# EXECUTIVE DEPARTMENT

## OFFICE OF MANAGEMENT AND BUDGET

Statewide Benefits Office
Statutory Authority: 29 Delaware Code, Section 9602 (29 **Del.C.,** §9602)
19 **DE Admin. Code** 2001

## FINAL

### ORDER

### 2001 Group Health Care Insurance Eligibility and Coverage Rules

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

Effective on March 1, 2013, under the authority of Title 29 of the **Delaware Code**, Section 9602(b)(4), the State Employee Benefits Committee is amending the Eligibility and Enrollment Rules regarding the Employees Eligible to Participate in the State Group Health Insurance Program to read as provided below. These amended rules were prepared by the Statewide Benefits Office and have been approved by the State Employee Benefits Committee with the consent of the State Employee Benefits Advisory Council. The amended rules are effective upon publication in the *Register of Regulations* in accordance with House Bill 190, Section 31.

### 2001 Group Health Care Insurance Eligibility and Coverage Rules
### (Effective March 1, 2013)

(Used to determine who may enroll. See "Cost of Coverage" to determine the amount of State contributions, toward an employee's coverage.)

**1.0 Authority**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.6 ~~Employees or pensioners who are enrolled in Medicare Part D may not have prescription coverage in the State Plan.~~ Pensioners who are enrolled in 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 Medicare Part D prescription plan for Medicare eligible retirees.

1.7 Enrollment in State plan is not indicative of eligibility to receive State Share contributions.

**6 DE Reg. 690 (11/1/02)**
**12 DE Reg. 986 (01/01/09)**
**15 DE Reg. 225 (08/01/11)**

**2.0 Dependents Eligible to Participate**

In compliance with the Civil Union and Equality Act of 2011, 13 **Del.C.**, Chapter 2, effective January 1, 2012 at 10 A.M., regular officers, employees, and pensioners who are party to a civil union in the State of Delaware shall be included in any definition or use of the terms "dependent", "family", "husband and wife", "immediate family", "next of kin", "spouse", "stepparent", "tenants by the entirety", and other terms whether or not gender-specific, that denote a spousal relationship or a person in a spousal relationship as they appear in the Groups Health Eligibility and Enrollment Rules. The same proof of relation required of "dependent", "family", "husband and wife", "immediate family", "next of kin", "spouse", "stepparent", "tenants by the entirety", will be required of employees and pensioners who are party to a civil union.

The Spousal Coordination of Benefits Policy will apply to parties to a civil union or same-sex marriage performed in other jurisdictions as recognized by Delaware law.

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

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

2.1.1.1 legal spouse or civil union partner (Delaware law does not recognize common law marriage.) 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 1/1/93 and revised 7-1-11. The policy applies to a spouse who is eligible for health coverage through his/her 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, will have a reduction in benefits under the State Plan. A new Spousal Coordination of Benefits form must be completed each year during Open Enrollment or anytime throughout the year the spouse's employment or health insurance status changes. Information on the Spousal Coordination of Benefits Policy, form and a Summary Plan Description (SPD) for each health care plan is available on the Statewide Benefit Office's website at http://ben.omb.delaware.gov/

2.1.1.2 child/ren under age 26 born to or legally adopted or lawfully placed for adoption by a regular officer's, or employee or eligible pensioner or a regular officer or employee's or pensioner's legal spouse;

2.1.1.3 child/ren who do not meet the requirements of section 2.1.1.2 above, who is unmarried, under age 19 (age 24 if a full time student), residing with a regular officer or employee or eligible pensioner in a regular parent child relationship, and who is dependent upon the regular officer or employee or eligible pensioner for at least fifty (50) percent support, and who would be considered the regular officer's or employee's or pensioner's "dependent" under Section 105(b) of the Internal Revenue Code. A statement of support form must be completed by the regular officer or employee or eligible pensioner and forwarded to the employee's Benefit Representative or Human Resources Office with the request for coverage together with a copy of the legal guardianship, permanent guardianship or custody order for the dependent child. If a natural parent resides in the same household as the insured regular officer or employee or eligible pensioner, it will be deemed that a regular parent-child relationship does not exist unless the regular officer or employee or eligible pensioner has legal guardianship documents or has legally adopted the dependent child.

