Location	Original	Proposed Revision/Addition	Reason for Revision/Addition	Category for Revision/Addition	Determination	Comments: Required if Disagree or Not Sure
Title	**2000 EMPLOYEE BENEFITS** **State Employee Benefits Committee** **2001 Group Health Insurance Plan Eligibility and Enrollment Rules** **(Effective December 1, 2020)**	**2000 EMPLOYEE BENEFITS** **State Employee Benefits Committee** **2001 Group Health Insurance Plan Eligibility and Enrollment Rules** **(Effective January 1, 2024)**	Effective Date change to coincide with HB 185	HB 185		
1.1.4	A limited term employee (as defined by 19 **DE Admin. Code** 3001, subsection 10.1);	A limited term employee (as defined by 19 **DE Admin. Code** 3001, subsection 11.1);	Clarification for a limited term employee	Clarifications		
1.1.5	A pensioner receiving or eligible to receive a pension from the State;	A pensioner eligible for and receiving a pension from the State;	Language consistency	Clarifications	Disagree	FOR DISCUSSION
1.1.8	A 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)**; or	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)**;	LTD beneficiary clarification	Clarifications		
1.2	Those employees who meet the definition outlined in subsection 1.1.1, 1.1.2, 1.1.4, 1.1.5 and 1.1.6 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 start dates apply to State employees as outlined in the Eligibility Table.	Those employees who meet the definition outlined in subsection 1.1.1, 1.1.2, 1.1.4, 1.1.5, 1.1.6. and 1.1.8 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.	Clarification for State Share eligibility; Aligning language with HB 185	HB 185	Not Sure	FOR DISCUSSION
1.5	Newly employed teachers become eligible employees when they start employment not when they sign their contract. (Review the Eligibility Table, see the Eligibility Table for coverage start date dependent upon the September hire date). Temporary teachers who have completed the prior year's contract period and are re-hired in September are eligible to choose coverage when re-hired. Temporary teachers who are re-hired in the next contract year are eligible for State Share and to choose coverage when re-hired without fulfilling another 3 month waiting period.	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.	Aligning language with HB 185	HB 185	Not Sure	FOR DISCUSSION
1.6	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 may not be enrolled in the State of Delaware's Special Medicfill Plan and Medicare Part D prescription plan for Medicare eligible retirees.	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).	CMS does not allow someone to be enrolled in more than one Part D prescription drug plan	CMS Requirements		

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2.1.1.1	Legal spouse or civil union partner (Delaware law does not recognize common law marriage). Ex spouses and ex-civil union partners may not be enrolled in the State's 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 or ex-civil union partner; **IMPORTANT NOTE:** Spousal Coordination of Benefits Policy has been in effect since January 1, 1993 and revised May 1, 2018. 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 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 .	Legal spouse or civil union partner (Delaware law does not recognize common law marriage). Ex spouses and ex-civil union partners and step-children may not be enrolled in the State's 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 step-children; **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.	Addition of "step-children"; date change to reflect last SCOB Policy revision; addition of reasons for when completion of SCOB Form is needed which is consistent with practice and other communications	Clarifications	Not Sure	FOR DISCUSSION
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 longest employment service . 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.	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.	Update consistent with the medical Summary Plan Descriptions (SPDs) and industry standard practice	Clarifications	Not Sure	FOR DISCUSSION

Location	Original	Proposed Revision/Addition	Reason for Revision/Addition	Category for Revision/Addition	Determination	Comments: Required if Disagree or Not Sure
2.3	An eligible dependent child or children whose parents are divorced or are 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 shall apply. Also see subsection 4.10 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 shall apply. Also see subsection 4.9 of this regulation.	Grammar correction; Update to relevant subsection reference	Clarifications		
2.4	Employing agencies 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.	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.	Addition of Office of Pensions as they administer retiree benefits	Clarifications		
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.	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.			Not Sure	FOR DISCUSSION
		Add: Enrollment of a dependent as defined in 2.1 is contingent upon enrollment of a regular officer, employee or eligible pensioner.	Proposed language addition to clarify spouse/dependent coverage	Clarifications	Not Sure	FOR DISCUSSION
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 date of hire or on the first of any month following date of hire up to the first of the month when eligible for State Share provided the employee submits a signed application within 30 days of the first of the month when coverage becomes effective. Refer to Eligibility Table for specific coverage date options for employees who choose coverage when eligible for State Share. Also see subsection 10.1 of this regulation regarding dental and vision plan coverage.	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.	Aligning language with HB 185	HB 185	Disagree	FOR DISCUSSION
		Add: 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.	Addition of language pertaining to pensioners returning to state employment which aligns with current practice	Clarifications	Disagree	FOR DISCUSSION

