Office of the State Comptroller

Health Care Policy and Services Division
165 Capitol Avenue
Harford, CT 06106

ACTIVE HEALTH BENEFIT ELIGIBILITY POLICY

1. Introduction

This policy defines the eligibility criteria and procedures for active health benefits based on provisions outlined in the Connecticut General Statutes, Department of Administrative Services Human Resources Policy, and relevant State Employees Bargaining Agent Coalition (SEBAC) agreements. Its goal is to ensure that all active employees of the State of Connecticut and their employing agencies clearly understand the rules for active employee health insurance benefits.

Each agency in the State of CT manages the health benefits for its employees. The Office of the State Comptroller, Healthcare Policy & Benefit Services Division, oversees the employee health plan. This includes issuing requests for proposals (RFPs) related to managing the employee health plan, contracting with health insurance vendors, tracking the employee health care budget appropriations, paying the vendors for health plan costs, administering employee health plan policies, handling employee communications about health benefits, and managing the annual open enrollment for health benefits. The OSC, Central Benefits Unit, supports agency HR, Benefits, and Payroll staff by answering questions related to employee health benefits administration policies or Core-CT system processing.

The State of Connecticut uses Core-CT, an integrated HRMS system, to handle enrollment in active employee benefits. Core-CT maintains HR, Benefits, and Payroll data specific to each employee. When hired, the agency's Human Resources Department inputs the employee's job, employment, and position details into Core-CT. This information triggers enrollment in a benefit program. The benefit program specifies the health benefits and group life insurance an employee qualifies for.

The employee has 31 days from their hire date to decide whether to enroll in health coverage and make their elections. Once an employee makes their benefit elections, the agency's HR/Benefits/Payroll staff processes them in Core-CT. Core-CT automatically generates payroll deductions for the chosen plan and coverage level. Each agency is responsible for ensuring that the employee share contributions are accurate and paid in full.

2. Definitions

The following definitions apply to active health benefit eligibility:

Effective Date of Coverage for New Hires, Qualifying Life Events, and Open Enrollment – Employee group health insurance coverage becomes effective on the first day of the month after the employee's hire date or qualifying life event date. Changes made during open enrollment take effect on July 1st.

Effective date of termination for employees or dependents losing coverage – Employee group health insurance coverage ends on the first day of the month after the employee's termination date or when a dependent loses coverage. This means coverage ends at midnight on the last day of the month in which employment ended or the dependent is no longer eligible. For example, if an employee's termination date is October 15th, Core-CT will show a benefit termination date of November 1st, meaning their active group health coverage ends at midnight on October 31st.

Active Employee – A permanent worker employed by the State of Connecticut.

Full-time Equivalent (FTE) – A measurement that calculates the total hours worked by employees relative to a full-time schedule. FTE is based on a 40-hour work week or the full-time hours specified in the applicable union contract. Employees must maintain at least a 0.5 FTE to qualify for health insurance.

Employee ID – A unique 6-digit identifier used in Core-CT for each employee in the state of Connecticut.

Employee Record – A unique number assigned to each job for which an employee is hired in the State of CT.

Job Indicators – Position indicators in Core-CT Job Data that determine an employee's eligibility for health coverage. An employee's job must be labeled as "Primary" (rather than Secondary) and "Regular" (instead of Temporary) to qualify for health insurance enrollment.

Dual Employment – An employee who holds two jobs at one or more state agencies. The employee is only eligible for health insurance through their primary job.

Benefit Program (see Appendix A below) - A configuration code in Core-CT linked to an employee's position that determines their eligibility for health and group life insurance. The Benefit Program is set up to allow the employee to enroll only in the benefit coverage they qualify for.

Eligible Dependents – Recognized individuals who qualify for enrollment in health coverage. Proof of the dependent relationship is required (see Appendix B below).

