, pensioner, or LTD beneficiary. If an employee and spouse, or a family contract is chosen, the health coverage will continue to be carried through the active employee's agency until such time that the Pensioner or LTD beneficiary becomes eligible for Medicare by reason of age. The 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 and enroll in the Medicare Supplement Plan through the Office of Pensions. Also see subsections 4.7 and 4.11 of this regulation.

6 DE Reg. 690 (11/01/02)

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

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

15 DE Reg. 225 (08/01/11)

15 DE Reg. 1071 (01/01/12)

16 DE Reg. 1003 (03/01/13)

17 DE Reg. 656 (12/01/13)

18 DE Reg. 79 (07/01/14)

24 DE Reg. 601 (12/01/20)

27 DE Reg. 532 (01/01/24)

4.0 Changes in Coverage

- 4.1 When a covered regular officer or employee, LTD beneficiary or eligible pensioner marries or enters into a legally recognized civil union, coverage for the ~~non-Medicare~~ spouse or civil union partner enrolling in a non-Medicare plan will become effective on the date of marriage or civil union, provided the regular officer, employee, or eligible pensioner requests enrollment of the new spouse or civil union partner within 30 days of the date of the marriage or civil union and provides the necessary paperwork within 30 days of the request to enroll. A copy of a valid marriage or civil union certificate must be provided (Delaware law does not recognize common law marriage nor domestic partnerships). A pensioner's Medicare eligible spouse or civil union partner will become eligible for coverage on the first of the month following the date of marriage or civil union provided the pensioner requests enrollment of the Medicare eligible spouse or civil union partner within 30 days of the date of marriage or civil union and provides necessary paperwork within 30 days of the request to enroll. Coverage effective date must be prospective and be sent a minimum of 30 days in advance of the effective date as required by CMS. A Spousal Coordination of Benefits form must be filled out when adding a spouse or civil union partner to coverage. The Spousal Coordination of Benefits form must be filled out during initial enrollment each year, during ~~annual~~ open enrollment and anytime the spouse's employment or insurance status

changes. A Dependent Coordination of Benefits form must be filled out for each enrolled dependent regardless of age upon enrollment in other health coverage, any time other health coverage changes, or upon request by the Statewide Benefits Office or the State Plan Administrator.

- 4.2 Coverage for a child or children born to a regular officer or employee, LTD beneficiary or eligible pensioner or legal spouse or civil union partner 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 an official birth certificate must be provided (and include the regular officer or employee, LTD beneficiary or eligible pensioner's name or legal spouse or civil union partner's name who is covered under the State Plan). Premiums are paid on a monthly basis and not prorated. If such a change is not made in the time period specified, a covered regular officer or employee, LTD beneficiary or eligible pensioner must wait until the next open enrollment period to add the child or children.
- 4.3 Coverage for a child or children legally adopted or placed for adoption with a regular officer or employee, LTD beneficiary or eligible pensioner or legal spouse or civil union partner 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 or children 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. 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 prorated. If such a change is not made in the time period specified, a covered regular officer or employee, LTD beneficiary or eligible pensioner must wait until the next open enrollment period to add the child or children.
- 4.4 Coverage for an eligible dependent, other than a newborn child or children, who becomes an eligible dependent after the regular officer or employee, LTD beneficiary or eligible pensioner has been enrolled, becomes effective the date of eligibility provided the regular officer or employee or eligible pensioner requests enrollment within 30 days of eligible status. The necessary paperwork must be filled out within 30 days of the request for enrollment.
 - 4.4.1 Coverage for an eligible Medicare dependent, who becomes an eligible dependent of an eligible pensioner after the eligible pensioner has been enrolled, becomes effective the first day of the month following eligibility provided the eligible pensioner requests enrollment within 30 days of eligible status. The necessary paperwork must be filled out within 30 days of the request for enrollment.
 - 4.4.2 A copy of valid documentation of dependent status must be provided, e.g. legal guardianship, permanent guardianship, custody order. Applicable premiums must be paid.
- 4.5 A regular officer or employee who transfers to another agency, school district or charter school may only change their plan and coverage without waiting until the next open enrollment period if the employee's cost charged for health coverage significantly increases or significantly decreases.— If the cost charged for health coverage significantly increases or significantly decreases as outlined in subsection 4.6.4.4, the regular officer or employee 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. The regular officer or employee must make the required change within 30 days of the transfer. Coverage will be effective the first of the month following the date of transfer.
- 4.6 Changes in coverage can only be made during the annual open enrollment period, except in the following situations and if a request is made within 30 days of the event and appropriate documentation is filled out and provided within 30 days of the request and must be tied to the qualifying event:
 - 4.6.1 A regular officer or employee, LTD beneficiary or eligible pensioner is making a change due to a qualifying event or Special Enrollment Right as previously outlined in subsections 3.7 through 3.9 of this regulation. Under special enrollment rights, employees and dependents who decline coverage due to other health coverage and then lost eligibility or lose employer contributions have special enrollment rights. Employees, spouses, civil union partners and dependents are permitted to special enroll because of marriage, civil union partnership, birth, adoption or placement for adoption, legal guardianship, permanent guardianship, or custody order;
 - 4.6.2 In the case of divorce or dissolution of civil union partnership, if there is a "qualifying event" under subsections 3.7 through 3.9 of this regulation, the regular officer or employee, LTD beneficiary or eligible pensioner's coverage status may change, but the plan cannot unless the provisions of 29 **Del.C.** §5202(d) apply. Also, see subsection 5.4 of this regulation;
 - ~~4.6.3 The spouse or civil union partner of a regular officer or employee, LTD beneficiary or eligible pensioner has become a State of Delaware employee entitled to State Share in which case the plan may be changed in accordance with subsection 3.10 of this regulation;~~
 - 4.6.43 A regular officer or employee, LTD beneficiary or eligible pensioner may change coverage or plan if the provisions of 29 **Del.C.** §5202(d) no longer apply, provided application is made within 30 calendar days of the qualifying event. Also, see subsection 5.4 of this regulation;
 - 4.6.45 A regular officer or employee, LTD beneficiary or eligible pensioner choosing to enroll or drop health coverage or enroll or drop one or more dependents (including the spouse of such regular officer, employee, LTD beneficiary or eligible pensioner) from health coverage may enroll or drop coverage of employee, LTD beneficiary or pensioner or dependents, under the following limited circumstances as per Section 125 of