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		Add: 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 3.1, given that Participating Organizations are not subject to the State of Delaware Section 125 Cafeteria Plan.	Addition to permit greater flexibility for Participating Groups	Clarifications	Not Sure	FOR DISCUSSION
3.1.2	Premiums are not pro-rated for employees who choose coverage on their date of hire which is not the first day of the calendar month. **IMPORTANT NOTES:** Spousal Coordination of Benefits Policy became effective January 1, 1993 and revised May 1, 2018 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. 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. 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.	Premiums are not pro-rated for employees whose coverage effective date is not the first day of a calendar month. Examples include family status changes, and return from leave (without benefits). **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. 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.	Alignment with current practice; date change to reflect latest SCOB revision	Clarifications	Not Sure	FOR DISCUSSION
		Add: 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 1.1.8 will have their benefits administered by the employing organization.	LTD clarification- addition of LTD beneficiary coverage effective date and administering office	Clarifications	Not Sure	FOR DISCUSSION
		Add: 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.	Addition of rule for coverage effective date for part-time benefit eligible employees	Clarifications	Not Sure	FOR DISCUSSION

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3.3	Employees 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 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% with the remainder becoming the responsibility of the employee 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).	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 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).	LTD beneficiary clarification; addition of reasons for when completion of SCOB Form is needed which is consistent with practice and other communications; alignment with current practice for sanctioning claims	Clarifications		
3.4	Any employee 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.	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.	Aligns with current practice for pensioners waiving coverage	Clarifications	Not Sure	FOR DISCUSSION
3.5	Eligible employees or pensioners who fail to submit a completed and signed application/enrollment form within 30 days of their date of hire or by the first of any month up to their date of eligibility for State Share (see subsection 3.1 of this regulation) 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 3.6 and 3.7 of this regulation. Also see subsection 10.1 regarding dental and vision plan coverage.	Eligible employees, LTD beneficiaries 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 regarding dental and vision plan coverage.	LTD beneficiary clarification; Removal of State Share waiting period language; Update to relevant subsection reference	Clarifications	Not Sure	FOR DISCUSSION
3.6	Pursuant to a federal law, Health Insurance Portability and Accountability Act (HIPAA), if an employee declines enrollment for themselves or their dependent or dependents (including the spouse) because of other health insurance coverage and later involuntarily loses the coverage, the State employee, spouse, or dependent 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 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 and spouse must wait until the next open enrollment period.	Pursuant to a federal law, Health Insurance Portability and Accountability Act (HIPAA), if an employee declines enrollment for themselves or their dependent or dependents because of other health insurance coverage and later involuntarily loses the coverage, the State employee, spouse, or dependent 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 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 and spouse must wait until the next open enrollment period.	Removal of "including the spouse" as it is included in definition of dependent	Clarifications	Not Sure	FOR DISCUSSION

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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 themselves and for dependent or dependents: • 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 Medicaid 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 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.	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 and for dependent or 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/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 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.	Addition of CHIP to allow for enrollment consistent with HIPAA special enrollment rights; Addition of involuntary loss of eligibility for a dependent child	Clarifications	Not Sure	FOR DISCUSSION
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 and LTD beneficiaries should contact the Office of Pensions to ask specific questions about eligibility.	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.	Addition of "pensioner"	Clarifications	Not Sure	FOR DISCUSSION

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3.6.3	See subsections 3.7, 3.8, and 4.7 for other instances when changes in coverage are permissible outside of annual open enrollment.	See subsections 3.8, 3.9, and 4.6 for other instances when changes in coverage are permissible outside of annual open enrollment.	Update to relevant subsection reference	Clarifications	Not Sure	FOR DISCUSSION
3.8	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 3.6 of this regulation, 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 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.	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's 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.	Update to relevant subsection reference; Special Enrollment Rights for Medicaid/CHIP coverage loss	Clarifications	Not Sure	FOR DISCUSSION
3.10	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 4.8 and 4.12 of this regulation.	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.	Update to relevant subsection reference	Clarifications		