3. Employee Eligibility Requirements

Employees must meet the following eligibility requirements to enroll in health coverage:

- Must be a permanent employee.
    - Must maintain a .5 FTE, which means that the employee works at least half of the time of their specific union contract's full-time work hours requirement. This is generally 20 hours for a 40-hour work week.

Requirements for enrollment in Core-CT:

- Must have a benefit-eligible **Benefit Program** in their **Job Data**.
- Must be a regular employee and **marked as "Regular" in the Regular/Temporary field** in Job Data.
- Must have **at least a .50 FTE** in Job Data.
- Benefits can only be provided through the **Primary Job** Record in Core-CT.

Other Employee Eligibility Considerations:

- Special rules apply to employees not in classified service, part-time professional employees in higher education agencies, and to non-employee groups participating in the state's employee plans under Section 5-259 of the CT General Statutes.

- If an agency hires an employee in a full-time position that requires or is expected to require the employee's services for more than six months, the employee will be eligible to enroll in health insurance coverage on the first day of the month after completing 60 days of continuous service, even if the position is labeled as temporary.

Affordable Care Act (ACA) Considerations: An employee must meet both the employee eligibility criteria and the ACA requirements to be offered health coverage.

- If an employee works the required hours under the Affordable Care Act, the employing agency must decide whether to offer coverage. The State's ACA vendor tracks employee hours and notifies the Central Benefits Unit if employees may need coverage offers based on ACA guidelines.

- Central Benefits will notify the employee's agency, which must review each employee's status and decide whether to offer coverage or confirm that the employee should stay ineligible for health benefits.

- If, at the time of hire, the agency cannot reasonably determine whether a new employee will work an average of 30 hours per week, the employee is classified as a variable-hour employee. For such employees, the state will use a 12-month initial measurement period to assess whether they worked an average of 30 hours weekly. If they meet this threshold, the employee will be eligible to enroll in the health plan during the following 12 months, as long as they remain employed, regardless of the actual hours worked during that time.

4. Dependent Eligibility

Eligible dependents include the employee's legal spouse, a recognized civil union from another state, or the employee's or spouse's legal child.

Employees can enroll their eligible dependents in their health insurance coverage when they are initially hired, during the annual open enrollment period, or when they experience life events such as marriage, divorce, birth of a child, adoption, or the loss of coverage from another source. The employee must notify their agency of any life event that affects dependent eligibility within 31 days of the event.

To enroll a dependent, the employee must submit the necessary documents to prove their relationship. Appendix B details the required documentation. The employing agency is responsible for ensuring these documents are on file. Dependent status can change over time; therefore, the plan may periodically review dependent status by requesting current documentation to confirm ongoing eligibility.

If an employee becomes legally separated or divorced, the spouse is no longer eligible as a dependent. The employee must notify their agency within 31 days of the event to report the divorce or separation. The agency is responsible for removing the ex-spouse from coverage and sending a COBRA Notice to inform the

dependent losing coverage of the option to continue coverage through COBRA, which is at the full cost of the benefit plus a 2% administrative fee.

Dependent children are eligible for coverage until the end of the calendar year they turn 26. The Core-CT "overage-dependent" process automatically removes dependents who turn 26 on December 31st each year. The agency is responsible for issuing the COBRA notice to the dependent losing coverage.

Other Dependent Eligibility Considerations and Exceptions:

- A newborn is covered from the moment of birth. The employee has 91 days to enroll the newborn in coverage; however, the agency should be notified as soon as possible.

- A newborn of an enrolled female dependent child is eligible for coverage from birth through 91 days after birth. The newborn of a covered dependent child is not eligible for coverage beyond this 91-day period.

- A totally disabled child who cannot hold a job because of a physical or mental disability may keep their coverage past age 26, as long as they:
  - Are unable to sustain employment due to a physical or mental disability, as certified by a physician or treating provider.
  - The employee is primarily responsible for providing financial support and maintenance according to IRS guidelines.
  - The dependent became disabled before age 26 and had comparable coverage as a dependent at the time of enrollment; and
  - If the dependent is older than 26, they must be unmarried.