2.1.1.4 unmarried dependent child/ren who meet the criteria of section~~s~~ 2.1.1.2 above, but who is age 26 or older and incapable of self-support because of a mental or physical disability which existed before the child reached age 26. The child/ren must have been covered under employee's contract immediately preceding age 26.

2.1.1.5 unmarried dependent child/ren who meet the criteria of section (c) above, but who is age 19 (age 24 if full-time student) or older and incapable of self-support because of a mental or physical disability which existed before the child reached age 19 (age 24 if full-time student). The child/ren must have been covered under employee's contract immediately preceding age 19 (age 24 if full-time student).

**IMPORTANT NOTES**: The Administration of Dependent Coverage to Age 26 policy became effective July 1, 2011 and provides for coverage of adult dependents until age 26 under the State Plan. As a "grandfathered" health care plan, the State Plan shall exclude adult dependents who are eligible to enroll in an employer-sponsored plan available through the adult dependent's employer until the plan year beginning July 1, 2014. The Adult Dependent Coordination of Benefits form must be completed by the regular officer, employee, or eligible pensioner on an annual basis at Open Enrollment or anytime throughout the year that the adult dependent's employment or health care status changes, except if enrolled in one of the non-grandfathered Consumer-Directed Health Plans.

A separate Dependent Coordination of Benefits (child/ren) form must be completed for each enrolled dependent regardless of age upon enrollment, any time coverage changes, or upon request by the Statewide Benefits Office to determine if the dependent is covered by any other health plan.

2.2 Eligible dependent child/ren covered under the health insurance plans of both parents will be primary to the parent's plan whose birthday is the first to occur during the calendar year. In the event the 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.

2.3 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.

2.4 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 Plan(s) or the Judiciary Pension Plan may not include a new spouse in the State's pension group health insurance plan effective June 1, 2012.

**6 DE Reg. 690 (11/1/02)**
**12 DE Reg. 986 (01/01/09)**
**15 DE Reg. 225 (08/01/11)**
**15 DE Reg. 1071 (01/01/12)**

**3.0 Coverage**

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

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

**IMPORTANT NOTES**: Spousal Coordination of Benefits Policy became effective 1/1/93 and revised 7/1/11 for a spouse who is eligible for health coverage through his or her own employer or former employer when spouse is retired. Spouses who work full time and are eligible for health coverage through their employer or spouses who are retired and eligible for health coverage through their former employer, but do not enroll under their former employer's health plan, will have a reduction in benefits under the State Plan. Information on the Spousal Coordination of Benefits Policy, form and a Summary Plan Description (SPD) for each health care plan is available on the Statewide Benefit Office's website at http://ben.omb.delaware.gov/

Adult Dependent Coordination of Benefits form must be completed for each enrolled adult dependent between ages of 21 to 26 upon enrollment, any time coverage changes, or upon request by the Statewide Benefits Office, except if enrolled in a Consumer-Directed Health Plan.

A separate Dependent Coordination of Benefits (child/ren) form must be completed for each enrolled dependent regardless of age upon enrollment, any time coverage changes, or upon request by the Statewide Benefits Office to determine if the dependent is covered by any other health plan.

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

re-enrolled in their previous plan as long as verification of employment is provided by the employee and the Statewide Benefits Office.

3.3 Employees or pensioners who cover their spouse on the State Plan must complete a Spousal Coordination of Benefits Policy Form during each annual Open Enrollment period as well as anytime there is a change in the spouse's employment or an insurance status change. Failure to supply the Spousal Coordination of Benefits form shall result in the spouse's medical claims being sanctioned, which reduces health care claims to be processed at 20 percent 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 percent minus the applicable copay).

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

3.5 Eligible employees or pensioners who fail to submit a completed and signed application/enrollment form within 30 days of their date of hire or their date of eligibility for State Share 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 Eligibility and Enrollment Rule 3.6.

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

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

- Loss of eligibility for coverage as a result of legal separation, divorce, death, termination of employment or reduction in the hours of employment;
- Loss of eligibility for coverage provided through a Health Maintenance Organization (HMO) because the individual no longer resides, lives, or works in an HMO service area (regardless of whether the choice of the individual) and no other benefit package is available to the individual;
- Loss of eligibility for coverage due to the cessation of dependent status;
- Loss of coverage because an individual incurs a claim that meets or exceeds a lifetime limit on all benefits under the plan;
- A plan discontinues a benefit package option and no other option is offered;
- If the employer ceases making contributions toward the employee's or dependent's coverage, the employee or dependent will be deemed to have lost coverage and does not need to drop coverage to have special enrollment rights;
- Exhaustion of Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, except that an employee/dependent losing coverage under another plan is not required to elect COBRA under that plan before using their special enrollment rights to enroll with the State.