the Internal Revenue Service Code and, for pensioners and LTD beneficiaries who make contributions on a post-tax basis, as allowed under the State Plan by the SEBC:

4.6.45.1 Change in status.

4.6.45.1.1 Due to death of spouse. An eligible employee or pensioner is permitted to enroll themselves if coverage is lost under the deceased spouse's plan or to enroll their dependents who lost coverage under the deceased spouse's plan. An eligible employee or pensioner can only drop coverage for the deceased spouse and any dependents who lost eligibility as a result of the spouse's death.

4.6.54.1.2 Due to changes in employment status of the employee or pensioner, the employee's or pensioner's spouse or the employee's or pensioner's dependent (e.g., beginning of employment, change of worksite or return from an unpaid leave of absence). An eligible employee or pensioner is permitted to enroll themselves due to beginning of employment (or other change in employment status) that creates eligibility under the Plan. An employee or pensioner whose spouse or dependent begins employment (or has another change in employment status) that creates eligibility under the spouse's or dependent's plan, can drop coverage for the spouse or any dependents who enroll under the spouse's or dependent's plan or may revoke all coverage if the employee or pensioner becomes eligible under the spouse's plan.

4.6.45.1.3 Change in the eligibility conditions for coverage under the spouse's or dependent's employer plan. If the employee's or pensioner's spouse or dependent becomes eligible under the spouse's or dependent's employer plan as a result of a change in the eligibility conditions, the employee or pensioner may drop coverage for the spouse or dependent or may revoke all coverage if the employee or pensioner becomes enrolled under the spouse's plan. If the employee's or pensioner's spouse or dependent loses eligibility under the spouse's or dependent's employer plan as a result of a change in the eligibility conditions, the employee or pensioner may enroll the spouse or dependent in the Plan. If a spouse's or dependent's eligibility changed because they satisfied the benefit waiting period, the employee can drop spouse or dependent from plan within 30 days of spouse's or dependent's enrollment.

4.6.45.1.4 Events that cause the employee's or pensioner's dependent to cease to satisfy the plan's eligibility requirements. (e.g. age, student status or similar circumstance). The employee or pensioner does not have to make an election change in order to terminate coverage for the dependent, but COBRA notice to the employee is required.

4.6.45.1.5 Change in the place of residence of the employee, spouse or dependent provided that in each of the circumstances described in subsections 4.6.45.1.1 through 4.6.45.1.5 of this regulation, 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. If employee's spouse or dependent gains eligibility under the spouse's or dependent's employer plan as a result of a change in residence, the employee may drop coverage for those who become covered under the spouse's or dependent's plan or may revoke all coverage if the employee becomes covered under the spouse's employer plan. If the employee's spouse loses eligibility under the spouse's employer plan as a result of a change in residence, the employee may enroll the spouse or any dependents who lost coverage under the spouse's plan.

4.6.45.2 Judicial Order, Decree, or Judgment. Health coverage for 1 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. Employee may drop coverage of affected dependent children.

4.6.54.3 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.

4.6.45.4 Change in Costs or Coverage. If the cost charged to an employee for health coverage significantly increases or significantly decreases 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 a change 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 going out on an unpaid leave of absence, which results in paying the full premium rate for health plan coverage) or from an action taken by an employer (such as reducing the amount of employer contributions for a class of employees).