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4.1	An eligible employee who chooses to be covered on their date of hire or on the first of any one month before the employee's eligibility for State Share may change health 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 the State Share contribution begins, 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 they begin to receive State Share, without waiting for the next open enrollment period). An eligible regular officer or employee, LTD beneficiary or pensioner who chooses State Plan dental or vision coverage or both in accordance with subsection 10.1.2 may not make changes to dental or vision coverage or both until the next open enrollment period unless the employee meets the requirements of subsections 3.6 through 3.8 of this regulation.	Delete	Removal of State Share waiting period language consistent with HB 185	HB 185		

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4.2	When a covered regular officer or employee, LTD beneficiary or eligible pensioner marries or enters into a legally recognized civil union, coverage for the spouse or civil union partner will become effective on the date of marriage or civil union, or first of the month following 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). 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.	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 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). A pensioner's Medicare eligible spouse or civil union partner will become eligible for coverage effective 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 the 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.	Further clarification of effective date for spouses of non-Medicare members; Addition of language for effective date for spouses of Medicare members as per CMS requirements.	CMS Requirements		
4.5	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 or 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 filled out within 30 days of the request for enrollment. A copy of valid documentation of dependent status must be provided, e.g. legal guardianship, permanent guardianship, custody order. Applicable premiums must be paid.	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. A copy of valid documentation of dependent status must be provided, e.g. legal guardianship, permanent guardianship, custody order. Applicable premiums must be paid.	Remove "or the first day of the month following eligibility" to align with current system configuration and practice whereas coverage is tied to date of event.	Clarifications	Not Sure	FOR DISCUSSION

Location	Original	Proposed Revision/Addition	Reason for Revision/Addition	Category for Revision/Addition	Determination	Comments: Required if Disagree or Not Sure
		Add: 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. A copy of valid documentation of dependent status must be provided, e.g. legal guardianship, permanent guardianship, custody order. Applicable premiums must be paid.	Coverage effective date of a Medicare eligible dependent of pensioner per CMS requirements	CMS Requirements	Not Sure	FOR DISCUSSION
4.6	A regular officer or employee who transfers to another agency, school district or charter school may change their plan and coverage without waiting until the next open enrollment period. If the cost charged for health coverage significantly increases or significantly decreases, 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.	A regular officer or employee who transfers to another agency, school district or charter school may change their plan and coverage without waiting until the next open enrollment period. If the cost charged for health coverage significantly increases or significantly decreases, 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.	Clarify coverage effective date after a transfer consistent with current practice	Clarifications	Not Sure	FOR DISCUSSION
4.7	Changes in coverage can only be made at the annual open enrollment period, except in 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:	Changes in coverage can only be made during the annual open enrollment period, except in 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:	Grammar correction	Clarifications		
4.7.1	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 3.6 through 3.8 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;	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;	Update to relevant subsection reference; Addition of "legal guardianship, permanent guardianship or custody order" to further clarify dependent relationship;	Clarifications	Not Sure	FOR DISCUSSION

Location	Original	Proposed Revision/Addition	Reason for Revision/Addition	Category for Revision/Addition	Determination	Comments: Required if Disagree or Not Sure
4.7.2	In the case of divorce or dissolution of civil union partnership, if there is a "qualifying event" under 3.6 through 3.8 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;	In the case of divorce or dissolution of civil union partnership, if there is a "qualifying event" under 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;	Update to relevant subsection reference	Clarifications	Not Sure	FOR DISCUSSION
4.7.3	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 3.9 of this regulation;	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;	Update to relevant subsection reference	Clarifications	Not Sure	FOR DISCUSSION
4.7.5	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:	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.	Addition of language to allow pensioners and LTD beneficiaries enrollment rights as allowed under the State Plan	IRS Section 125	Not Sure	FOR DISCUSSION
4.7.5.1.5	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. 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.	Change in the place of residence of the employee, spouse or dependent provided that in each of the circumstances described in subsections 4.6.5.1.1 through 4.6.5.1.5, 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.	Update to relevant subsection reference	Clarifications	Not Sure	FOR DISCUSSION