- The employee and the dependent child's treating physician or provider must complete the "Certification for a Mentally or Physically Impaired Dependent Child Over Maximum Age" form provided by the medical carrier. This form requires documentation that the dependent financially relies on the employee or the employee's spouse for support. Usually, this documentation is the employee's and/or spouse's federal tax return showing the child claimed as a dependent. Proof of ongoing disability and dependency must be submitted at least annually thereafter.

- A minor child living with a covered member and who has been legally appointed as the child's guardian by a court of competent jurisdiction can be enrolled as a dependent. Coverage will end when the child turns 18 or when the guardianship ends, whichever occurs first.

- If the covered person demonstrates that a former ward who was enrolled under the Plan immediately before turning 18 still qualifies as a dependent—either as a "qualifying child" or a "qualifying relative" for federal income tax purposes—coverage can continue beyond the age of legal guardianship until the last day of the calendar year in which the child turns 26. Proof of ongoing dependency must be provided each year. If the covered person maintains a parental or supportive relationship with a former ward who was enrolled in the Plan immediately before turning 18 but cannot claim the child as a dependent for federal income tax purposes, the fair market value of such coverage will be considered income to the covered person.

- A dependent child under 26 years old may be covered due to a domestic relations order (Qualified Medical Child Support Order) issued by a state court to a parent who is covered under the plan as an employee or spouse. Enrollment may be required even if the child was not previously covered under the Plan.

- A person who is divorced or legally separated from the employee is not eligible for coverage unless specific conditions are satisfied.

  – An individual from whom the Employee is legally separated may continue coverage under the Plan for up to three years after the judgment date or until either party remarries, whichever happens first. This is valid if the former spouse was covered by the Plan immediately before the legal separation judgment and the employee pays 100% of the total cost of individual coverage (Employee and state share for medical, pharmacy, and/or dental) for the former spouse on a post-tax basis. This amount will be in addition to the employee's own coverage costs; or

  – A person from whom the Employee is divorced can continue coverage under the Plan for up to three years after the judgment date or until either party remarries, whichever happens first. This applies if the ex-spouse was covered by the Plan immediately before the divorce and the judgment requires the covered employee to provide health insurance for the ex-spouse. **The covered employee pays 100% of the cost of individual coverage (Employee plus state share for medical, pharmacy, and/or dental) for the former spouse on a post-tax basis. This cost is in addition to the covered employee's own coverage expenses.**

5. Medicare Eligibility for Active Employees and Dependents Enrolled in the Active Employee Health Plan

Note: The eligibility rule varies when the employee and/or dependent is enrolled in the Retiree group health plan.

When an employee or dependent is enrolled in an active group health plan, the plan must follow Medicare Secondary Payor (MSP) rules for coordinating benefits. Coordination of Benefits occurs when an employee or dependent is enrolled in two health insurance plans. This section specifically explains how the coordination of benefits works with the State of CT's active employee group health plan and Medicare.

Members become eligible to enroll in Medicare for various reasons. Medicare eligibility typically depends on age, disability, or End-Stage Renal Disease (ESRD). The following section explains the requirements for Medicare enrollment and how the Coordination of Benefits functions in each case.

- **Age** - When an employee or dependent turns 65, they become eligible to enroll in Medicare. Under MSP rules, if an employee (or enrolled dependent) is 65 but is still actively working or enrolled as a dependent in an active group health plan, the group health plan remains the primary payor for all services. Since our plan provides very comprehensive coverage, enrolling in Medicare would not offer any additional benefits. Medicare Part A is free, so there is no harm in enrolling, but Medicare Part B requires a premium; therefore, we recommend waiting to enroll in Medicare Part B until the employee retires and enrolls in the retiree group health plan. Because the employee or dependent

is transitioning directly from an active group health plan to a retiree group health plan, they can enroll in Medicare without facing a late enrollment penalty.

