NEW CASTLE COUNTY

PERSONNEL POLICY

NUMBER	2.04
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DATE	10/21/2015

SUBJECT: GROUP HEALTH INSURANCE COVERAGE **APPROVED:**

OBJECTIVE: To establish a policy concerning health insurance coverage for active employees, employees on leave of absence, retirees, and for individuals who become eligible for coverage due to a continuing qualifying event defined below.

Definition:

1. Active Employee - A full time employee of New Castle County.

2. Retired Employee - A full time employee who terminates employment and immediately receives a pension annuity.

3. Employee on Leave of Absence - A full time employee who has been granted a leave without pay by the Chief Human Resources Officer with the approval of the County Executive for a period not to exceed two (2) years.

4. Domestic Partner - Two adults who reside together, have chosen to share their lives in an intimate relationship and have a mutual obligation of each other's support for the basic necessities of life. Domestic Partners do not include roommates, siblings, parents, or casual relationships.

5. Basic Coverage - That portion of the premium paid by the County in accordance with existing union contracts.

6. Continuing Qualifying Event - Termination of full time employee by resignation or dismissal (except in the case of gross misconduct), or a termination of dependent's coverage because of termination of an employee's full time employment, death of an employee, divorce or legal separation, loss of dependent child status (e.g. children attaining maximum age limit under the plan - January 1 following attainment of age 19). COBRA (Consolidated Omnibus Budget Reconciliation Action of 1985. Pub L. 99-272-Title X 4/7/86, effective 1/1/87).

STATEMENT:

Active Employee: Beginning on the first day of the month following the completion of 60 days of full time employment, the County assumes the full cost of providing basic family group health insurance coverage. Individual coverage is provided to full time married/unmarried employees * or subscriber/child(ren) coverage to married/unmarried employees with child(ren) dependents. Optional coverage is provided at cost to full time employees who elect coverage in excess of the basic group health insurance provided by the County. Coverage is continuous through the last day of the month in which the employee ceases to be an active employee.

Retired Employee: The County provides for the retiree the full cost of Cooperative 80 Individual coverage under the Blue Cross/Blue Shield Plan, or the carrier providing equivalent coverage for those employees retiring on or after July 1, 1973, but before April 1, 1997, who are not eligible for Medicare.

For those employees retiring on or after April 1, 1997, (who are not eligible for Medicare), the County agrees to assume the full cost of providing Cooperative 80 Individual coverage under the Blue Cross/Blue Shield Plan, or the carrier providing equivalent coverage. The County further agrees to issue health insurance credits to be used exclusively to purchase health insurance coverage (through New Castle County) for the retiree's spouse/domestic partner *. The value of the monthly credit will be the product of $10 times the number of years of credited service. For sworn police officers the value of the monthly credit will be the product of $15 times the number of years of credited service. The maximum value of the monthly insurance credit for each retiree shall be $300, regardless of length of service. Credits cannot be banked for future use. If the cost of the health insurance program selected by the retiree exceeds the amount of the individual retiree's health insurance credit, the retiree will be responsible to contribute the difference. In the event other coverage is available to the spouse/domestic partner, the County will be considered the secondary provider of insurance under coordination of benefits. When a retiree or his or her spouse/domestic partner becomes eligible for Medicare, the County's insurance will cease. Upon verification of enrollment in Medicare Parts A and B, the County will pay the full cost of providing the retiree and his or her spouse/domestic partner with Standard Medicfill coverage or its equivalent insurance. In the event of the retiree's death, the County will not assume the cost of providing coverage for the surviving spouse/domestic partner.

*Domestic Partner: A domestic partner policy statement will be issued as clarification of domestic partners and supporting documentation must be placed on file with the Human Resources Division.

Employee on Leave of Absence: Coverage for full time employees on an approved leave of absence may continue to be covered under the Group Health Insurance Plan provided that the full cost of such coverage is received by the Human Resources Division from the employee prior to the first day of each month in which the employee is on the approved leave of absence.

Continuing Qualifiable Event: The County will provide the option to employees and/or their dependents of continuing coverage under the Group Health Insurance Plan for a period of eighteen (18) months following termination of full time employment by resignation or dismissal (except in cases of gross misconduct) by payment of the appropriate premium to the Human Resources Division in advance monthly for such coverage (COBRA).

The County will provide the option to dependents of employees of continuing coverage under the Group Health Insurance Plan for a period of thirty-six (36) months following the death, divorce, or legal separation, or the loss of dependent child status by the payment of the appropriate premium to the Human Resources Division in advance monthly for such coverage (COBRA).

REQUIRED ACTION:

1. The Chief Human Resources Officer or designee will insure dissemination and execution of this policy.

2. The Human Resources Division will insure receipt of health insurance payments from individuals on leave and will process the same in accordance with this policy.

Established: 07/14/87
Revised: 08/01/97
Revised: 10/21/15

NEW CASTLE COUNTY
DOMESTIC PARTNER CLARIFICATION STATEMENT

New Castle County has amended the Health Benefit Plan provided by both Blue Cross/Blue Shield of Delaware and Aetna HMO to include coverage for Domestic Partners. Domestic Partners are defined as two adults who reside together, have chosen to share their lives in an intimate relationship and have a mutual obligation of each other's support for the basic necessities of life. Domestic Partners do not include roommates, siblings, parents or casual relationships.