Location	Original	Proposed Revision/Addition	Reason for Revision/Addition	Category for Revision/Addition	Determination	Comments: Required if Disagree or Not Sure
4.7.5.4	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 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).	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, resulting 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).	Grammar correction; Further clarification of employment status changes	Clarifications	Not Sure	FOR DISCUSSION
4.7.6	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 Program, provided the request for enrollment is made within 30 days of the loss of coverage. A Spousal Coordination of Benefits form must be filled out upon enrolling the spouse in the State's plan. If the spouse was previously covered under the State's 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.	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. A Spousal Coordination of Benefits form must be filled out upon enrolling the spouse in the State's plan. If the spouse was previously covered under the State's 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.	Changed "Program" to "Plan"	Clarifications		
4.8.1	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 3.10 of this regulation.	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.	Update to relevant subsection reference	Clarifications	Not Sure	FOR DISCUSSION
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) 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 State Plan for the period of time as outlined in the Medicare guidelines. Employees with ESRD or ALS should contact their State Plan insurance carrier to discuss coverage options.	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.	Further clarification of "non-Medicare" State Plan; Revision from "State Plan insurance carrier" to "Human Resources Office" to align with current practice.	Clarifications	Not Sure	FOR DISCUSSION

Location	Original	Proposed Revision/Addition	Reason for Revision/Addition	Category for Revision/Addition	Determination	Comments: Required if Disagree or Not Sure
		Add: 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.	Provide flexibility to members eligible for Medicare due to disability.	Clarifications	Not Sure	FOR DISCUSSION
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 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 unless the employer is provided satisfactory written evidence that:	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:	Addition of "including during the annual open enrollment period" to align with current practice.	Clarifications		
4.11	When a covered regular officer or employee, LTD beneficiary or eligible pensioner divorces or dissolves a civil union, coverage for the ex-spouse or civil union partner and any 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 before or 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.	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 civil union partner and any 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 civil union partner 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.	Further clarification of termination date for ex-spouses/step-children of non-Medicare members; Removal of "30 days before or" to align with current practice; Addition of language for termination date for ex-spouse/step-children of Medicare members as per CMS requirements.	CMS Requirements	Not Sure	FOR DISCUSSION

Location	Original	Proposed Revision/Addition	Reason for Revision/Addition	Category for Revision/Addition	Determination	Comments: Required if Disagree or Not Sure
4.12	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. If a LTD beneficiary or pensioner or their spouse or their dependent eligible for Medicare 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 and coverage in the non-Medicare plan will be reduced and paid as if secondary coverage at 20% of allowable charges for both medical and prescription claims.	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. 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 and 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).	Grammar correction, changed "plan" to "Plan"; Addition of "by reason of age" to further clarify the requirement for enrollment in Medicare Parts A and B; Clarification, changed "will" to "may" to provide the State flexibility; Further explanation of reduction of coverage.	Clarifications	Not Sure	FOR DISCUSSION
4.12.1	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 Medicare Supplement coverage until the next open enrollment period and only if re-enrolled in Medicare Part B coverage. Also, see subsection 3.10 of this regulation.	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 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.	Grammar correction, changed "coverage" to "Plan"; Update to relevant subsection reference	Clarifications	Not Sure	FOR DISCUSSION
5.1	Regular officers and employees become eligible for State Share contributions on the first of the month following three full months of employment, except if the regular officer or employee was a benefit eligible employee of the University of Delaware, Delaware Solid Waste Authority, Delaware Transit Cooperation or Delaware State Housing Authority and the time period between the employment termination and the date of hire as an eligible State employee is no more than three-months, the employee is eligible for state share on the date of hire. State Share contributions are limited to State regular officers, employees, LTD beneficiaries and pensioners. See the Eligibility Table for specific information regarding State Share payments and employee payroll deductions for employees who elect coverage when eligible for State Share.	Regular officers and employees become eligible for State Share contributions on the first of the month following date of hire. State Share contributions are limited to State regular officers, employees, LTD beneficiaries and pensioners.	Revisions related to the State Share waiting period to comply with HB 185, including deletion of Eligibility Table reference which is no longer required.	HB 185	Disagree	FOR DISCUSSION