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

3.7 If an employee declines enrollment for him/her-self or his/her dependents (including the spouse) and later has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may be able to enroll him/her-self and his/her dependents provided that he/she request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Necessary forms must be completed within 30 days of the request to enroll. Please see Eligibility and Enrollment Rule 2.4 for exception for new spouses of surviving pensioners.

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

enrollment is made within 30 days after the marriage, birth, adoption, or placement for adoption and the necessary paperwork is completed within 30 days of the request.

3.9 When two active eligible regular officers, employees, or pensioners and all eligible dependents elect to be covered under “employee and spouse” or one “family” contract then the spouse whose birthday occurs earlier in the calendar year shall sign an application for coverage form requesting coverage. A change of agency is considered re-enrollment. (In the event the birth dates are the same, length of service, and mutual choice of parents will be applied as described in Eligibility and Enrollment Rule 2.02). Beginning with the effective date, May 2003, of these rules, State Share contributions for all new enrollment will be charged to the agency or organization whose employee enrolls for employee, employee and spouse, employee and children or family coverage. Enrollment prior to February 1990 shall continue to be charged to the agency or organization as was previously determined.

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

The increment of cost of the contracts selected by the two regular officers or employees, or eligible pensioners who were hired and married on or before December 31, 2011, which exceeds the cost of two First State Basic family plans, shall be deducted by the Director of the Office of Management and Budget (OMB) from salary, pension, or disability payment or checks through June 30, 2012. Effective July 1, 2012, a charge of $25 per contract per month, or the employee premium associated with the contract (whichever is less in the event one of the plans is an employee only plan) will be assessed to each contract chosen by the husband and wife who were married and active eligible regular officers, employees, or pensioners prior to December 31, 2011.

Any regular officer, employee, and pensioner who marries or whose civil union is legal with another regular officer, employee, or pensioner on or after January 1, 2012, shall pay the applicable employee premium associated with the chosen contract/s.

3.10 When the spouse of an eligible regular officer or employee is a retired State of Delaware employee receiving a pension, and enrolled under separate individual contracts, the employing agency and the Pension Office will carry the coverage for their respective employee/pensioner. If an Employee & Spouse, or a Family contract is chosen, the coverage will continue to be carried through the active employee's agency until such time that the Pensioner turns 65. The over age 65 spouse may continue to have the State Plan as primary payor of benefits with the contract to continue under the active employee's agency, or the spouse may choose Medicare as the primary payor through the Pension Office. Also see Eligibility and Enrollment Rules 4.8 and 4/12.

**6 DE Reg. 690 (11/1/02)**
**12 DE Reg. 986 (01/01/09)**
**13 DE Reg. 126 (07/01/09)**
**15 DE Reg. 225 (08/01/11)**
**15 DE Reg. 1071 (01/01/12)**

**4.0 Changes In Coverage**

4.1 An eligible employee who elects to be covered on his/her EMPLOYMENT COVERAGE DATE may change health insurance (medical) coverage when the employee first becomes eligible for the State Share payment. (Examples: (1) An employee who at hire enrolls in the "First State Basic" plan may change to "Comprehensive PPO" (or another optional coverage) when beginning State Share contribution, without waiting for the next open enrollment period. (2) An employee who at hire enrolls for "Employee" coverage may change to "Employee and Child/ren", "Employee and Spouse", or "Family" coverage when he/she begins to receive State Share, without waiting for the next open enrollment period. The employee who elects coverage to dental and/or vision coverage on his/her EMPLOYMENT COVERAGE DATE may not make changes to dental and/or vision coverage until the next open enrollment period unless the employee meets the requirements of Eligibility and Enrollment Rule 3.6.

4.2 When a covered regular officer or employee or eligible pensioner marries, or enters into a 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 valid marriage license or civil union certificate must be provided. (Delaware law does not recognize common law marriage.) A Spousal Coordination of Benefits Policy form must be completed when adding a spouse or civil union partner to coverage. The Spousal Coordination of Benefits Policy form must be completed on-line (a copy of certification should be printed and provided to your Benefits Representative/HR Office.