SUMMARY OF NEW BENEFITS

Effective August 1, 1997, persons covered under the Health Benefit Plan may enroll their Domestic Partners and their Domestic Partner's eligible dependent children for medical coverage. Domestic Partners and their eligible dependent children will not be eligible for continued medical coverage upon the death or termination of employment of the employee, or after the termination of the Domestic Partner relationship, or when an eligible dependent child is no longer considered a dependent. All other provisions of the Health Benefit Plan are applicable. This clarification of domestic partners is issued as an addendum to Personnel Policy 2.04, Group Health Insurance Coverage.

ELIGIBILITY REQUIREMENTS

In order for your Domestic Partner to be eligible for medical benefits under the Health Benefit Plan, you and your Domestic Partner must meet the following criteria:

1. You have resided together for at least 6 months and intend to do so permanently (□reside together□ means that the two of you share your principal place of residence; if one of you temporarily leaves the shared residence but intends to return, you still will be considered to reside together).

2. You are both at least 18 years of age and are mentally competent to enter into a contract;

3. You are not related by blood to a degree of closeness which would prohibit marriage in the state in which you reside were you of the opposite sex;

4. Neither of you is married to someone else;

5. Neither of you currently is in a Domestic Partnership relationship with someone else;

6. You are mutually responsible for basic living expenses; and

7. You have filed an Affidavit of Domestic Partnership (attached). In addition, if you reside in a jurisdiction which permits the registration of Domestic Partners, you must register and submit a copy of such registration along with your signed Affidavit.

Proof of Cohabitation and Financial Interdependence
You must submit proof of cohabitation and financial interdependence in addition to your Affidavit of Domestic Partnership. You may do so in any of the following ways.

Cohabitation: In order to prove your 6 months of cohabitation, you may submit any one of the following.

- Copy of a signed, dated lease showing both names;
- Copy of a dated deed showing both names;
- Copies of (choose one) driver's licenses, car registrations, voter registration cards, insurance policies, account statements or tax returns at the same address (as long as these documents are dated at least 6 months ago).

If you have not yet resided together for 6 months, you may submit an Affidavit of Domestic Partnership now and enroll your Domestic Partner once he/she becomes eligible.

Financial Interdependence: In order to prove financial interdependence, you may submit any one of the following:

- Copy of joint mortgage note;
- Copies of statements of joint accounts (i.e., bank accounts, investment accounts);
- Copies of life insurance beneficiary designations naming each of you the beneficiary of the other's life insurance policy;
- Copies of wills indicating that each of you has named the other as a beneficiary under his or her will.

To enroll your Domestic Partner in the medical plan, please complete the Enrollment Form and return it to the Pension and Benefits Section of the Human Resources Division.

Established: 08/01/97

AFFIDAVIT OF DOMESTIC PARTNERSHIP

We, _____ (name of employee), and _____(name of Domestic Partner), certify that:

1. We have an intimate relationship;
2. We have resided together for at least 6 months and intend to do so permanently;
3. We both are at least 18 years of age and are mentally competent to enter into a contract;
4. We are not related by blood to a degree of closeness which would prohibit marriage in the state in which we reside were we of the opposite sex.
5. Neither one of us is married to someone else;
6. Neither one of us currently is in a Domestic Partnership relationship with someone else;
7. Neither one of us is in default of support payments in connection with agreements concluding previous marriages or relationships;
8. We are mutually responsible for basic living expenses;
9. If we reside in a jurisdiction which permits registration of Domestic Partners, we declare that we have registered or will register in that jurisdiction within 31 days from the date of this Affidavit;
10. We understand and have considered the possible legal consequences of signing this Affidavit and acknowledge that we do so voluntarily;
11. We understand that continuation of medical coverage in the event of death, termination of employment or retirement of the employee is not available to the Domestic Partner or the Domestic Partner's eligible dependent children; and
12. I, _____ (name of employee), further understand that I must notify the Pension and Benefits Section if this relationship terminates and must file and Affidavit of Termination of Domestic Partnership within 30 days from the date of termination.

We declare that the statements in this Affidavit are true to the best of our knowledge.

_____ _____

Date *Signature of Employee*

_____ _____

Date *Signature of Domestic Partner*

Sworn to and Subscribed before me, a Notary Public of the State of Delaware, New Castle County on this _____ day of _____, in the year of _____.

_____

Signature of Notary Public

AFFIDAVIT OF TERMINATION OF DOMESTIC PARTNERSHIP

I, _____ (name of employee), declare and acknowledge as follows:

☐ I request the removal of my Domestic Partner, _____ (name of Domestic partner), and his/her eligible dependent children from my medical coverage effective _____.

OR

☐ The Domestic Partnership Relationship between me and _____(name of Domestic Partner), ended on _____.

OR

☐ My Domestic Partner, _____ (name of Domestic Partner), died on _____.

I understand that I will not be able to submit another Affidavit of Domestic Partnership for 6 months from the date of signing this Affidavit of Termination of Domestic Partnership.

_____ _____

Date *Signature of Employee*

cc: Domestic Partner
File