Location	Original	Proposed Revision/Addition	Reason for Revision/Addition	Category for Revision/Addition	Determination	Comments: Required if Disagree or Not Sure
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 Services by the first day of the month for which the employee's coverage becomes effective.	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.	Addition of "Administrative" to align with name change	Clarifications		
5.3.4	If employee and spouse are eligible pensioners where one or both retire on or after July 1, 2012, and before July 1, 2017, only one $25 per month charge shall apply when separate contracts are required for a Medicare Supplement plan.	If employee and spouse are eligible pensioners and covered under the same pension employee identification number, where one or both retire on or after July 1, 2012, one monthly charge shall apply for the lessor of the pensioner cost share premium for Medicare coverage.	Clarification to align with Office of Pensions current practice	Clarifications	Not Sure	FOR DISCUSSION
		Add: If employee and spouse are eligible pensioners and enrolled under separate pension employee identification numbers, where one or both retire on or after July 1, 2012, two monthly premium charges shall apply for the lessor of the pensioner cost share premium for Medicare coverage.	Clarification to align with Office of Pensions current practice	Clarifications	Not Sure	FOR DISCUSSION
5.3.5.2	If one spouse is a regular officer or employee and one 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.	If one spouse is a regular officer or employee and one 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, the employee will be charged 50% of the employee cost share premium and the Medicare eligible spouse will be charged the cost share premium for Medicare coverage or $25, whichever is less.	Clarification to align with Office of Pensions current practice	Clarifications	Not Sure	FOR DISCUSSION
5.3.5.3	If both spouses are Medicare eligible and one 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.	Delete	Already mentioned in 5.3.4	Clarifications	Not Sure	FOR DISCUSSION
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.	Delete	Already mentioned in 5.3.4.1	Clarifications	Not Sure	FOR DISCUSSION
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 Service), 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 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.	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 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.	Grammar correction, replaced "service" with "share"	Clarifications	Not Sure	FOR DISCUSSION

Location	Original	Proposed Revision/Addition	Reason for Revision/Addition	Category for Revision/Addition	Determination	Comments: Required if Disagree or Not Sure
5.5	An eligible employee who chooses to be covered before becoming eligible for State Share must pay the full cost of coverage, State Share and employee share, until State Share begins.	Delete	Removal of State Share waiting period language consistent with HB 185	HB 185	Not Sure	FOR DISCUSSION
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 or the first of the following month following the date of the return from leave.	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.	Revisions related to the State Share waiting period to comply with HB 185.	HB 185		
5.10	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 month that a regular officer or employee, LTD beneficiary or eligible pensioner fails to pay the required share for the coverage selected.	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.	Addition of "following" to further clarify when coverage will be cancelled	Clarifications	Not Sure	FOR DISCUSSION
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. (See subsection 5.22 of this regulation for additional FMLA considerations.)	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. (See subsection 5.21 of this regulation for additional FMLA considerations.)	Update to relevant subsection reference	Clarifications	Not Sure	FOR DISCUSSION

Location	Original	Proposed Revision/Addition	Reason for Revision/Addition	Category for Revision/Addition	Determination	Comments: Required if Disagree or Not Sure
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 to the organization for the month in order to retain coverage and the organization shall remit payment to the Department of Human Resources/Financial Services. 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:	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	Further clarification of payment due date; Addition of "Administrative" to align with name change; Revision related to the State Share waiting period to comply with HB 185.	HB 185		
5.11.3	Termination or unauthorized leave of absence for a period less than 30 calendar days. **IMPORTANT NOTE**: A LTD beneficiary whose LTD benefits have ended and who returns to active employment with the State as a regular officer or employee is entitled to State Share without fulfilling a three-month waiting period provided the return to work was less than 24 months after the last day of their LTD benefits.	Termination or unauthorized leave of absence for a period less than 30 calendar days.	Revision related to the State Share waiting period to comply with HB 185.	HB 185		
5.14	Any refund of State Share or employee share for health plan coverage is subject to the following requirements:	Any refund of State Share or employee or pensioner share for health plan coverage is subject to the following requirements:	Addition of "pensioner" to align with current practice	Clarifications	Not Sure	FOR DISCUSSION
5.14.1	A regular officer, employee, LTD beneficiary or eligible pensioner 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 or pensioner must make application for the refund within one calendar year of the date the employee first paid the State Share to be refunded as required under 10 Del.C. §8111.	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 one calendar year of the date the employee first paid the State Share to be refunded as required under 10 Del.C. §8111.	Grammar correction, changed "insure" to "ensure"	Clarifications		
		Add: A regular officer, employee, LTD beneficiary or pensioner who has paid the employee or pensioner share for themselves and/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.	Addition of language allowing refunds for members with dual coverage to align with current practice	Clarifications	Disagree	FOR DISCUSSION