- **Disability—**If an active employee or dependent is under 65 and qualifies for Medicare due to a disability, the active group health plan pays primary, and Medicare pays secondary. The disabled member is automatically enrolled in Medicare A and B based on their disability status.

- **End-Stage Renal Disease (ESRD)** - When an employee or dependent is enrolled in the active group health insurance plan and becomes eligible for Medicare due to a diagnosis of End-Stage Renal Disease (ESRD), the plan will coordinate with Medicare. The employee or dependent must sign up for Medicare Parts A & B after the 30-month coordination period. The MSP rules are as follows:
    - Initial Coordination Period (30 Months) – The active group health plan pays as primary.
        - After 30 months, Medicare becomes the primary payer, and the active group health plan pays secondary.
        - The dependent should receive a letter from Anthem 60 days before the end of the 30-month coordination period.
    - The member must sign up for Medicare Part A and Part B.
    - Medicare becomes the primary payer, and the active group health plan pays second.

    More details about Medicare are available at Medicare.gov:
    Welcome to Medicare | Medicare

6. COBRA Continuation Coverage

COBRA is a federally mandated program that enables employees or dependents who lose group health insurance coverage to extend their benefits for 30 or 36 months. The length of coverage depends on the reason for loss of coverage (such as termination, reaching the maximum age, divorce, etc.).

Coverage is provided at the full benefit cost plus a 2% administration fee. Employees or dependents who lose coverage have 60 days to enroll in COBRA; however, COBRA coverage is effective starting the day after their active coverage ends. There cannot be a gap in coverage.

Once an agency processes an employee termination or a family status change in Core-CT to remove a dependent from coverage, a COBRA Notice is generated. The agency will run the COBRA Notice the next day and mail it to the employee or dependent who is losing coverage. Anthem is the plan's COBRA administrator and handles the enrollment and billing process for COBRA coverage.

7. Cost

Premium rates are set each fiscal year and published during the annual open enrollment period. The employee and state share rates are entered into Core-CT, which automatically calculates the employee's payroll deductions based on their enrollment and coverage level. The employee share rates can be found on Care Compass.

8. Enrollment Timeframe: New Hire, Qualifying Life Events, and Open Enrollment

Employees have 31 days from their hire date to enroll in health insurance. Coverage begins on the first day of the month following the hire date. Each year, there is a four-week Open Enrollment period. This is the only time employees can modify their benefits or coverage. Open enrollment typically occurs in May, with coverage starting on July 1st.

The only time employees can make coverage changes outside of Open Enrollment is when they experience a qualifying life event. Qualifying life events include marriage, divorce, legal separation, birth or adoption of a child, death of an enrolled dependent, loss of coverage from another source, or voluntary termination of coverage with proof of other coverage. Coverage will start or end on the first day of the month following the date of the event. If an employee does not report a qualifying life event within 31 days, they will need to wait until the next Open Enrollment to update their coverage.

Employees must report qualifying events to their employing agency within 31 days of the event. It is the employee's responsibility to notify their agency if a dependent loses their status as an eligible dependent. The agency must promptly remove the ineligible dependent and send out a COBRA Notice.

9. Unpaid Leave of Absence, Benefits Billing, and Non-Payment of Premium

When an employee is on an unpaid leave of absence without paychecks, the agency issues them a Core-CT-generated bill for their portion of the health insurance cost. It is the employee's responsibility to pay their premium share according to the benefits billing payment terms.

Employees enrolled in Benefits Billing are billed monthly according to the benefit month. Usually, the benefit month runs from the 20th to the 19th of the next month, as specified by the benefits billing calendar. Payments are due on the third day of the benefit month. (Example: For the December 2025 benefit month, the billing period is 1225 and will appear as 11/20/25 - 12/19/25. The payment due date is 12/3/25.)