- 4.6.56 If an employee's spouse's or dependent's employer drops health care coverage entirely for its employees, the spouse or dependent is eligible to be enrolled in the State's Group Health Insurance Plan, provided the request for enrollment is made within 30 days of the loss of coverage and must be tied to the qualifying event. A Spousal Coordination of Benefits form must be filled out upon enrolling the spouse in the State Plan. If the spouse was previously covered under the State Plan as secondary, a Spousal Coordination of Benefits form must be filled out indicating the date of the loss of coverage. The form will be reviewed to determine the appropriate level of coverage for the spouse.
- 4.6.76 If an employee's spouse's employer is offering coverage to its employees through the Small Business Health Options Program (SHOP), the spouse is required to enroll in the SHOP coverage unless the share of the premium for the lowest priced plan offered is more than 50% of the total cost of the coverage. An employee can cover their spouse through the State Plan, however the State Plan will pay as secondary. If the employee's spouse is required to pay more than 50% of the total cost of the lowest plan offered, their spouse can choose not to enroll in the SHOP coverage and enroll in coverage through the employee and the spouse will be covered as primary. Enrollment must be completed within 30 days of the spouse's loss of employer coverage and must be tied to the qualifying event. Coverage in SHOP constitutes employer coverage and requires completion of a current Spousal Coordination of Benefits form.
- 4.6.87 Enrollment in the Health Insurance Marketplace. An employee can drop coverage for themselves, their spouse or their dependents to enroll in coverage through the Marketplace. The request to disenroll from the State Plan must be in writing, noting the effective date of the Marketplace coverage and provided to the employee's Benefits Representative within 30 days of the effective date of the Marketplace coverage.
- 4.6.98 If an eligible employee or pensioner loses coverage under another employer group health plan other than during the State Plan ~~annual~~ open enrollment period, the State Plan permits such eligible employee or pensioner to make a prospective election change that is on account of and corresponds with a change made under the other employer group health plan.
- 4.7 An eligible regular officer, employee, and their legal spouse or civil union partner (eligible to receive State Share) who becomes eligible for Medicare by reason of age or disability shall continue to be covered under the State Plan as the primary payor of benefits.
 - 4.7.1 Regular officers or employees, spouses, civil union partners 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 subsection 3.11 of this regulation.
 - 4.7.2 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) ~~or Amyotrophic Lateral Sclerosis (ALS)~~ the covered individual must enroll in Medicare Parts A and B and these plans will be primary after the first 30 months to the non-Medicare State Plan for the period of time as outlined in the Medicare guidelines. Employees with ESRD ~~or ALS~~ should contact their Human Resources Office to discuss coverage options.
 - 4.7.3 A pensioner, pensioner's spouse, or dependent, or LTD beneficiary who becomes eligible for Medicare by reason of disability shall choose to either continue to be covered under the non-Medicare State Plan as the primary payor of benefits or enroll in the Medicare Supplement Plan. Contact the Office of Pensions to discuss options.
- 4.8 An employee who becomes eligible for pension or Long Term Disability (LTD) may change their plan at the onset of receiving pension or LTD and must enroll in Medicare Parts A and B upon eligibility. LTD beneficiaries who are not actively working in a benefit eligible position will have State Plan coverage through the Office of Pensions. and must enroll in Medicare Parts A and B upon eligibility by reason of age or disability.
- 4.9 A regular officer or employee or eligible pensioner who is required by Court or Administrative Order to provide health insurance coverage for a child or children shall be permitted to enroll under family or employee and child or children coverage, any child or children 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 or children, the child or children shall be enrolled under such family or employee and child or children coverage upon application by the Division of Child Support Enforcement or Division of Social Services. The employee shall not be permitted to disenroll (or eliminate coverage of) any child or children, including during the ~~annual~~ open enrollment period, unless the employer is provided satisfactory written evidence that:
 - 4.9.1 The Court or Administrative Order is no longer in effect, or
 - 4.9.2 The child or children is or will be enrolled in comparable health coverage, which will take effect no later than the effective date of such disenrollment.
 - 4.9.3 See subsections 2.2 and 2.3 of this regulation for Dependent Coordination of Benefits determination.
- 4.10 When a covered regular officer or employee, LTD beneficiary or eligible pensioner divorces or dissolves a civil union, coverage for the non-Medicare ex-spouse or non-Medicare ex-civil union partner and any ex-step-children 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, LTD beneficiary or eligible pensioner must remit the employee contribution for the plan, which included the spouse and dependents for the entire month. The regular officer or

employee, LTD beneficiary or eligible pensioner must submit a signed application within 30 days following the date of divorce or civil union dissolution. If the provisions of subsection 5.3 of this regulation no longer apply 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. Coverage for the Medicare ex-spouse or Medicare ex-civil union partner and any ex-step-children will terminate on the first of the month following the date of divorce or civil union dissolution, provided the pensioner submits a signed application within 30 days of the date of divorce or civil union dissolution. Termination of coverage must be prospective as required by CMS.

4.11 LTD beneficiaries and pensioners or their spouses and dependents eligible for Medicare, by reason of age or disability, must enroll in Medicare Part A and B when first eligible and may enroll in the Medicare Supplement Plan provided by the State Group Health Plan through the Office of Pensions.