Location	Original	Proposed Revision/Addition	Reason for Revision/Addition	Category for Revision/Addition	Determination	Comments: Required if Disagree or Not Sure
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 of the month. A refund will be given, if the employee makes request for 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.	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 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.	Addition of "day" to align with current practice	Clarifications		
5.16	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 will be eligible for State Share without fulfilling another three-month qualification period. Also see subsection 8.3 of this regulation.	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. Also see subsection 8.3 of this regulation.	Addition of language consistent with HB 185	HB 185	Not Sure	FOR DISCUSSION
5.17	A temporary, casual, seasonal employee, or substitute teacher of the State who becomes a "Regular Officer or Employee" shall have their 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 teacher must have worked each pay cycle for the three months prior to hire to be eligible for State Share or last three full months of the school year before September hire.	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”.	Addition of language consistent with HB 185	HB 185	Not Sure	FOR DISCUSSION
5.19	Any regular officer, employee or pensioner who is also receiving a survivor’s pension through the State of Delaware is also 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.	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.	Addition of "shall" and "be"	Clarifications	Not Sure	FOR DISCUSSION
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.	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.	Capitalization of "State Share"	Clarifications		
		Add: Pensioner State Share eligibility is set forth in 29 Del.C. §5202(b).	Reference DE Code section permitting eligibility	Clarifications	Not Sure	FOR DISCUSSION
		Add: 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.	State Share eligibility clarification for pensioner returning to active state employment	Clarifications	Not Sure	FOR DISCUSSION

Location	Original	Proposed Revision/Addition	Reason for Revision/Addition	Category for Revision/Addition	Determination	Comments: Required if Disagree or Not Sure
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 they maintain 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 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 5.10 of this regulation.	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 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.	Removal of State Share waiting period language consistent with HB 185; Update to relevant subsection reference	HB 185		
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 is 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 5.15 of this regulation.	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 is 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.	Update to relevant subsection reference	Clarifications	Not Sure	FOR DISCUSSION
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 one 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 optional coverage selected, coverage will be terminated. Coverage will end on the first day of the month employee did not make required payment.	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 one 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 employment.	Removal of "optional"; Clarification of coverage termination date	Clarifications		

Location	Original	Proposed Revision/Addition	Reason for Revision/Addition	Category for Revision/Addition	Determination	Comments: Required if Disagree or Not Sure
7.4	Ex spouses or ex-civil union partners 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.	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.	Grammar correction, addition of "who"	Clarifications		
7.4.2	Coverage for the ex-spouse or ex-civil union partner of a pensioner covered by a Medicare supplement plan with or without prescription will end on the last day of the month in which the divorce is final.	Coverage for the ex-spouse, ex-civil union partner or 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.	Addition of "step-children" and language for termination date of ex-spouses/step-children of Medicare members as per CMS requirements.	CMS Requirements	Not Sure	FOR DISCUSSION
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 or 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 5.14 and 5.21 of this regulation.	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 or 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.	Update to relevant subsection reference	Clarifications	Not Sure	FOR DISCUSSION
7.6	Coverage for a LTD beneficiary will end as of the end of the month in which their LTD benefits end. If a LTD beneficiary is rehired into a full-time position within 24 months of the LTD termination or exhaustion date, the three-month State Share waiting period will not apply. Also, see subsection 8.4 of this regulation.	Coverage for a LTD beneficiary will end as of the end of the month in which their LTD benefits end.	Removal of State Share waiting period language consistent with HB 185	HB 185		
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 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 5.9 of this regulation.	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, 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 5.9 of this regulation.	Clarification for reinstatement of coverage for an employee returning from an authorized LOA clarification as first of the month to coincide with current practice; Update to relevant subsection reference	Clarifications	Not Sure	FOR DISCUSSION

