DEPARTMENT OF LABOR
DIVISION OF PAID LEAVE
1400 Division of Paid Leave

1401 Rules Defining and Regulating the Healthy Delaware Families Act, Family and Medical Leave Insurance Program and the Division of Paid Leave

1.0 Definitions

The following words and terms, when used in this regulation, have the following meaning:

"**Act**" means the Healthy Delaware Families Act. 19 **Del.C.** Ch. 37.

"**Application year**" means the 12-month period of leave as defined in the Family Medical Leave Act ("FMLA") Regulations, 29 CFR 825.200(b).

"**Average weekly wage**" means the employee's gross earnings, whether salaried or hourly (prior to any payroll deductions or withholdings) for the prior 52 weeks divided by 52.

"**Board**" means Family and Medical Leave Insurance Appeal Board.

"**Child**" means "son or daughter" as defined in the FMLA Regulations, 29 CFR 825.

"**Continuing treatment**"" means as defined in the FMLA, 29 CFR 825.102.

"**Covered active duty**" means duty during the deployment of the member with the Armed Forces to a foreign country; and duty during the deployment of a reserve member with the Armed Forces to a foreign country under a call or order to active duty under a provision of law referred to in Section 101(a)(13)(B) of Title 10 of the United States Code. 10 USC §101(a)(13)(B).

"**Covered individual**" means an individual employed for at least 1,250 hours of service performed within the territory of the State of Delaware with the employer during the previous 12-month period.

"**Department**" means Department of Labor.

"**Division**" means Department of Labor, Division of Paid Leave.

"**Employee**" means an individual employed by an employer. For purposes of the Act, individuals primarily reporting for work at a worksite in this State are employees unless otherwise excluded. "Primarily" is defined as working at least 60% of an employee's work hours physically in Delaware each calendar quarter. Individuals primarily reporting for work at a worksite or telecommuting outside of this State are not considered employees under the Act unless the employer and employee elect in writing to reclassify them as such. Employee does not include those in business for themselves in a non-corporate form who offer services to the public as a sole proprietor or partner in a partnership. Notwithstanding, these individuals may "reclassify" to be considered employees to participate in the Paid Family and Medical Leave Insurance Program 19 **Del.C.** Ch. 37 ("PFML"). An "employee" under PFML does not include the following types of individuals:

- Federal government workers, railroad workers, and employees of Tribal Governments;
- State of Delaware employees in a casual/seasonal position covered under §5903(17)a. of Title 29; and
- Department of Education employees who are in a casual/seasonal position that would be covered under §5903(17)a. of Title 29, or in an equivalent casual/seasonal position with an entity covered by State employee benefits.

"**Employer**" means those who engage in commerce, or any industry or activity affecting commerce, anywhere within the State of Delaware as well as those acting, directly or indirectly, in the interest of a covered employer to any of the employees of the employer, subject to the limitations set forth in the Act. Employer also includes any successor in interest of the employer as defined by 29 CFR 825.107, an integrated employer as defined by 29 CFR 825.104(c)(2), and a joint employer where 2 or more businesses exercise some control over the work or working conditions of the employee. Joint employers may be separate and distinct entities with separate owners, managers, and facilities. For purposes of the PFML, the employer who actually pays the employee will be considered that individual's employer.

"**Family and Medical Leave Act**" or "**FMLA**" means the Family and Medical Leave Act of 1993, 2006 (29 USC §§2601-2654).

"**Family caregiving**" means those acts as set forth in the Act.

"**Family member**" means parent, child, and spouse, but it does not include siblings, parents-in-law, or any other relations not specified.

"**Fund**" means the Family and Medical Leave Insurance Account Fund created by the Act.

"**Health care provider**" means as defined under the FMLA 29 CFR 825.125.

"**Inpatient care**" means an overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity as defined in 29 CFR 825.113(b) or any subsequent treatment in connection with the inpatient care.

"**Line of coverage**" means the different coverages for the 4 different types of leave that are authorized under the Act:

- Parental leave: Leave authorized which offers covered individuals time off in the event of the birth, adoption, or fostering of a child.
- Family caregiving leave: Leave authorized which offers covered individuals time off in the event of a serious health condition (illness or accident) of a child, spouse, or parent.
- Medical leave: Leave authorized which offers covered individuals time off in the event of a serious health condition (illness or accident) of the employee themselves.
- Qualified Exigencies: Leave authorized which offers covered individuals time off for qualified issues that arise in connection with a military deployment.

"**Parent**" means as defined under the FMLA, 29 U.S.C. §2611(7).

"**Private plan**" means a paid time off employee benefit to which the State of Delaware is not a party to the agreement, except in instances where the State of Delaware is the employer.

"**Public plan**" or "**PFML**" means the paid family and medical leave insurance program created by the Act.

"**Qualifying exigency**" means as defined under the FMLA, 29 CFR §825.126.

"**Serious health condition**" means as defined under the FMLA. including 29 CFR 825.113 and 29 CFR 825.113.

"**Small business**" means those who employ 9 or less employees working anywhere within the State for the parent leave benefit and means those who employ 24 or less employees working anywhere within the State for family caregiving and medical leave benefits.

"**Spouse**" means as defined under the FMLA, 29 CFR 825.102.

2.0 Relevant federal laws and regulations

2.1 Application year under FMLA. The employer has the right to choose which method of counting the 12-month period works best for its business. Whichever method is chosen by the employer must be uniformly applied to all employees. Any change to an employer's selected application year must be made in accordance with 29 CFR 825.200. FMLA provides the 12-month period can be established in any of the following ways:

2.1.1 "Calendar year" is a 12-month period that runs from January 1 through December 31;

2.1.2 "Any fixed 12-months" is a 12-month period such as a fiscal year, a year starting on an employee's anniversary date, or a 12-month period required by state law;

2.1.3 "12-month period measured forward" is a 12-month period measured forward from the first date an employee takes family and medical leave. The next 12-month period would begin the first-time family and medical leave is taken after completion of the prior 12-month period; or

2.1.4 "A 'rolling' 12-month period measured backward" is 12-month period measured backward from the date an employee uses any family and medical leave. Under the "rolling" 12-month period, each time an employee takes family and medical leave, the remaining leave entitlement would be the balance of the 12 weeks which has not been used during the immediately preceding 12-months.