The agency mails out premium bills. The employee sends the payment back to the agency, where it is recorded in Core-CT. When the employee returns from unpaid leave, their payroll deductions for benefits will restart, and they will stop receiving bills.

Termination for Non-Payment Process (TNP)

The agency monitors that benefits billing payments are made on time, addresses delinquent payments, and initiates the termination process for non-payment promptly.

If the employee is 60 days overdue, the agency will send a certified termination for non-payment letter to the employee. The employee has 15 days from the date they receive the letter to make a payment to the agency.

If the certified TNP letter is signed for and the employee does not make a payment within 15 days, the agency must email a completed TNP checklist to the Central Benefits Unit at osc.benefitcorrections@ct.gov to process a TNP event.

If the certified TNP letter is returned to the agency as unclaimed or undeliverable, the agency must make at least one attempt to contact the employee about the unpaid billing balances before submitting a TNP request. The agency must record in the TNP checklist the date of the contact attempt and the outcome.

The Central Benefits Unit will process a TNP event to retroactively end the employee's health benefits for the months of coverage that have not been fully paid. A separate group life TNP event will be processed prospectively for those employees enrolled in the coverage.

The Central Benefits Unit will set the billing charges to zero and email a Confirmation Statement to the agency once the TNP event has been processed. The agency will review current and past health and group life benefits to ensure the coverage is accurate.

The employee will be deactivated in Benefits Billing, and their coverage will end on the first of the month after the TNP event date. A TNP event is not considered a COBRA qualifying event.

10. Amendments to this Policy

Employees are encouraged to stay updated on SEBAC negotiations, as changes could affect employee and dependent healthcare eligibility, premium contributions, and benefits. This policy may be modified due to future SEBAC contracts or amendments to Connecticut General Statutes.

Appendix A – Core-CT Benefit Program Definitions

Benefit Program	Description	Eligible Benefit
SCT	**Standard State Program** Employees in the SCT Benefit Program are eligible for health coverage at the state sponsored rates. They are eligible for Basic Life insurance after 6 months of continuous service if coded as Regular in the Regular/ Temporary field in Job Data. The employees may be eligible for Supplemental life insurance based on their union code and compensation rate. The employees have a minimum salary requirement of $45,500.00 for enrollment in Supplemental Life coverage.	Medical & Group Life Supplemental Life
NST	**Non-Bargaining Standard State Program** Employees in the NST Benefit Program have a non-bargaining union code and are eligible for health insurance. They are eligible for Extended Basic Life insurance. The employees are eligible for Supple-mental life based on their union code and compensation rate. The union code will determine if they have a minimum salary requirement for enrollment in Supple-mental life coverage.	Medical & Group Life Supplemental Life
HST	**Standard State Prgm-New Hires** The Benefit Program Date field in the Job Information tab in Job Data is populated with Hired On/After 7/1/2017. Employees in the HST Benefit Program are eligible for health coverage and Basic Group life insurance. They may also be eligible for the Supplemental life insurance plan based on their union code and compensation rate. The employees have a minimum salary requirement of $45,500.00 for enrollment in Supplemental life coverage.	Medical & Group Life Supplemental Life
HLN	**Supp Life No Min Sal Prgm-New Hires**	Medical & Group Life Supplemental Life