Location	Original	Proposed Revision/Addition	Reason for Revision/Addition	Category for Revision/Addition	Determination	Comments: Required if Disagree or Not Sure
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 without fulfilling another three- month waiting period if they return to full-time State employment within 24 months of termination. Also see subsection 5.16 of this regulation.	Delete	Removal of State Share waiting period language consistent with HB 185	HB 185		
		Add: 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.	Addition of language clarifying State Share eligibility for pensioners returning to active State	Clarifications	Not Sure	FOR DISCUSSION
8.4	A LTD beneficiary who is rehired into a full-time position within 24 months of LTD termination or exhaustion date will be eligible for State Share without fulfilling another three- month waiting period.	Delete	Removal of State Share waiting period language consistent with HB 185	HB 185		
9.0	**Miscellaneous**	**Employee and Employing Agency Responsibilities**	Title change to align to rules in section	Clarifications		
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 dependent/s (marriage, divorce, birth, death, adoption, etc.) that affects their health care coverage. 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 5.14 and 5.21 of this regulation.	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 dependent/s (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.	Qualifying Event enrollment requirements clarification; Update to relevant subsection reference	Clarifications	Not Sure	FOR DISCUSSION
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.	Delete	Language not needed per the DOJ	Clarifications	Not Sure	FOR DISCUSSION
		Add: 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/confirmation statement in the regular officer or employee or eligible pensioner's file. Also see subsection 5.13 and 5.20 of this regulation.	Clarification of premium payment responsibility for ineligible members	Clarifications	Disagree	FOR DISCUSSION

Location	Original	Proposed Revision/Addition	Reason for Revision/Addition	Category for Revision/Addition	Determination	Comments: Required if Disagree or Not Sure
10.2.2	Employees may enroll in a Dental or Vision plan or both effective on their date of hire if the first day of the month, the first of the month after being hired (and eligible), or 90 days after their hire date;	Employees may enroll in a Dental or Vision plan on the first of the month following the date of hire;	Clarification of enrollment date and to align with health plan changes per HB 185	Clarifications	Disagree	FOR DISCUSSION
10.2.3	The Dental and Vision Plans' effective date is always the first of the month and not on date of hire (unless date of hire is the first day of the month) or date of qualifying event as for the health plan;	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);	Clarification of enrollment date and to align with health plan changes per HB 185	Clarifications	Disagree	FOR DISCUSSION
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. Refunds are not made if notification is not provided within 30 days of the qualifying event;	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;	Clarification of refund eligibility to align with practice for health plan	Clarifications	Not Sure	FOR DISCUSSION
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;	Dental and Vision Plans' term dates are limited to 60 days or less from the date of the notification by the employee;			Not Sure	FOR DISCUSSION
10.2.6	Dental or Vision Plan or both will be terminated in the event that employee is 60 days delinquent in payment of Dental or Vision Plans' premium and any paid claims in the same period will be reversed;	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 any paid claims in the same period may be reversed;	Change from "60 days" to "30 days" and "will" to "may" to align with practice for health plan	Clarifications	Not Sure	FOR DISCUSSION
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 may be terminated as of the first of the month, any claims paid for that month will be reversed and a refund may be given, if employee makes request for refund within 60 days of the termination date;	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;	Change from "may" to "will" to align with current practice	Clarifications	Not Sure	FOR DISCUSSION
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 3.6 through 3.8 of this regulation.	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.	Update to relevant subsection reference	Clarifications	Not Sure	FOR DISCUSSION
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, participation will be reinstated in the appropriate enrollment system to be effective the first of the month following employee's return to work.	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.	Addition of "upon submission of signed enrollment form," and "as of the date of the" to align with current practice	Clarifications		
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 end of each month or coverage will be terminated. Employee must make payment to Benefit Representative or Human Resources Office for further processing.	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.	Premium payment due date clarification for an employee on an authorized LOA	Clarifications	Not Sure	FOR DISCUSSION

Location	Original	Proposed Revision/Addition	Reason for Revision/Addition	Category for Revision/Addition	Determination	Comments: Required if Disagree or Not Sure
Program Eligibility Table	State Of Delaware Group Health Insurance Program Eligibility Table	Delete	Deletion of Eligibility Table which is no longer required per HB 185 changes	HB 185		