4.11.1 If a LTD beneficiary or pensioner or their spouse or their dependent eligible for Medicare by reason of age does not enroll, or remain enrolled, in Medicare Part A and B, they will not be eligible to enroll in the Medicare Supplement Plan. In this instance, they must remain enrolled in a non-Medicare plan until the next available opportunity to enroll in Medicare Part A and B. Coverage in the non-Medicare plan may be reduced and paid as if secondary coverage at 20% of allowable charges which reduces health care claims to be processed at 20% of the allowable charges for services covered under the State health care plan with the remainder becoming the responsibility of the employee, LTD beneficiary, or pensioner; prescriptions must be paid in full at the pharmacy and a claim submitted to the State's pharmacy benefit manager to be reimbursed at the allowable charge (20% minus the applicable copay).

4.11.2 If a LTD beneficiary or pensioner or their spouse or dependent loses Medicare Part B coverage due to non-payment of Part B premiums, they will not be eligible to enroll in a non-Medicare plan and will not be eligible for enrollment in the Medicare Supplement Plan until the next open enrollment period and only if re-enrolled in Medicare Part B coverage. Also, see subsection 3.11 of this regulation.

6 DE Reg. 690 (11/01/02)

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

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

15 DE Reg. 225 (08/01/11)

15 DE Reg. 1071 (01/01/12)

16 DE Reg. 1003 (03/01/13)

17 DE Reg. 656 (12/01/13)

18 DE Reg. 79 (07/01/14)

24 DE Reg. 601 (12/01/20)

27 DE Reg. 532 (01/01/24)

5.0 Cost of Coverage

5.1 Regular officers and employees become eligible for State Share contributions on the first of the month following the date of hire. State Share contributions are limited to State regular officers, employees, LTD beneficiaries and pensioners.

5.2 Permanent part-time (regularly scheduled to work less than 130 hours per month), temporary per diem and contractual employees of the General Assembly as described in subsection 1.1 of this regulation 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 Department of Human Resources/Financial & Administrative Services 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 Pursuant to 29 **Del.C.** §5202(d), eligible employees who were both each first employed as a regular officer or employee by the State on or before December 31, 2011 and a husband and wife legally married on or before December 31, 2011, may each qualify as a regular officer, employee or eligible pensioner of the State. In the case where 2 members of a family qualify, the following options are set forth:

5.3.1 The 2 employees, or an eligible pensioner, and all eligible dependents may choose to enroll under 1 family contract.

5.3.2 Each employee, or an eligible pensioner, may choose to enroll under a separate contract. Eligible dependents may be enrolled under either contract, but no dependent shall be enrolled more than once under the state health insurance program.

5.3.3 The provisions of this paragraph shall continue to apply to a surviving spouse for employee only or employee and children contracts after the death of 1 of the spouses covered in response to this paragraph has occurred, as long as the surviving spouse is entitled to a survivor's pension in response to 29 **Del.C.** §5528.

5.3.4 If employee and spouse are eligible pensioners where 1 or both retire on or after July 1, 2012, and before July 1, 2017, only 1 \$25 per month charge shall apply when separate contracts are required for a Medicare Supplement plan.

- 5.3.5 Effective January 1, 2018, if the 2 employees or non-Medicare pensioners enroll under an employee and spouse or family contract, the employee or non-Medicare pensioner who enrolls for the coverage shall be charged 50% of the employee or non-Medicare pensioner cost share premium per month, or \$25 per month, whichever is greater. If the employees or non-Medicare pensioners choose to enroll in separate plans, employee only and employee and children contracts, each employee or non-Medicare pensioner shall be charged 50% of the employee or non-Medicare cost share premium per month, or \$25 per month, whichever is greater for the plans chosen.
- 5.3.5.1 If both spouses are eligible pensioners and 1 is not yet Medicare eligible, the non-Medicare pensioner will enroll under a pensioner only or pensioner and children contract and the Medicare pensioner will enroll in the Medicare Supplement plan. The non-Medicare pensioner shall be charged 50% of the cost share premium, or \$25 per month, whichever is greater.
- 5.3.5.2 If 1 spouse is a regular officer or employee and 1 spouse is a Medicare eligible pensioner, the regular officer or employee who enrolls for employee and spouse or family coverage shall be charged 50% of the employee cost share premium. If the employee and Medicare eligible spouse choose to enroll in separate plans, employee and Medicare eligible pensioner shall be charged 50% of the employee and Medicare supplement cost share premium per month, or \$25 per month, whichever is greater for the plans chosen.
- 5.3.5.3 If both spouses are Medicare eligible and 1 or both retired on or after July 1, 2017, only one 50% pensioner only, or \$25 per month premium, whichever is greater, shall apply when separate contracts are required for a Medicare Supplement Plan.
- 5.3.5.4 If both spouses are Medicare eligible and both retired after July 1, 2012, and before July 1, 2017, each Medicare eligible pensioner shall be charged \$25 per month premium when separate contracts are required for a Medicare Supplement plan.
- 5.3.6 In no case shall there be a monetary credit or return to the spouse for that spouse's basic credits.
- 5.4 If a husband and wife are both permanent full-time active employees or pensioners and married to each other on or before December 31, 2011, and leave State Service, on authorized unpaid leave of absence (no longer eligible for State Share), or stop collecting a pension, on or after January 1, 2012, they will be eligible to earn State Share as indicated in subsection 5.3 of this regulation if they return or are permanent full-time active employees or pensioners at a future date as long as they are married to the same spouse who is also a regular officer or employee or pensioner.
- 5.5 If a regular officer or employee, LTD beneficiary or eligible pensioner, or beneficiary selects coverage under any plan, the employee or pensioner is responsible for paying the monthly employee premium cost for the selected plan and coverage class (employee, employee and child, employee and spouse, or family).
- 5.6 A regular officer or employee, LTD beneficiary or eligible pensioner who is eligible for the State Share contribution may not receive the cash equivalent in lieu of the coverage itself.
- 5.7 Health coverage premiums for State of Delaware regular officers and employees 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).
- 5.7.1 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/PHRST's automated payroll system, and all adjustments must be submitted in accordance with Statewide Benefits Office procedures. The State Plan will not be responsible for payment of premiums or claims if a signed enrollment form/confirmation statement/waiver is not in the employee file.
- 5.7.2 When a regular officer or employee of the State transfers from one State agency, school district, or charter school to another ~~mid-month~~ [on any day other than the first of the month](#), the State agency, school district, or charter school where the employee left is responsible for the health plan premium payment for the entire month.
- 5.8 An eligible employee who returns from an authorized unpaid leave of absence is entitled to State Share payments upon return. 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.
- 5.9 Any regular officer or employee, LTD beneficiary or eligible pensioner who fails to make payment for their share of the cost of health coverage when they are eligible to continue coverage and does not have sufficient salary, disability or pension from which payment can be deducted will have coverage canceled on the first day of the following month that a regular officer or employee, LTD beneficiary or eligible pensioner fails to pay the required share for the coverage selected.
- 5.9.1 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.
- 5.9.2 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. (See subsection 5.21 of this regulation for additional FMLA considerations.)