	Based on SEBAC17, the Benefit Program Date field in the Job Information tab in Job Data is populated with Hired On/After 7/1/2017. Employees in the HLN Benefit Program are eligible for health coverage and Basic Group life insurance. They may also be eligible for Supplemental life insurance without the minimum salary requirement based on their union code.	
SLN	**Supp Life No Min Sal Program** Employees in the SLN Benefit Program are eligible for health insurance at state sponsored rates and Basic Group Life insurance. They also may be eligible for Supplemental life insurance without the minimum salary requirement based on their union code.	Medical & Group Life Supplemental Life
GRD	**Grad Assistant Program-UCONN** Employees are eligible for the Graduate Assistant health plans and are not eligible for life insurance. The Employee Class field in the Job Information tab in Job Data must be populated with UOCGrad.	Medical (CT Partnership Plan)
HGA	**Grad Assistant Program-UCONN Health** Employees are eligible for the Graduate Assistant health plans and are not eligible for life insurance. The Employee Class field in the Job Information tab in Job data must be populated with GrdAstUCHC.	Medical (CT Partnership Plan)
PTN	**Part-Time w/out Sup Min Salary** Employees in the PTN Benefit Program are employed at the State Universities and UConn Health Center. They are coded as Regular. The majority of employees in this Benefit Program are part-time adjuncts/ lecturers with an FTE below .50. They are eligible for health coverage at the 100% rate. The employees are eligible for Basic Group Life insurance and Supplemental Life without a minimum salary requirement of $45,500.00.	Medical & Group Life Supplemental Life
PTS	**Part-Time w/Sup Min Salary**	Medical & Group Life Supplemental Life

	Employees in the PTS Benefit Program are employed at higher education agencies, UCONN and UConn Health Center. The employees have an FTE below .50 and are eligible for health coverage at the 100% rate if they are coded as Regular. Employees can be coded as Temporary at UCONN and are not eligible for health or life insurance. This Benefit Program includes part-time lectures. They are eligible for Extended Basic Life insurance based on their union code. They may be eligible for Supplemental life if they meet the minimum salary requirement of $45,500.00.	
SES	**Sessional Employee Program** Employees in the SES Benefit Program are employed by Legislative Management during a legislative session or as a University Assistant at the state Universities and the Board of Academic Awards. The University Assistants can be coded as Regular or Temporary. Employees in this Benefit Program are eligible for health insurance at the 100% rates and are eligible for Extended Basic life insurance if they are coded as Regular in the Regular/Temporary indicator field.	Medical & Group Life
FIV	**Legislators Program-5 Pay** Employees are eligible for health insurance at the 5 pay legislator rates are eligible for Extended Basic Life insurance. The Legislator Pay Freq field in the Benefit Program tab in Job Data must be set to FIV.	Medical & Group Life
LEG	**Legislators Program 12-Pay** Employees are eligible for health insurance at the 12 pay legislator rates and are eligible for Extended Basic Life insurance. The Legislator Pay Freq field in the Benefit Program Participation page must be set to TWL.	Medical & Group Life
AET	**Aetna Dis Premium Waive Program**	Not Valid

	The Benefit Program was included in Core conversion. The Benefit Program is no longer has any employees in it. Aetna is no longer the life insurance vendor.	
DPW	**Disability Premium Waiver Program** This Benefit Program is used by the Group Life unit only. Employees may be on leave or terminated. To be eligible, the Elig for Higher Life Coverage field must be populated with a value of **D**. Employees must complete an annual form from the life insurance vendor to remain eligible to be paid the full amount of their life insurance.	Group Life
HEN	**Part-Time w/no Sup Mn Sal-New Hires** Based on SEBAC17, the Benefit Program Date field in the Job Information tab in Job Data is populated with Hired On/After 7/1/2017. HEN only includes employees in the Department of Education (SDE) who are substitutes or teachers that are not certified. The employees can be coded as regular or temporary. Employees are not eligible for health insurance but are eligible for group life and supplemental life with no minimum salary requirement if they are coded as Regular in the Regular/Temporary indicator field in the Job Information tab in Job Data.	Group Life Supplemental Life
HES	**Part-Time w/Sup Mn Sal-New Hires** Based on SEBAC17, the Benefit Program Date field in the Job Information tab in Job Data is populated with Hired On/After 7/1/2017. Employees in the HES Benefit Program can be regular or temporary and have an FTE below .50. This Benefit Program includes Per Diem employees. Employees in the HES Benefit Program are not eligible for health insurance. They are eligible for Basic Group life insurance if they are coded as Regular in the Regular/ Temporary field in Job Data.	Group Life
NPS	**NB Part-Time w/Sup Min Sal** Employees in the Benefit Program can be regular or temporary and have an FTE below	Group Life