2.2 Spouses, children, and parents under FMLA

2.2.1 A spouse, under the FMLA, is a husband or wife as defined or recognized in the state where the individuals were married and includes persons in common law or same-sex marriage. Spouse also includes a husband or wife in a marriage that was validly entered into outside of the United States if the marriage could have occurred here in at least 1 State. 29 CFR 825.102.

2.2.2 A "son or daughter" under the FMLA is a biological, adopted, or foster child, a stepchild, a legal ward, or a child of person standing *in loco parentis* who is either:

2.2.2.1 Under 18 years of age; or

2.2.2.2 18 years of age or older and incapable of self-care because of a mental or physical disability at the time that leave under the FMLA is to commence.

2.2.3 A parent under the FMLA is the biological, adoptive, step, foster father or mother, or any other individual who stood in loco parentis to the employee when the employee was a son or daughter as defined by FMLA. This term does not include parents "in law".

2.2.3.1 "*In loco parentis*" includes those with day-to-day responsibilities to care for and financially support a child.

2.2.3.2 An employee is to provide sufficient information to make the employer aware of the in loco parentis relationship. A simple statement asserting the relationship, including the name of the child and a statement of the employee's *in loco parentis* relationship to the child may be sufficient.

2.3 Health care provider, serious health condition, and continuing treatment under FMLA

2.3.1 A health care provider under the FMLA includes:

2.3.1.1 A Doctor of Medicine or osteopathy who is authorized to practice medicine or surgery (as appropriate) by the State in which the doctor practices; or

2.3.1.2 Any other person determined by the State to be capable of providing health care services. Others capable of providing health care services include only:

2.3.1.2.1 Podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist) authorized to practice in the State and performing within the scope of their practice as defined under State law;

2.3.1.2.2 Nurse practitioners, nurse-midwives, clinical social workers, and physician assistants who are authorized to practice under State law and who are performing within the scope of their practice as defined under State law;

2.3.1.2.3 Christian Science Practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts. Where an employee or family member is receiving treatment from a Christian Science practitioner, an employee may not object to any requirement from an employer that the employee or family member submit to examination (though not treatment) to obtain a second or third certification from a health care provider other than a Christian Science practitioner except as otherwise provided under applicable State or local law or collective bargaining agreement;

2.3.1.2.4 Any health care provider from whom an employer or the employer's group health plan's benefits manager will accept certification of the existence of a serious health condition to substantiate a claim for benefits; and

2.3.1.2.5 A health care provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country, and who is performing within the scope of the health care provider's practice as defined under that country's law.

2.3.1.3 The phrase "authorized to practice" as used in subsection 2.3 means that the provider must be authorized to diagnose and treat physical or mental health conditions by the state where they practice.

2.3.2 Serious health condition under the FMLA is an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider.

2.3.2.1 Treatment does not include routine physical examinations, eye examinations, or dental examinations.

2.3.2.2 Ordinarily, unless complications arise, the common cold, the flu, earaches, upset stomach, minor ulcers, headaches other than migraine, routine dental or orthodontia problems, periodontal disease, etc., are examples of conditions that do not meet the definition of a serious health condition and do not qualify for PFML. Conditions for which cosmetic treatments are administered (for example, most treatments for acne or plastic surgery) are not serious health conditions unless inpatient hospital care is required or unless complications develop. Restorative dental or plastic surgery after an injury or removal of cancerous growths are serious health conditions provided all the other conditions of the FMLA regulation are met. Mental illness or allergies may be serious health conditions but only if all the conditions of 29 CFR 825.113 are met.

2.3.3 Continuing treatment by a health care provider under the FMLA includes incapacity and treatment; pregnancy and prenatal care; chronic conditions; permanent or long-term conditions; and conditions requiring multiple treatments. Treatment is an in-person visit to a health care provider. The first in-person treatment visit must take place within 7 days of the first day of incapacity. Whether additional treatment

visits or a regimen of continuing treatment is necessary within the 30-day period shall be determined by the health care provider.

2.3.3.1 Permanent or long-term conditions include Alzheimer's, a severe stroke, or the terminal stages of a disease.

2.3.3.2 Absences attributable to incapacity qualify for leave even though the employee or the covered family member does not receive treatment from a health care provider during the absence, and even if the absence does not last more than 3 consecutive, full calendar days.

2.4 Employee hours, work location and job protection

2.4.1 For purposes of determining the service hours requirement, the legal standard under the FMLA is "those hours actually worked for the employer." Time not actually worked, whether paid leave or unpaid leave, including vacation, holidays, furlough, sick leave, leave under the FMLA, or other time off is not included. Per 29 CFR 825.110, whether the employee has worked the minimum 1,250 hours of service is determined by the principles of the Fair Labor Standards Act.

2.4.2 The determination of whether an employee's particular work hours or wages were earned in Delaware or outside of Delaware shall be determined according to whether the income that arose from those hours or wages was withheld from the employee's paycheck as in-state or out-of-state by the Delaware Department of Finance's rules and regulations.

2.4.3 Equivalent position under the FMLA is one that is virtually identical to the employee's former position in terms of pay, benefits and working conditions, including privileges, prerequisites, and status. It must involve the same or substantially similar duties and responsibilities, which must entail substantially equivalent skill, effort, responsibility, and authority.