- 5.10 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 to the organization by the first of each month in order to retain coverage and the organization shall remit payment to the Department of Human Resources/Financial & Administrative Services. Upon return, the employee is eligible for State Share, provided the break was the result of any of the following:
- 5.10.1 An authorized leave of absence;
 - 5.10.2 A suspension without pay; or
 - 5.10.3 Termination or unauthorized leave of absence for a period less than 30 calendar days.
- 5.11 State Share will be paid for employees drawing Workers' Compensation and State Personal Injury Protection (PIP), 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 their salary.
- 5.12 –State Share will be paid for employees approved for Family Caregiving Leave or Qualifying Exigency Leave per the Healthy Delaware Families Act, 19 Del. C. §3707(b). Such an employee must submit payment for the share of the coverage that would normally be deducted from their salary.
- 5.12.1 A regular officer or employee whose spouse is also a regular officer or employee and both are employed by the same or different school district that offers flex credits to offset benefit premiums and are enrolled in separate contracts and become approved for Family Caregiving Leave or Qualifying Exigency Leave per the Healthy Delaware Families Act, 19 Del. C. §3707(b), may change their contract and coverage class without waiting until the next open enrollment period upon agreement from the school district(s).
- 5.132 State Share will be paid for employees who are approved for Short Term or Long Term Disability or both through the State's DIP.
- 5.132.1 Employee's share of premium shall be deducted by OMB from employee's salary or by the DIP Plan Administrator from the beneficiary's monthly LTD check.
 - 5.132.2 Employees whose STD claims are in a pending status are entitled to receive State Share for the period the STD claim is in a pending status. If STD claim is denied, the employee is responsible for the State Share paid on their behalf while the claim was in a pending status.
 - 5.132.3 —Employees who are appealing a STD termination or benefit denial or both are eligible to receive State Share for the period the employee is appealing or requesting STD benefits. If the appeal results in a denial, the employee is responsible for the State Share paid on their behalf during the period the claim was in a pending appeal status.
- 5.134 Any refund of State Share or employee or pensioner share for health plan coverage is subject to the following requirements:
- 5.143.1 A regular officer, employee, LTD beneficiary or eligible pensioner who has paid the State Share in order to ensure 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 or pensioner must make application for the refund within 1 calendar year of the date the employee first paid the State Share to be refunded as required under [10 Del.C. §8111](#).
 - 5.134.2 A regular officer, employee, LTD beneficiary or eligible pensioner who has paid the employee or pensioner share then later is found to have been eligible for State Share in accordance with [29 Del.C. §5202\(d\)](#) is to be refunded the amount paid for employee or pensioner share for a period not to exceed 1 calendar year. The employee or pensioner seeking a refund must make application for the refund within 1 year of the date the employee or pensioner first paid the employee or pensioner share to be refunded as required under [10 Del.C. §8111](#).
 - 5.143.3 A regular officer, employee, LTD beneficiary or pensioner who has paid the employee or pensioner share for an ineligible dependent (for example following divorce, death, or exceeding the dependent age limits) is to be refunded the amount paid for employee or pensioner share for a period not to exceed 60 days, provided that the State Plan has not paid claims for the dependent during the period of ineligibility. The employee or pensioner seeking a refund must make application for the refund within 60 days of the date the employee or pensioner paid the employee or pensioner share to be refunded. The employee or pensioner shall be liable for any amounts paid by the State Plan on behalf of the ineligible dependent and which exceed employee or pensioner share paid and attributable to the dependent for the period of ineligibility. A regular officer, employee, LTD beneficiary or pensioner who fails to make notification of a divorce or civil union dissolution within 30 days shall not be eligible for a refund.
 - 5.143.4 A regular officer, employee, LTD beneficiary, or pensioner who has paid the employee or pensioner share for themselves or a covered dependent and later found to be dual covered under another health plan contract through the GHIP shall be refunded the amount paid for the employee or pensioner share for a period not to exceed 60 days, assuming the dual coverage has been resolved.
 - 5.134.5 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 day of the month. A