	.50. The majority of employees are in the National Guard. Judicial temps and Special Payroll employees are also included. The employees are not eligible for health insurance but may be eligible for Extended Basic life insurance based on the data entered in their key fields in Job Data including their Job Indicator, Job Code, Union Code and their status in the Regular/Temporary field.	
PEN	**Pre-Exist Elig w/no Sup Min Salary** The Benefit Program of PEN only includes employees in the Department of Education who are substitutes or teachers that are not certified. The employees can be coded as regular or temporary. Employees in this Benefit Program are not eligible for health insurance but are eligible for Basic group life insurance. They may be eligible for Supplemental Life with no minimum salary requirement if they are coded as Regular in the Regular/Temporary indicator field in the Job Information tab in Job Data.	Group Life Supplemental Life
PES	**Pre-Exist Elig w/Sup Min Salary** Employees in the PES Benefit Program can be regular or temporary and have an FTE below .50. This PES Benefit Program includes Per Diem employees. Employees in this Benefit Program are not eligible for health insurance but are eligible for Basic Group Life insurance if they are coded as Regular in the Regular/Temporary field in Job Data.	Group Life
RET	**Retiree Program** Employees in the RET Benefit Program may be eligible for retirement health insurance if	Retiree Health Group Life-Paid-up Policy

	they deemed eligible based on their age and years of service. If they were enrolled in life insurance as an active employee, they would be eligible for a full paid-up policy if they have 25 years of service. The amount of the life insurance policy will be pro-rated based on the employee's years of service if less than 25 years.	
STU	**Stdnt, Inmt, Patnt, Cntrct Pgm** Employees in the STU Benefit Program are not eligible for health or life insurance. This group also includes rehired retirees.	Not eligible.
LPO	**Leave Plan Only Program** Employees who have a Job Indicator of Secondary in Job Data are not eligible for health or life insurance.	Not eligible.

Appendix B: Dependent Eligibility Rules and Supporting Documentation Requirements

Copies are acceptable

Dependent	Relationship	Required Documents
Spouse	The lawful spouse of the Employee under a legally valid, existing marriage or a recognized civil union as defined by the State of Connecticut	• Marriage Certificate or Connecticut-issued Civil Union Certificate
Child(ren)	Biological children (up to the end of the calendar year in which they turn age 26)*	• Long Form Birth Certificate listing parents
	Legally adopted children (up to the end of the calendar year in which they turn age 26)*	• Adoption documentation issued by the appropriate agency or a certified copy of the adoption decree
	Stepchildren (up to the end of the calendar year in which they turn age 26)	• Long Form Birth Certificate **AND** • Marriage Certificate
	Children under legal guardianship (to age 18)**	• Proof of guardianship or custody from a court of competent jurisdiction **AND** • Form CO-1318***
	Children covered under a Qualified Medical Child Support Order	• Qualified Medical Child Support Order (QMCSO) issued by a Government Agency or Court

***** Disabled Children over age 26 are certified and verified by the medical insurance carrier.

** Continuation of coverage for a former ward after termination of legal guardianship may continue after age 18 if the covered person demonstrates that a former ward who was enrolled under the Plan immediately before reaching the age of 18 continues to be dependent upon them either as a "qualifying child" or a "qualifying relative" for federal income tax purposes. Proof of continued dependency must be provided annually. If the covered person continues in a parental/supportive relationship to a former ward who was enrolled in the Plan immediately before reaching the age of 18, but is not eligible to claim the child as a Dependent for federal income tax purposes, the fair market value of such coverage will be imputed as income to the covered person.

***Form CO-1318 is available at https://carecompass.ct.gov/forms (search 1318).