2.5 Integrated employer and successor in interest

2.5.1 An integrated employer exists where separate entities are deemed to be part of a single employer for purposes of FMLA, based upon the entire relationship between the entities viewed in its totality. Factors considered in determining an integrated employer include:

2.5.1.1 Common management;

2.5.1.2 Interrelation between operations;

2.5.1.3 Centralized control of labor relations; and

2.5.1.4 Degree of common ownership/financial control.

2.5.2 Successor in interest. The factors to consider when determining if an employer is a "successor in interest" are as follows:

2.5.2.1 Substantial continuity of the same business operations;

2.5.2.2 Use of the same plant;

2.5.2.3 Continuity of the work force;

2.5.2.4 Similarity of jobs and working conditions;

2.5.2.5 Similarity of supervisory personnel;

2.5.2.6 Similarity in machinery, equipment, and production methods;

2.5.2.7 Similarity of products or services; and

2.5.2.8 The ability of the predecessor to provide relief.

2.5.3 A successor in interest is determined by the totality of the circumstances, when considering the factors set forth in subsections 2.5.2.1 - 2.5.2.8. When an employer is a successor in interest, employees' entitlements are the same as if the employment by the predecessor and successor were continuous employment by a single employer.

2.6 Qualified exigency under FMLA

2.6.1 Qualified exigency is a separate line of coverage which has its own FMLA rules and regulations but is required under the Act to be combined with family caregiving leave in terms of eligibility and contributions. The Act combines coverage for both qualified exigencies and family caregiving leave into a single contribution rate, so both coverages must be provided by employers.

2.6.2 Qualified exigency leave under the FMLA occurs "while the employee's spouse, son, daughter, or parent is on covered active duty or call to covered active-duty status (or has been notified of an impending call or order to covered active duty)." FMLA regulations limits "active-duty status" for the sake of qualified exigency leave to deployment in a foreign country. FMLA further defines a "qualifying exigency" as:

2.6.2.1 Issues arising from the military member's short notice deployment (i.e., deployment within 7 or less days of notice). For a period of up to 7 days from the day the military member receives notice of deployment, an employee may take qualifying exigency leave to address any issue that arises from the short notice deployment;

2.6.2.2 Attending military events and related activities, such as official ceremonies, programs, events and informational briefings, or family support or assistance programs sponsored by the military, military service organizations, or the American Red Cross that are related to the member's deployment;

2.6.2.3 Certain childcare and related activities arising from the military member's covered active duty, including arranging for alternative childcare, providing childcare on a non-routine, urgent, immediate need basis, enrolling in or transferring a child to a new school or day care facility. The employee taking FMLA qualifying exigency leave does not need to be related to the military member's child; however:

2.6.2.3.1 The military member must be the parent, spouse, son, or daughter of the employee taking FMLA leave; and

2.6.2.3.2 The child must be the child of the military member (including a child to whom the military member stands *in loco parentis*).

2.6.2.4 Certain activities arising from the military member's covered active duty related to care of the military member's parent who is incapable of self-care, such as arranging for alternative care, providing care on a non-routine, urgent, immediate need basis, admitting or transferring a parent to a new care facility, and attending certain meetings with staff at a care facility, such as meetings with hospice or social service providers. The employee taking FMLA qualifying exigency leave does not need to be related to the military member's parent; however:

2.6.2.4.1 The military member must be the parent, spouse, son, or daughter of the employee taking FMLA leave; and

2.6.2.4.2 The parent must be the parent of the military member (including an individual who stood *in loco parentis* to the military member when the member was a child).

2.6.2.5 Making or updating financial and legal arrangements to address a military member's absence while on covered active duty, including preparing and executing financial and healthcare powers of attorney, enrolling in the Defense Enrollment Eligibility Reporting System, or obtaining military identification cards;

2.6.2.6 Attending counseling for the employee, the military member, or the child of the military member when the need for that counseling arises from the covered active duty of the military member and is provided by someone other than a health care provider;

2.6.2.7 Taking up to 15 calendar days of leave to spend time with a military member who is on short-term, temporary Rest and Recuperation leave during deployment. The employee's leave for this reason must be taken while the military member is on Rest and Recuperation leave;

2.6.2.8 Certain post-deployment activities within 90 days of the end of the military member's covered active duty, including attending arrival ceremonies, reintegration briefings and events, and other official ceremonies or programs sponsored by the military, and addressing issues arising from the death of a military member, including attending the funeral; and

2.6.2.9 Any other event that the employee and employer agree is a qualifying exigency.

3.0 Eligibility for benefits; serious health condition; certification or documentation of leave

3.1 Employer exclusions. For purposes of the Act, the following are not considered employers and are excluded from coverage under the Act:

3.1.1 Anyone who employs less than 10 employees;

3.1.2 The Federal government; or

3.1.3 Employers that completely close their business for 30 consecutive days or more per year. To qualify under this exception, employers must not pay its employees during the annual closure, and the employer must not do any business with any client.

3.2 Employer eligibility and employee threshold number.

3.2.1 To be eligible under the Act, an employer must first employ the minimum number of employees who are subject to the provisions of the Act (the "threshold number") during the previous 12-month period. As

contributions begin on January 1, 2025, the initial 12-month period to determine the employer's employee threshold number will be the 12-month period prior to the start of contributions. For parental leave, that threshold number is 10 employees. For family caregiving and medical leave, that threshold number is 25 employees. Employees subject to the provisions of the Act are those who meet or are reasonably expected to meet the requirements of a covered individual under the Act, being the 12-month employment period requirement and the 1,250 hours of service requirement during the previous 12-month period.

3.2.2 Employees who are covered by a waiver as set forth in subsection 6.8 of this regulation, signed by both the employer and employee, are excluded from this count towards the 10 or 25 employee threshold numbers. Employees who would normally be excluded from the count, as they are physically employed outside of Delaware, but who have signed a reclassification form, as set forth in subsection 6.15 of this regulation, with their employer, shall be included in this count towards the 10 or 25 employee threshold numbers.