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

**IMPORTANT NOTES:** Adult Dependent Coordination of Benefits form must be completed for each enrolled adult dependent between ages of 21 to 26 upon enrollment, any time coverage changes, or upon request by the Statewide Benefits Office, except if enrolled in a Consumer-Directed Health Plan.

A separate Dependent Coordination of Benefits (child/ren) form must be completed for each enrolled dependent regardless of age upon enrollment, any time coverage changes, or upon request by the Statewide Benefits Office to determine if the dependent is covered by any other health plan.

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

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

4.5 Coverage for an eligible dependent, other than a newborn child/ren, who becomes an eligible dependent after the employee has been enrolled, becomes covered on the first day of the month following eligibility provided the regular officer or employee or eligible pensioner requests enrollment within 30 days of eligible status. The necessary paperwork must be completed within 30 days of the request for enrollment. A copy of valid documentation of dependent status must be provided, i.e. legal guardianship, permanent guardianship, custody order. Applicable premiums must be paid.

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

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

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

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

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

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

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

"1. Change in status.

(i) Due to death of spouse.

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

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

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

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

2. Judicial Order, Decree, or Judgment. Health coverage for one or more of dependent children may be dropped if a judicial order, decree, or judgment permits the cancellation of dependent child coverage, provided that the spouse, former spouse or another individual is required to cover such child and such coverage is in fact provided.
3. Medicare or Medicaid Eligibility. If an employee, spouse, or dependent who is enrolled in an accident or health plan of the employer becomes entitled to coverage (i.e., becomes enrolled) under Part A or Part B of Title XVII of the Social Security Act (Medicare) (Public Law 89-97 (79 Stat. 291) or Title XIX of the Social Security Act (Medicaid) (Public Law 89-97 (79 Stat. 343), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the regular officer, employee or eligible pensioner may for themselves or for their dependents make a prospective election change to cancel or reduce coverage of that employee or dependent under the health plan.
4. Change in Costs or Coverage. If the cost charged to an employee for health coverage significantly increases during a period of coverage, the regular officer, employee or eligible pensioner may make a corresponding change in election under the plan, including commencing participation in an option with a decrease in cost, or, in the case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving on a prospective basis coverage under another benefit package option providing similar coverage or dropping coverage if no other health plan option providing similar coverage is available. (For purposes of this paragraph, a cost increase or decrease refers to an increase or decrease in the amount of the elective contributions under the cafeteria plan, whether that increase or decrease results from an action taken by the employee (such as switching between full-time and part-time status) or from an action taken by an employer (such as reducing the amount of employer contributions for a class of employees)."

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

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

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

4.9 An employee who becomes eligible for pension or Long-Term Disability (LTD) may change their plan at the onset of receiving pension or LTD and must enroll in Medicare Parts A and B upon eligibility.

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

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

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

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

of the divorce, the regular officer or employee or eligible pensioner must pay the employee contribution for the entire month that the divorce occurred.

4.12 Pensioners and dependents eligible for Medicare, by reason of age or disability, must also enroll in Medicare Part A and B when first eligible for these plans and may enroll in the Medicare Supplement plan provided by the State Group Health Plan through the Pension Office. ~~No pensioner or their dependent eligible for Medicare, by reason of age or disability, may be enrolled in a non-Medicare plan through the State.~~ If a pensioner 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. Coverage in the non-Medicare plan will be reduced and paid as if secondary coverage at 20 percent (20%) of allowable charges for both medical and prescription claims. Also see Eligibility and Enrollment Rule 3.10.

**6 DE Reg. 690 (11/1/02)**
**12 DE Reg. 986 (01/01/09)**
**13 DE Reg. 126 (07/01/09)**
**15 DE Reg. 225 (08/01/11)**
**15 DE Reg. 1071 (01/01/12)**

**5.0 Cost Of Coverage**

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

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

5.2 Permanent part-time (regularly scheduled to work less than 130 hours per month), temporary per diem and contractual employees of the General Assembly as described in Eligibility and Enrollment Rule 1.01 are eligible to participate in the State Plan, but are not eligible for State Share. Therefore, any such employee joining the State Plan must pay the full cost of the health plan selected. Payment must be collected by the organization and forwarded to the Statewide Benefits Office by the first day of the month for which the employee's coverage becomes effective.