refund will be given, if the employee makes request for a refund within 60 days and upon determination that the State Plan did not pay claims for any enrolled members during the month of employment termination.

- 5.134.6 Refunds of less than \$1.00 will not be made.
- 5.134.7 The refund is limited to the amount paid by the regular officer, employee, or eligible pensioner ~~during the~~ ~~for the~~ employee or pensioner share for which the State should have paid the State Share or employee or pensioner share as established in accordance with 10 Del.C. §8111.
- 5.154 Teachers who are granted a sabbatical leave of absence are eligible for State Share while they are on such leave. Also see subsection 6.3 of this regulation.
- 5.165 All employees whose positions are involuntarily terminated after they have been employed for a full calendar year (or full school year) who return to full-time State employment within 24 months of their termination or rehired shall be eligible for coverage and State Share on the first of the month following the date of rehire.
- 5.176 A temporary, casual, seasonal employee, or substitute teacher of the State who becomes a "Regular Officer or Employee" will be eligible for coverage and State Share on the first of the month following the date they become a "Regular Officer or Employee".
- 5.178 State Share shall continue for a "Regular Officer or Employee" who is temporarily appointed to a position that results in a dual incumbency.
- 5.198 Any regular officer, employee or pensioner who is also receiving a survivor's pension through the State of Delaware shall also be entitled to State Share for the survivor's pension. The increment of cost of the contract selected by the regular officer or employee or eligible pensioner who is also receiving a survivor's pension, shall be deducted by the Director of the Office of Management and Budget (OMB) from salary, pension, or disability payment or checks. Also see subsection 5.3.3 of this regulation.
- 5.2049 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 2 years. Employee's share must be remitted to Benefit Representative or Human Resources Office for further processing.
- 5.201 In the event that the State Plan has paid the employee or pensioner share or any copays, coinsurance, deductibles or other amounts that the Statewide Benefits Office determines should have been paid by the regular officer, employee, LTD beneficiary or pensioner or covered spouse or dependent of the regular officer, employee, LTD beneficiary or pensioner after deducting premiums paid during the applicable period and upon prior written notice to such regular officer, employee, LTD beneficiary or pensioner (which shall not be less than 60 days), the State Plan, to the extent permissible under applicable law, may recover such amounts from such regular officer, employee, LTD beneficiary or pensioner by deducting the amount paid by the State Plan from the after tax pay due to the regular officer or employee, LTD beneficiary or by invoicing the regular officer, employee, LTD beneficiary or pensioner.
- 5.210.1 The regular officer, employee or pensioner shall be provided an opportunity to dispute such amounts owed to the State Plan to the Statewide Benefits Office; and
- 5.210.2 If the amount owed by the regular officer, employee, LTD beneficiary or pensioner exceeds \$500 then the regular officer, employee, LTD beneficiary or pensioner shall be provided an opportunity to have the amount owed deducted or invoiced in monthly installments over a period of time not less than 12 months. In accordance with 10 Del.C. §8106(a), payment which the State Plan has made for the employee, LTD beneficiary or pensioner share or any copays, coinsurance, deductible or other amounts that the Statewide Benefits Office determines should have been paid by the regular officer, employee, LTD beneficiary or pensioners or covered spouse or dependent of the regular officer, employee, LTD beneficiary or pensioner for a period of up to 1 year may be collected from the regular officer, employee, LTD beneficiary or pensioner after deducting premiums paid during the applicable period and provided the State Plan shall provide such regular officer, employee, LTD beneficiary or pensioner an opportunity to repay the amount due in a period of time not less than the total number of months being collected by the State Plan or not less than 12 months if the amount owed exceeds \$500.
- 5.242 Family and Medical Leave Act (FMLA) regulations provide that employees who fail to return to work after their FMLA leave entitlement has been exhausted shall be responsible for repayment of the State Share under the group health plan unless they fail to return to work due to their own or eligible family member's serious health condition, or for some other reason beyond their control, including STD leave.
- 5.232 Pensioner State Share eligibility is set forth in 29 Del.C. §5202(b).
- 5.243 A pensioner who returns to active State employment as a "Regular Officer or Employee" is entitled to coverage and State Share on the first of the month following ~~the date of hire~~ ~~termination from 29 Del.-C. §55-~~