3.3 Employers with fewer than 10 employees. If the number of employees working for an employer is below 10 for all of the previous 12-months (the "lookback period"), that employer shall not be subject to any of the provisions of the Act, unless they elect to "opt-in" to any of the lines of coverage as permitted by the provisions of the Act. Those employees on waivers are not included in this count, while those employees who have been reclassified are included in this count.

3.4 Employers with 10 to 24 employees. Employers that have 10 but fewer than 25 employees during the previous 12-months shall only be subject to the parental leave provisions of the Act.

3.4.1 This means that once an employer has 10 or more employees, they are required to provide parental leave coverage for at least the next 12-months, within 30 days after which the employer threshold count rose to 10 or more employees.

3.4.2 If more than 12 consecutive months pass and the employer continues to stay below 10 employees, the employer will no longer be required to provide parental leave coverage, effective the next pay period after they fall below 10 employees for 12 consecutive months.

3.4.3 If the employee count should thereafter rise to 10 or more (but fewer than 25) employees, the employer will once again be required to provide parental leave coverage for at least the next 12-months, within 30 days after which the employee count rose to 10 or more employees.

3.4.4 At any time while the employee count is between 10 and 24 employees, the employer may select to voluntarily "opt-in" to any of the other lines of coverage per the provisions of the Act.

3.4.5 Those employees with waivers are not included in this count towards either the 10 or 25 employee threshold numbers, while those employees who have been reclassified are included in this count.

3.4.6 If an employee is on leave, that leave will continue as approved, even if an employer's employee threshold count has decreased and ended an employer's obligation to provide a particular line of coverage. This applies to both continuous and reduced or intermittent leave approved prior to the change in the employee threshold count.

3.5 Employers with more than 24 employees. An employer with 25 or more employees during the previous 12-months shall be subject to the parental, family caregiving, medical leave, and qualified exigency leave provisions of the Act.

3.5.1 If the employee count should fall under 25 employees, the employer will still be required to provide all lines of coverage until the employee count remains below the 25 employee threshold for 12 consecutive months. On the 13th consecutive month, if the employer is still below the threshold, they will no longer be required to offer medical leave, family caregiving leave, or qualified exigency leave.

3.5.2 If the employee count should ever rise above 24 employees, the employer will once again be required to provide all lines of coverage for at least the next 12-months, within 30 days after which the employer threshold count rose above 24 employees.

3.5.3 Those employees on waivers are not included in this count towards the 25 employee threshold number, while those employees who have been reclassified are included in this count.

3.6 Employee notice. Whenever an employee gains or loses any coverage provided under the Act due to a change in the number of employees in the employer, the employer must provide notice to its employees within 30 days of the date of the change in coverage.

3.7 Continuation of waivers and reclassifications. If an employee and employer sign a waiver where the employee acknowledges that the terms of their employment do not anticipate them meeting the requirements for coverage, the waiver remains in effect regardless of any fluctuation in the employer's threshold account.

3.7.1 If an employee has signed a waiver to decline coverage, they will not need to sign a new waiver in the event that the employer should fall below 9 employees for more than 12-months, then rise back above 9 employees at some point thereafter.

3.7.2 If an employee and employer sign a reclassification form where the employee acknowledges that they should be included in this PFML insurance program despite the employee not being physically located in the State of Delaware, the reclassification remains in effect regardless of any fluctuation in the employer's threshold count. If an employee has signed a reclassification to accept coverage, they will not need to sign a new reclassification form if the employer should fall below 9 employees for more than 12-months, then rise back above 9 employees at some point thereafter.

3.8 Certification. A certification from a health care provider is sufficient if it contains all of the following:

3.8.1 Date on which the serious health condition began;

3.8.2 Probable duration of the serious health condition;

3.8.3 Appropriate medical facts known to the medical provider regarding the condition;

3.8.4 Statement that either:

3.8.4.1 The covered individual is needed to care for the family member who has a serious health condition, along with an estimate of the time the covered individual will need to care for the family member; or

3.8.4.2 The covered individual is unable to perform the functions of the covered individual's position due to their own serious health condition.

3.8.5 If leave is going to be taken intermittently or on a reduced leave schedule for planned medical treatment, the certification must include the dates on which the medical treatment is expected to be given and the duration of the medical treatment.

3.8.6 If leave is to be taken intermittently or on a reduced leave schedule by a covered individual to care for a family member who has a serious health condition, then the statement should include that the intermittent or reduced leave schedule is necessary for the care of the family member with the serious health condition or will assist in the family member's recovery and the expected duration and schedule of the intermittent or reduced leave.

3.8.7 If leave is going to be taken intermittently or on a reduced leave schedule for covered individual who has a serious health condition, the statement should include a determination that the intermittent or reduced leave schedule is medically necessary and the expected duration of intermittent or reduced leave.

3.8.8 This certification may also require any other information as the Division may determine. The employee is responsible for the cost of obtaining the initial certification form.

3.8.9 Validity of certification. Any reason to doubt the validity of a certification means the employer, or approved private plan administrator has credible, objective evidence that would reasonably support a belief to suspect, question or not trust the legitimacy or soundness of a certification of a serious health condition submitted on the behalf of a covered individual.

3.8.9.1 Health care provider opinions. If the employer or approved private plan reasonably believes the certification provided by the health care provider is invalid for the reasons set forth in subsection 3.8.9, then an employer or approved private plan can request, at its expense, a second opinion.

3.8.9.2 Should the second opinion differ from the first, the employer or approved private plan may request, from a health care provider mutually agreed upon by all parties, a third opinion, which shall also be at the expense of the employer or approved private plan.

3.8.9.3 Provisional leave when obtaining second or third opinion. Once a claim has been approved, leave and benefit payments will begin and will continue while any second or third opinion is being obtained.