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

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

5.3 When a husband and wife are both permanent full time active employees or pensioners employed and married on or before December 31, 2011, they shall earn State Share contributions in accordance with the following as of July 1, 2012:

5.3.1 If they elect to enroll in two separate contracts, a charge of $25 per each contract per month, or the employee premium associated with the contract (whichever is less), will be assessed to each contract chosen by the individuals and deducted by OMB from salary, pension, or disability check.

5.3.2 If they elect to enroll in one employee and spouse or family contract, one charge of $25 per contract per month shall be deducted by OMB from salary, pension, or disability payments. If a husband and wife who are both permanent full-time active employees or pensioners and married to each other on or before December 31, 2011 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 above if they return or are permanent full-time active employees or pensioners at a future date as long as they are married to the same spouse who is also a regular officer or employee or pensioner.

5.4 When the spouse of an eligible employee is a retired State of Delaware employee receiving a monthly pension or a Disability Insurance Program (DIP) LTD beneficiary receiving an LTD check on or before December 31, 2011 each may enroll as two separate contracts, employee, and spouse contract or a family contract. The increment of cost of the option selected by the employee that exceeds the cost of two First State Basic family plans, shall be deducted by OMB from salary, pension or disability payments until June 30, 2012. (A notation should be made in the employee's file that the spouse is a State of Delaware pensioner or DIP LTD beneficiary). The Pension Office should be notified when the active employee terminates State Service. Effective July 1, 2012 a charge of $25 per contract per month, or the employee premium associated with the contract (whichever is less in the event one of the plans is an employee only plan) will be assessed to each contract chosen by the husband and wife who were married and active eligible regular officers, employees, or pensioners prior to December 30, 2011.

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

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

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

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

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

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

5.10.1 Family and Medical Leave Act (FMLA) regulations provide that employees have a 30 day grace period for late premium payments. The employer's obligation to maintain health coverage ceases if an employee's premium payment is more than 30 days late. Benefit Representative or Human Resources Offices should continue the employee's health coverage for the 30 day period provided under FMLA. The Benefit Representative or Human Resources Offices can then do a retroactive cancellation if the required employee contribution was not paid by the end of the 30 day grace period. (See Eligibility and Enrollment Rule 5.22 for additional FMLA considerations.)

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

5.11.1 an authorized leave of absence;

5.11.2 a suspension without pay;

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

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

A LTD recipient whose LTD benefits have terminated 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 30 days after the last day of their LTD benefits. If the time period between the termination of LTD benefits and return to work is 30 days or more, a three month waiting period will apply.

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

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

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

5.13.2 Employees whose STD claims are in a pending status are entitled to receive State Share. If STD claim is denied, the employee is responsible for the State Share paid on his/her behalf while the claim was in a pending status.

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

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

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

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

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

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

5.14.5 In any event, refunds of less than $1.00 will not be made.

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

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

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

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

5.19 Any 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, which exceeds the cost of two First State Basic family plans, shall be deducted by the Director of the Office of Management and Budget (OMB) from salary, pension, or disability payment or checks through June 30, 2012. Effective July 1, 2012 a charge of $25 per contract per month, or the employee premium associated with the contract (whichever is less in the event one of the plans is an employee only plan), will be assessed to the contract chosen by regular officer, employee, or pensioner who is also receiving a survivor’s pension.

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.

5.21 In the event that the State has paid the employee share or any co-pays, coinsurance, deductibles or other amounts that OMB determines should have been paid by the regular officer or employee or covered spouse or dependent of the regular officer or employee upon prior written notice to such regular officer or employee (which shall not be less than sixty (60) days), the State, to the extent permissible under applicable law, may recover such amounts from such regular officer or employee by deducting the amount paid by the State from the after tax pay due to the regular officer or employee

5.21.1 the regular officer or employee shall be provided an opportunity to dispute such amounts owed to the State to the Statewide Benefits Office and

5.21.2 if the amount owed by the regular officer or employee exceeds $1,000 then the regular officer or employee shall be provided an opportunity to have the amount owed deducted in monthly installments over a period of time not less than twelve (12) months.

5.22 Family and Medical Leave Act (FMLA) regulations provide that employees who fail to return to work after their FMLA leave entitlement has been exhausted shall be responsible for repayment of the State Share under the group health plan unless they fail to return to work due to their own or eligible family member's serious health condition, or for some other reason beyond their control.