6 DE Reg. 690 (11/01/02)

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

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

13 DE Reg. 683 (11/01/09)

15 DE Reg. 225 (08/01/11)

15 DE Reg. 1071 (01/01/12)

16 DE Reg. 1003 (03/01/13)

16 DE Reg. 1090 (04/01/13)

24 DE Reg. 601 (12/01/20)

6.0 Continuation of Coverage

- 6.1 To continue coverage, a covered regular officer, employee, LTD beneficiary or pensioner must pay the difference between the State Share contribution and the cost of the coverage selected. Coverage will end on the first day of the month the employee did not make the 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 2 years. An employee who returns from an authorized leave of absence, whether they maintain coverage or not while on leave of absence, is authorized to receive State Share immediately upon return. An employee on FMLA leave is entitled to have health insurance benefits (including the State Share) maintained while on an FMLA leave. If an employee was paying State Share or employee share or both of the premium payments before leave, the employee would continue to pay the same share during the leave period. Premium payments are due by the first day of the month following the effective date of coverage. Failure to make such payment within 30 days of the due date will result in termination of coverage. Also see subsection 5.9 of this regulation.
- 6.3 Coverage 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 ends effective the last day of the month in which the employee share of the premium was received. State Share continues while employee is on sabbatical leave provided that the teacher on sabbatical leave makes the required payments for their share of the cost of coverage. Also see subsection 5.14 of this regulation.
- 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 or dependents 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)

16 DE Reg. 1003 (03/01/13)

24 DE Reg. 601 (12/01/20)

27 DE Reg. 532 (01/01/24)

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. If an employee works 1 day in the month in which they are terminated, they shall earn State Share for the entire month. In the event an employee fails to make the required payment for any coverage selected, coverage will be terminated effective the first of the month in which the employee terminated coverage.
- 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 and dependent children for covered persons who died in the line of duty after January 1, 2004 in accordance with 18 Del.C. §6602(a)(5), 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 or ex-civil union partners who are not employed by the State of Delaware are not eligible for coverage under the State Plan even if a divorce decree, civil union dissolution, settlement agreement or other document requires an employee to provide coverage for an ex-spouse or ex-civil union partner.
 - 7.4.1 Coverage for the ex-spouse, or ex-civil union partner of an active employee, LTD beneficiary or pensioner covered by a non-Medicare plan will end on the day after the date of divorce.
 - 7.4.2 Coverage for the ex-spouse, ex-civil union partner, or ex-step-children of a pensioner covered in the Medicare supplement plan will terminate on the last day of the month following the date of divorce or civil union dissolution provided the pensioner submits a signed application within 30 days of the date of divorce or civil union dissolution. Termination of coverage must be prospective as required by CMS.
 - 7.4.3 Premiums are paid on a monthly basis and not prorated. The regular officer or employee, LTD beneficiary or eligible pensioner must remit the employee or pensioner share for the plan which included the spouse for the entire month. The regular officer or employee, LTD beneficiary or eligible pensioner must submit a signed application within 30 days before the date of divorce. If the provisions of 29 Del.C. §5202(d) no

longer apply as a result of the divorce, each regular officer, employee, LTD beneficiary 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. Also see subsections 5.13 and 5.20 of this regulation.

- 7.5 Coverage for a dependent child or children will end the earlier of the following:
- 7.5.1 The end of the month in which the dependent child or children as defined in subsection 2.1.1.23 of this regulation attains age 26; or
 - 7.5.2 The end of the month in which the dependent child or children as defined in subsection 2.1.1.3-4 of this regulation marries, or attains age 19 (or age 24 if full-time student); or
 - 7.5.3 The date the child or children ceases to be dependent on the regular officer or employee or eligible pensioner for at least 50% support per subsections 2.1.1.34, 2.1.1.45, and 2.1.1.56 of this regulation.

- 7.6 Coverage for a LTD beneficiary will end as of the end of the month in which their LTD benefits end.

6 DE Reg. 690 (11/01/02)

6 DE Reg. 1515 (05/01/03)

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

15 DE Reg. 225 (08/01/11)

15 DE Reg. 1071 (01/01/12)

16 DE Reg. 1003 (03/01/13)

24 DE Reg. 601 (12/01/20)

27 DE Reg. 532 (01/01/24)

8.0 Reinstatement of Coverage

- 8.1 Once a regular officer or employee, LTD beneficiary or eligible pensioner has requested that their coverage be canceled, they 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 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 ~~the first of the month following date of hire~~ ~~as of the return to work date~~, provided the employee requests enrollment within 30 days of return and fills out the necessary paperwork required to enroll within 30 days of the request for enrollment. ~~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. Also see subsection 5.8 of this regulation.
- 8.3 A pensioner who returns to active State employment will be eligible for State Share ~~on the first of the month following the date of hire when coverage becomes effective.~~ ~~See s~~Subsection 5.23 of this regulation.