3.9 Recertification standards. The standards to determine a reasonable basis for recertification may be governed by a collective bargaining agreement. If no collective bargaining agreement or provision in an agreement exists, the standard to determine a reasonable basis for recertification is objective, specific evidence of an event that brings the seriousness of the health issue into doubt.

3.9.1 This evidence shall be set forth in a sworn, notarized statement by those with direct knowledge of the event in question.

3.9.2 Only 1 recertification process can be requested or required every 30 days.

3.9.3 Employers shall process a recertification request through the Division's online portal, which will provide the necessary forms and notice of the request to the appropriate parties.

3.9.4 It is unreasonable for an employer to request a recertification prior to the expiration of the leave period set forth in the initial medical certification, unless the employer has a reasonable basis to do so, based upon objective, specific evidence of an event that brings the seriousness of the health issue into doubt.

3.10 Payment for recertification. Should any amount for recertification not be covered by a covered individual's health insurance, an employer or private plan is responsible for the cost of obtaining a recertification. As with all aspects of plan administration, the recertification process is subject to audits by the Division. If the Division determines that the employer routinely requires employees on approved leave to undergo the recertification process where it becomes a pattern of behavior, especially if the majority of those recertification processes reconfirm the justification for the employee's leave, the employer may be subject to either the job protections provisions or the retaliation provisions of the Act.

3.11 Documentation or self-certification. Documentation demonstrating the nature and extent of the relationship between the covered individual and the family member with the serious health condition may include self-certification by the applicant on a form in the Division's online portal, as the Division may determine.

3.12 Penalty. If a willfully false claim is made, the individual shall be disqualified from receiving benefits for 3 years and the Division shall seek repayment of any benefits improperly paid from the Fund and may seek an additional penalty of up to 50% of overpayment and a penalty as permitted by the Act. The case may also be referred to the Delaware Department of Justice for investigation and possible prosecution.

4.0 Duration of benefits

4.1 Maximum allowable benefit period. Depending on the type of leave, covered individuals can only take a maximum of 12 weeks of PFML in any application year. If a covered individual in the public plan should elect to return to work earlier than the date provided for in the approved leave schedule, the covered individual's benefit payments will end 1 week after the payment period in which they returned.

4.1.1 Parental leave. The maximum duration of approved parental leave is 12 weeks in any application year.

4.1.1.1 The Act provides employers with 10 to 24 employees with the option to temporarily reduce the parental leave maximum benefit duration from 12 weeks to a minimum of 6 weeks for claims submitted prior to January 1, 2031 (the first 5 years after the start of benefits on January 1, 2026). To qualify for this option to temporarily reduce the maximum benefit duration, employers must notify the Division of their intention to do so by January 1, 2024.

4.1.1.2 If prior to January 1, 2031, employers who have availed themselves of this reduced parental leave option decide to offer the full 12 week benefit for parental leave claims, the employer may do so by notifying the Division.

4.1.1.3 Employers who chose to reduce maximum parental leave benefits must inform their employees, in writing, of this decision no later than December 1, 2024.

4.1.1.4 If the Division receives a complaint that the changes were discriminatory or done in a discriminatory manner, the Division shall investigate the claims as it would any other claim of discrimination.

4.1.2 Family caregiving leave. If the covered individual is on approved family caregiving leave and that person dies, the reason for that leave has ended. For the public plan, the Division may continue paying the benefit to the covered individual until 7 days after the death of the family member or the previously approved end date for the leave. The covered individual must notify the employer and the Division via the Division's online portal of the date of death of this family member for whom the covered individual was caring within 72 hours of the person's passing. The job protection provisions of the Act also remain in effect as they would during any other period of approved leave.

4.1.3 Family and medical leave look-back period. The maximum aggregate number of weeks during which benefits are payable for family caregiving leave and medical leave is 6 weeks in any 24-month period. For all new claim applications, a look-back period will be required. The Division determines the look-back period is the 24-month period that ends on the first day of requested leave.

4.2 Parent or multiple family members. The Division may limit aggregate family caregiving leave requested when multiple employees who are family members work for the same employer and are requesting leave for the same qualifying event. The Division hereby determines those limits are that both employees who are family members may take the full amount of leave that they would otherwise be allowed, but the employees may not

take leave concurrently, unless the employer decides that all similarly situated covered individuals shall be allowed to take leave concurrently.

4.2.1 If an employer decides that 1 set of covered individuals in the same or an equivalent situation can take leave concurrently, then all similar requests for that employer thereafter shall be allowed to be done concurrently.

4.2.2 When 2 parents working for the same employer are both entitled to parental, family caregiving or qualified exigency leave for the same qualifying event, the employer may limit the aggregate number of weeks of leave to which they may be entitled to 12 weeks during any 12-month period.

4.3 Receipt of a completed application. An employer, insurance carrier, or third-party administrator has 5 business days after the receipt of a completed application to approve or deny the claim for benefits.

4.3.1 The date of an employer, insurance carrier, or third party administrator's receipt of the completed application is not counted. The 5 business day time period does not begin until an employer, insurance carrier, or third party administrator is in receipt of all necessary documentation, including the required documentation from the relevant healthcare provider. Upon review of the claim, if the employer, insurance carrier, or third party administrator finds the information required to make a decision is missing or materially incorrect, then the employer, insurance carrier, or third party administrator will notify the employee that the claim is incomplete and additional information is needed. The 5 business day time frame will again begin upon receipt of an updated claim application from the employee.

4.3.2 For the PFML public plan, once all of the required information has been uploaded to the Division's online portal by the appropriate parties, the software system will provide an advisory notice to the employer regarding the approval or denial of a claim.

4.3.3 The final decision to approve or deny a claim, however, will be made by an employer, insurance carrier, or third party administrator based on the totality of the circumstances known to the employer, insurance carrier, or third party administrator.

