

24 §2319-A. MANDATED OFFER OF DOMESTIC PARTNER BENEFITS

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1. Definition. As used in this section, unless the context otherwise indicates, "domestic partner" means the partner of a subscriber or member who:

A. Is a mentally competent adult as is the subscriber or member; [2001, c. 347, §1 (NEW); 2001, c. 347, §5 (AFF).]

B. Has been legally domiciled with the subscriber or member for at least 12 months; [2001, c. 347, §1 (NEW); 2001, c. 347, §5 (AFF).]

C. Is not legally married to or legally separated from another individual; [2001, c. 347, §1 (NEW); 2001, c. 347, §5 (AFF).]

D. Is the sole partner of the subscriber or member and expects to remain so; and [2001, c. 347, §1 (NEW); 2001, c. 347, §5 (AFF).]

E. Is jointly responsible with the subscriber or member for each other's common welfare as evidenced by joint living arrangements, joint financial arrangements or joint ownership of real or personal property. [2001, c. 347, §1 (NEW); 2001, c. 347, §5 (AFF).]

[2001, c. 347, §1 (NEW); 2001, c. 347, §5 (AFF) .]

2. Mandated offer of domestic partner benefits. All individual or group contracts issued by any nonprofit hospital or medical service organization operating pursuant to this chapter must make available to an individual or group policyholder the option for additional benefits for the domestic partner of a subscriber or member, at appropriate rates and under the same terms and conditions as those benefits or options for benefits are provided to spouses of married subscribers or members covered under an individual or group policy.

[2001, c. 347, §1 (NEW); 2001, c. 347, §5 (AFF) .]

3. Financial dependency. Financial dependency of a domestic partner on the subscriber or member may not be required as a condition for eligibility for coverage.

[2001, c. 347, §1 (NEW); 2001, c. 347, §5 (AFF) .]

4. Evidence of domestic partnership. As a condition of eligibility for coverage, a nonprofit hospital and medical service organization or a group policyholder may require a subscriber or member and the subscriber's or member's domestic partner to sign an affidavit attesting that the subscriber or member and the subscriber's or member's domestic partner meet the definition in subsection 1 and to show documentation of joint ownership or occupancy of real property, such as a joint deed, joint mortgage or joint lease, or the existence of a joint credit card, joint bank account or powers of attorney in which each domestic partner is authorized to act for the other.

[2001, c. 347, §1 (NEW); 2001, c. 347, §5 (AFF) .]

5. Preexisting conditions. A domestic partner is subject to the same provisions on coverage of preexisting conditions as any spouse or dependent of a subscriber or member.

[2001, c. 347, §1 (NEW); 2001, c. 347, §5 (AFF) .]

6. Termination of domestic partner benefits. A nonprofit hospital and medical service organization may terminate coverage in accordance with other applicable provisions of this Title for the domestic partner of a subscriber or member upon notification by the subscriber or member that the domestic partner

relationship has terminated. A subscriber or member may not enroll another individual as a domestic partner under an individual or group contract until 12 months after the termination of coverage for a prior domestic partner.

[2001, c. 347, §1 (NEW); 2001, c. 347, §5 (AFF) .]

7. Construction. This section does not prohibit a nonprofit hospital and medical service organization from negotiating a policy providing domestic partner benefits to a policyholder that does not comply with the requirements of this section.

[2001, c. 347, §1 (NEW); 2001, c. 347, §5 (AFF) .]

SECTION HISTORY

2001, c. 347, §1 (NEW). 2001, c. 347, §5 (AFF).

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