6 DE Reg. 690 (11/01/02)

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

24 DE Reg. 601 (12/01/20)

27 DE Reg. 532 (01/01/24)

9.0 Employee and Employing Agency Responsibilities

- 9.1 It is the responsibility of the regular officer, employee or eligible pensioner to keep their Benefit Representative or Human Resources Office informed of any change of address or change in status which results in the adding or dropping of dependents (marriage, divorce, birth, death, adoption, etc.) that affects their health care coverage. The request for enrollment/changes to enrollment must be made within 30 days of the qualifying event and the necessary paperwork must be filled out within 30 days of the request. In turn, it is the responsibility of the Benefit Representative or Human Resources Office to 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 or claims in the event of ineligibility or the absence of a signed enrollment form/confirmation statement in the regular officer or employee or eligible pensioner's file. Also see subsections 5.13 and 5.20 of this regulation.
- 9.2 The State Plan shall not be responsible for payment of premiums or claims in the event of ineligibility or the absence of a signed enrollment form or confirmation statement in the regular officer or employee or eligible pensioner's file. Also see subsections 5.13 and 5.20 of this regulation.

6 DE Reg. 690 (11/01/02)

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

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

24 DE Reg. 601 (12/01/20)

27 DE Reg. 532 (01/01/24)

10.0 Dental and Vision Plans

- 10.1 Any rules related to the dental and vision plans not contained herein are subject to the applicable guidelines within Section 1.0 through subsection 9.2 of this regulation.

- 10.2 Employees or pensioners choosing to pay for and receive coverage under one of the Dental or Vision Plans should be aware of the following terms:
- 10.2.1 Dental and Vision Plans are not affected by the provisions of 29 **Del.C.** §5202(d). Employees and Pensioners are required to pay the full premium;
 - ~~10.2.2 Employees may enroll in a Dental or Vision plan on the first of the month following the date of hire;~~
 - ~~10.2.3 The Dental and Vision Plans' effective date is always the first of the month following the date of hire and not on date of hire (even if the date of hire is the first day of the month);~~
 - ~~10.2.4 Dental and Vision Plans' refund rules are limited to 60 days or less because the Dental and Vision Plans are fully insured provided that no claims were paid during the period of the refund requested. Refunds are not made if notification is not provided within 60 days of the qualifying event;~~
 - ~~10.2.5 Dental and Vision Plans' term dates are limited to 60 days or less from the date of the notification by the employee;~~
 - 10.2.26 Dental or Vision Plan or both ~~will be terminated in the event that employee is 30 days delinquent in payment of Dental or Vision Plans' premium and~~ pursuant to subsection 5.9 of this regulation may result in any paid claims in the same period ~~may be being~~ reversed;
 - 10.2.7 ~~If an employee is terminated from employment and does not pay the Dental or Vision Plans' premium for the second half of the month in which terminated, coverage under the Dental or Vision Plans will be terminated as of the first of the month, any claims paid for that month may be reversed and a refund may be given, if employee makes request for refund within 60 days of the termination date;~~
 - 10.2.38 School district, charter and higher education employees (except those of Delaware Technical Community College) who are offered school district or employer dental and vision coverage are not eligible for coverage under the State Dental or Vision Plans;
 - 10.2.9 ~~The employee or pensioner's selection of a Dental or Vision plan is binding for the plan year and the employee or pensioner may not change such coverage until the next open enrollment period unless the employee meets the requirements of subsections 3.7 through 3.9 of this regulation.~~
 - 10.2.10 ~~An employee on approved leave of absence without pay may waive participation in the Dental or Vision Plan. Employee must notify their Benefit Representative or Human Resources Office of request as their waive of coverage must be designated in the appropriate enrollment System and notification made to the dental or vision plan. When employee returns to work and upon submission of a signed enrollment form, participation will be reinstated in the appropriate enrollment system to be effective as of the date of the employee's return to work.~~
 - ~~10.2.11 An employee on approved leave of absence without pay may continue to participate in the Dental or Vision Plan by making full payment of premium by the first 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)
15 DE Reg. 225 (08/01/11)
15 DE Reg. 1071 (01/01/12)
16 DE Reg. 1003 (03/01/13)
16 DE Reg. 1090 (04/01/13)
18 DE Reg. 79 (07/01/14)
24 DE Reg. 601 (12/01/20)
27 DE Reg. 532 (01/01/24)

6 DE Reg. 690 (11/01/02)
6 DE Reg. 1515 (05/01/03)
12 DE Reg. 986 (01/01/09)
13 DE Reg. 126 (07/01/09)
13 DE Reg. 683 (11/01/09)
15 DE Reg. 225 (08/01/11)
15 DE Reg. 1071 (01/01/12)
16 DE Reg. 1003 (03/01/13)
16 DE Reg. 1090 (04/01/13)
17 DE Reg. 91 (07/01/13)
17 DE Reg. 656 (12/01/13)
18 DE Reg. 79 (07/01/14)
24 DE Reg. 601 (12/01/20)
27 DE Reg. 532 (01/01/24)