4.3.4 To approve a public plan claim, an employer must do so through the Division's online electronic system. If not already in the system, all supporting documentation relied upon by the employer to adjudicate the claim must be uploaded into the Division's online electronic system, or its insurance carrier's administrative system, within 3 business days of a claim being approved under the Act.

4.3.5 Upon approving an application, the employer, insurance carrier or third-party administrator, shall provide the claimant with written notice of this determination. If approval was for public plan benefits done within the Division's online portal, the covered individual will automatically receive the required notification electronically through an electronic mail system to the email address provided.

4.3.6 If approval is done by an insurance carrier or third-party administrator, written notice shall be provided through an electronic mail system, if the covered individual's email address is known to the insurance carrier/administrator, or via regular mail.

4.3.7 The written approved notice referred to above shall include at least the following information:

4.3.7.1 The amount of the benefit payment;

4.3.7.2 The party or parties to whom the benefit payment instrument is made payable;

4.3.7.3 The party to whom the benefit payment instrument was forwarded;

4.3.7.4 The address of the party to whom the benefit payment instrument was forwarded; and

4.3.7.5 The date benefit payments began and expected date they will end, if known.

4.3.8 If a claim is denied, an employer shall notify the employee and provide the reason for denial.

4.3.8.1 If the denial was for public plan benefits submitted through the Division's online portal, the covered individual will automatically receive the required notification electronically through an electronic mail system to the email address provided by the employee.

4.3.8.2 If the denial is through an insurance carrier or third-party administrator, written notice shall be provided through an electronic mail system, if the covered individual's email address is known to the insurance carrier/administrator, or via regular mail.

4.3.8.3 The employer must ensure that all documents relating to the claim application and decision have been uploaded into the online portal. This requirement applies to all employers, regardless of whether they are utilizing a private insurance plan, self-insure, or third party administrator, to meet the requirements under the Act.

4.3.8.4 The notice shall inform the employee of the right to appeal the decision and shall provide the employee with instructions on how to file an appeal.

5.0 Amount of benefits

5.1 Standard benefit calculation. Weekly benefit payments shall be calculated by the online portal system on the following basis:

5.1.1 Average weekly wage. This is the "starting point" for the calculation. Take the average gross (before any deductions for taxes, premiums, or any other cause) weekly wages for the 52 weeks prior to the submission of the claims application. If the employee is salaried, divide the employee's gross wages by 52 weeks to obtain the average weekly wage.

5.1.2 Benefit percentage, minimum and maximum. Multiply the average weekly wage by the benefit percentage, which is currently 0.8 (80%).

5.1.2.1 If the result of the benefit calculation is below $100, then the weekly benefit for that individual will instead be the average of the employee's weekly wages.

5.1.2.2 If the result of the benefit calculation is above the current maximum benefit, the weekly benefit amount shall be limited to the current maximum benefit.

5.1.3 Preservation of the Fund balance. At the Secretary of Labor's discretion, the benefit percentage may be reduced to a level sufficient to maintain the solvency of the Fund on the effective date specified by the Secretary of Labor. The reduced benefit percentage will then stay in effect for the next 12-months. This will only be done to protect the integrity of the Fund. Notice will be provided by the Division to all employers in the Fund at least 90 days before any change in the benefit percentage occurs. Employers shall provide notice to their employees within 30 days from the date the employers were notified by the Division of this change.

5.2 Inflation indexing the maximum benefit amount. Beginning on January 1, 2028, the maximum weekly benefit amount may be increased in line with the inflation rate of the prior year. Before December of 2027 (for the 2028 calendar year) and prior to every December thereafter, the Division will issue the maximum benefit amount that shall be used for the applicable calendar year. Unless the Act states otherwise, the inflation measure to be used in the Division's calculation will be the Consumer Price Index for all Urban Consumers, Philadelphia-Camden-Wilmington Metropolitan area, published by the Bureau of Labor Statistics of the United States Department of Labor. The maximum benefit for each calendar year shall be rounded to the nearest $5.00 increment.

5.3 The Division has determined that benefits shall be calculated for a covered individual with more than 1 source of wages as follows:

5.3.1 If an employee is working multiple jobs at the time of the qualifying event, each employer, insurance carrier, or third-party administrator must review the employee's claims application based on the information about that particular job.

5.3.2 The applicable private or public plans will pay an approved claim as a separate claim.

5.3.3 If the State is the payer on multiple claims, it may combine the benefit payments into a single, bi-weekly payment, instead of multiple checks per payment cycle. However, the program requires that employees may not receive combined income-replacement benefits in excess of the employee's most recent wages.

5.4 If the employer has not submitted the required wage information, then the Division will accept the required wage information (12 months of wages and proof of hours requirement preceding the submission of an application for benefits) from the employee. The wage information must be uploaded into the Division's online portal supported by the appropriate documentation to verify the employee's missing weekly wages, subject to the Division's approval.

5.5 FICA Limits. The required contribution is subject to the FICA limits each year as established by the Internal Revenue Service. Once the employee's wage reaches the FICA limit in any given year, the employer and employee's required contributions will cease for that particular year and will restart at the next calendar year.

5.6 Delaware wages. As the State of Delaware has no jurisdiction over wages earned outside of its boundaries and has no authority to require contributions on wages earned outside of the State, PFML insurance program benefits will be calculated only on the basis of wages earned within the State of Delaware.

6.0 Contributions

6.1 If the employer is participating in the PFML public plan, the Division requires that contributions be paid at least quarterly, or more frequently if and as the Division regulates, based on the relevant information received during the period of coverage. Payroll contributions will be assessed against wages paid on or after January 1, 2025. Payroll contributions are assessed against individual employee's wages on the first day of employment or on the first day that the employer's employee count rises above the threshold number or when the employee's waiver is revoked or when a reclassification form is submitted.

6.1.1 Payroll contributions for an employer shall begin the first day of the payroll period after the employer adds an employee and rise above the threshold number for 1 or all of the mandated lines of coverage under the Act.