**6 DE Reg. 690 (11/1/02)**
**12 DE Reg. 986 (01/01/09)**
**13 DE Reg. 126 (07/01/09)**
**13 DE Reg. 683 (11/01/09)**
**15 DE Reg. 225 (08/01/11)**
**15 DE Reg. 1071 (01/01/12)**

**6.0 Continuation Of Coverage**

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

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

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

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

6.5 An eligible employee or eligible dependent that loses coverage under the State Plan may continue coverage under COBRA. If a COBRA qualifying event occurs, the employee or the employee's dependent(s) must notify the employee's Benefit Representative or Human Resources Office or the State's COBRA Administrator to provide notice of the qualifying event within 60 days of its occurrence.

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

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

**7.0 Termination Of Coverage**

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

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

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

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

Ex-spouses not employed by the State of Delaware are not eligible for coverage under the State Plan - even if a divorce decree, settlement agreement or other document requires an employee to provide coverage for an ex-spouse.

7.4.1 Coverage for the ex-spouse of an active employee or pensioner covered by a non-Medicare plan will terminate on the day after the date of divorce.

7.4.2 Coverage for the ex-spouse of a pensioner covered by a Medicare supplement plan with or without prescription will terminate on the last day of the month in which the divorce is final.

7.4.3 Premiums are paid on a monthly basis and not prorated. The regular officer or employee or eligible pensioner must remit the employee share for the plan which included the spouse for the entire month. The regular officer or employee or eligible pensioner must submit a signed application within 30 days prior to or the date of divorce. If DSS terminates as a result of the divorce, each regular officer, employee or eligible pensioner must pay the employee contribution for the entire month that the divorce occurred. The State Plan will not be responsible for payment of claims when a dependent is no longer eligible for coverage 30 days following.

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

7.5.1 The end of the month in which the dependent child/ren as defined in Section 2.1.1 attains age 26.

7.5.2 The end of the month in which the dependent child/ren as defined in Section 2.1.2 marries, or attains age 19 (or age 24 if full time student); or

7.5.3 The date the child/ren ceases to be dependent on the regular officer or employee or eligible pensioner for at least fifty (50) percent support per Sections 2.1.1.3, 2.1.1.4 and 2.1.1.5.

7.6 Coverage for a LTD recipient will end as of the end of the month in which their LTD benefits are terminated.

**6 DE Reg. 690 (11/1/02)**
**6 DE Reg. 1515 (5/1/03)**
**12 DE Reg. 986 (01/01/09)**
**15 DE Reg. 225 (08/01/11)**
**15 DE Reg. 1071 (01/01/12)**

## 8.0 Reinstatement of Coverage

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

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

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

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

**9.0 Miscellaneous**

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

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

**6 DE Reg. 690 (11/1/02)**
**12 DE Reg. 986 (01/01/09)**
**13 DE Reg. 126 (07/01/09)**

**10.0 Dental and Vision Plans**

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

10.1.1 Dental and Vision Plans are not affected by Double State Share (DSS);

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

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

10.1.4 Dental and Vision Plans' refund rules are limited to 60 days or less because the Dental and Vision Plans are fully insured;

10.1.5 Dental and Vision Plans' term dates are limited to 60 days or less;

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

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

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

10.1.9. Terminations in Dental and/or Vision coverage can only be made during the annual Open Enrollment period, except that a regular officer or employee or eligible pensioner may elect to drop Dental or Vision coverage for one or more dependents within the plan year due to same circumstances as noted in Section 4.7.5.

10.1.10 The employee's election of a Dental and/or Vision plan is binding for the plan year. <u>The employee who elects to enroll in dental and/or vision coverage on his/her EMPLOYMENT COVERAGE DATE may not change such coverage until the next open enrollment period unless the employee meets the requirements of Eligibility and Enrollment Rule 3.6.</u>

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

10.1.12 An employee on approved leave of absence without pay may continue to participate in the Dental and/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.

**12 DE Reg. 986 (01/01/09)**
**15 DE Reg. 225 (08/01/11)**
**15 DE Reg. 1071 (01/01/12)**
**16 DE Reg. 1003 (03/01/13) (Final)**

**STATE OF DELAWARE GROUP HEALTH INSURANCE PROGRAM ELIGIBILITY TABLE**

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