6.1.2 Payroll contributions shall cease being assessed against individual employees on the day that they either sign a waiver or a declassification form, when the employee's wages reach the FICA limit, or when they are no longer employed by the employer.

6.1.3 Payroll contributions for the employees of an employer shall end on the first day of the payroll period after an employer is no longer required to provide 1 or all mandated lines of coverage due to a sustained drop in the employee count or on the day that any eligible employer should permanently end operations.

6.1.4 Payroll contributions shall be submitted to the Division on a quarterly basis on the 30th day after the end of each quarter (or, if the 30th day after the end of a particular quarter falls on a weekend or holiday, the first business day after the 30th day). At its discretion, the Division may provide up to a 6 business-day grace period during which contributions can be submitted after the due date without late fees or penalties or both.

6.2 In remitting contributions to the fund, an employer or authorized intermediary acting on the employer's behalf shall provide contributions in any of the following forms and manners: for each employee, the employer shall provide the employee's name and unique identifying information (DOB, SSN, etc.) and the employee's previous quarter's weekly wages and hours worked, with each week's data broken out separately by the particular week, by in-state versus out-of-state hours and wages, and listed separately for each employee. The determination of whether an employee's particular hours or wages were earned in Delaware or outside of Delaware shall be determined in accordance with the Delaware Department of Finance's rules or regulations.

6.2.1 Form of the contribution, Contributions shall be paid quarterly and in a lump sum that combines the employee and employer shares for each of the 13 weeks in each quarter, accompanied by the information specified in subsection 6.3 of this regulation.

6.2.2 An employer must select its employer/employee contribution split if it differs from the Act's default of 50/50. Employers may contribute more than 50% of the total contribution, but not less than 50%. If an employer decides to contribute a variation of 50/50, the employer must properly notice the employer's variation to all affected employees and file the change with the Division through its online portal system.

6.2.2.1 Any change in an employee/employer contribution split, either increase or decrease, shall be noticed to the Division and to all employees of the employer by December 15 of the year prior to the January 1 effective date the following year.

6.2.2.2 Employers may have different employee/employer contribution splits for different classes of employees, if:

6.2.2.2.1 The split applies equally to all that employee classes' lines of coverage; and

6.2.2.2.2 The employee classes are defined without reference to protected classes.

6.2.2.3 All rules regarding employee/employer contribution splits shall also apply to voluntary plans where an employer opts into PFML coverage.

6.3 Manner of Contribution. Funds and information must be submitted to the Division in electronic form; cash and checks will not be accepted. The Division may elect to allow employers to submit contributions by credit card, with an additional fee set by the Division for the convenience. In addition to monies, all employers shall be required to provide the following information, itemized by employee:

6.3.1 Employer name and employer identification number or individual tax identification number (for sole proprietorships);

6.3.2 Employee name & unique identifier (social security number, individual tax identification number, permanent resident card, or visa foil number);

6.3.3 Weekly hours (broken into Delaware vs. non-Delaware hours, if appropriate);

6.3.4 Weekly wages (broken into Delaware vs. non-Delaware wages, if appropriate).

6.3.5 Contributions and benefits shall be calculated according to the employee's FICA wages. The Division will perform these calculations on the data provided quarterly by the employer, which is recorded and tracked by the Division.

6.3.6 For full-time salaried employees for whom the employer does not track hours, the Division will accept 37.5 hours (or 40 hours, if appropriate), in place of an employee's actual hours worked.

6.3.7 If the Employer's system (or payroll servicing company's system) does not have this information available at a weekly level, but rather only on the basis of a payroll period, then the Division will accept the above information based on an estimated weekly basis.

6.3.7.1 For firms that send out paychecks once every other week, the Division will accept the payroll period information divided by 2 (so that both weeks have the same numbers for all 4 datapoints).

6.3.7.2 For monthly paychecks, the Division will accept estimated weekly information by dividing the monthly wages and hours by the number of days in the pay period, then multiplying it by 7 to arrive at an estimated weekly number for hours and wages (or by some other formula, as appropriate).

6.4 The contribution rates for medical, parental, and family caregiving leave benefits for the years 2025, 2026, and 2027 and each rating period thereafter shall be tracked separately by the Division.

6.5 Current rates are in effect for 12-months and will automatically renew at the same rates as stated in the Act. Beginning in 2027, if there is a new rate, the new rate will be changed by modification to this regulation. Employers will be provided at least 90 days' notice of any change in the payroll contributions rates for this program.

6.6 Employers can only withhold contributions from employees' paychecks at the time that the contribution was assessed. If the employer makes an error which would call for additional "back contributions" to be collected from the employee, once the paycheck that would have been reduced by the error has been issued, the employer cannot require the employee to pay their "share" of the employer's error.

6.7 The Division determines that an unpaid contribution as of the date it is due and payable shall accrue interest at a rate of 1.5% per month regardless of the total amount owed, from and after the due date until payment plus the accrued interest is received by the Fund. The employer is responsible for paying both any unpaid contribution amounts and any interest accrued to the Division as the employer is responsible for collecting the employee's contribution share, if any, from the employee.

6.8 Opting to file a waiver. If both the employer and the employee agree that the employee was not hired to work on a permanent basis or not expected to work at least 25 hours per week or both, so that they reasonably don't expect the employee to be covered by the Act, the employee and employer can apply to waive coverage.

6.8.1 To do so, the employer and employee must both sign the waiver of coverage form provided by the Division and return it to the Division via the Division's online electronic system.

6.8.2 The waiver will be accepted by the Division unless the Division has a substantial and verifiable reason compelling them to not accept the waiver, including reasonable proof that the employee is not temporary or will be expected to work over 25 hours per week.

6.8.3 Any waivers that were signed by the employee under any type of duress, intimidation, or coercion, whether explicit or implied, will be considered null and void. If evidence is obtained to indicate that a waiver was signed under any condition indicating that it was not voluntarily chosen by the employee, the case may be referred to the Delaware Department of Justice for consideration.

6.9 An employer's notice to an employee that the employee's work schedule or length of employment, on a permanent or temporary basis, does not meet the requirements for eligibility for PFML benefits, must be provided in writing within the most recent quarter of when that situation occurs.

6.9.1 The employer must then file either a waiver form or a reclassification form, as the situation dictates, with the Division through its online portal.

6.9.2 In its discretion, the Division may waive coverages and the employee's portion of the payroll contribution for prior quarters, if the employer's failure to submit the waiver on a timely basis was due to clerical error. The employer's contribution shall not be waived for prior quarters.

6.9.3 Waivers will be effective in the quarter they are received.

6.10 Waiver. Should a waiver not be submitted to the Division, be unsigned, contain a clerical error or otherwise, the Division may accept a sworn statement from the employer or employee, as appropriate, as explanation and support for a missed deadline, missed payment, or other clerical error.

6.11 Revocation of improper waivers. Coverage under the Act is not optional. Waivers cannot be used to "decline coverage" for employees who would otherwise be eligible for coverage and who reasonably expect they should be covered due to either the term of the employee's employment or the number of hours that they work.

6.11.1 Employers are required to provide accurate quarterly information on all employees, including those employees who are on waivers.

6.11.2 If those records show that the employee has worked for more than 12-months for the employer and that they have satisfied the 1,250 hours of service requirement during the preceding 12-months, the waiver will be revoked by the Division.

6.11.3 Upon revocation of a waiver, the employer will be responsible for the required payroll contributions for past relevant quarters.

6.11.4 Employees will become eligible for benefits beginning at the moment of the revocation of the waiver.

6.12 Fines for improper waivers. If the Division determines that the employer or the employee or both signed the waiver in a willfully false manner or if the employee worked substantially more than the minimum 1,250 hours in the previous 12-months, the employer may be fined up to $1,000 for each instance and the employee may be required to pay an amount equal to what they ought to have paid in payroll deductions. If it is determined that the employee was forced to sign a waiver by the employer or any other individual or entity, the employee will not be subject to any fines or penalties under this rule.

6.13 Voluntary return to plan after waiver. After an employer voluntarily submits to the Division a form cancelling an employee's waiver and reinstating an employee's eligibility for the public plan, deductions from wages will begin. Upon submitting a voluntary return to plan after waiver form, the employee will thereafter be subject to the payroll contribution if the contribution is being shared by the employer and employee.

6.14 Form of waiver. The Division has adopted a form for each a waiver and a revocation of waiver which shall be available on the Division's website and the online portal.

6.15 Reclassification and Declassification Forms. Employers may reclassify an employee who primarily reports for work at a worksite in another state as working primarily in Delaware through the duration of that individual's tenure at the out-of-state worksite.

6.15.1 The purpose of this reclassification provision is to either:

6.15.1.1 Continue to provide coverage for those Delaware-based employees who are temporarily assigned to an out-of-state location; or

6.15.1.2 To make eligible for coverage those employees who are telecommuting or who work on a continuing basis out-of-state when they would normally be located in the State of Delaware.

6.15.2 A reclassification shall be memorialized through a reclassification form signed by both the employee and employer stating that, while the employee is not physically located in the State of Delaware, the employer and employee voluntarily agree to designate the employee as a Delaware-based employee for the purposes of paying payroll contributions into the PFML insurance program and to be eligible to apply for paid leave under the terms of this program.

6.15.3 Once an employee is reclassified in this manner, they will remain so until both the employee and employer voluntarily sign a form to declassify the employee. Upon declassification, the employer and employee will no longer be subject to the provisions of the PFML insurance program with respect to that particular employee.

6.15.4 Any reclassification or declassification forms that were signed by the employee under any type of duress, intimidation, or coercion, whether explicit or implied, will be considered null and void. If evidence is obtained to indicate that a reclassification or declassification form was signed under any condition indicating that it was not freely chosen by the employee, the case may be referred to the Delaware Department of Justice for consideration.

6.15.5 While an employee is covered under a reclassification form, they will be included in the employer's count towards the various thresholds for coverage (either more than 10 or more than 25 employees).

6.15.6 Once an employee and employer have signed a declassification form, the employee will no longer be counted towards any of the employer's threshold numbers.

6.16 While an employee is on leave, no contribution payments are required under the public plan.

7.0 Reduced leave schedule and intermittent leave

7.1 Family and medical leave benefits for intermittent or reduced leave schedules must first be determined by the employer in conjunction with the health care provider certification and recommendation and, if approved per the terms, then prorated by employer. The requirements to approve an application for benefits under a reduced leave schedule are the same as exist for leave periods of longer durations and may only be take when medically necessary. For purposes of this section only, employers are permitted to request recertification once every 90 days, without the need to establish doubt regarding the seriousness of the covered individual's health condition.

7.2 Minimum duration of a leave on reduced schedule. If employee requests leave on a reduced schedule, the shortest leave that can be approved will be 1 full workday. Reduced leave will not be allowed in increments less than a full day under the PFML program.

7.2.1 Leave under the FMLA Regulations, 29 CFR 825.205, may be taken in periods of whole weeks, single days, hours, and, in some cases, even less than an hour. Nothing in the PFML Act changes the protections of the FMLA.

7.2.2 The employer must allow employees to use FMLA leave in the smallest increment of time the employer allows for the use of other forms of leave, as long as it is no less than 1 hour.

7.3 Prior notice. An employee should provide the employer with at least 30 days advance notice of a need for leave under the PFML program. If 30 days' notice is not practicable, because of a lack of knowledge of approximately when leave will be required to begin, a change in circumstances, or a medical emergency, notice must be given as soon as practicable. "As soon as practicable" means as soon as both possible and practical, considering all the facts and circumstances in the individual case. When an employee becomes aware of a need for Delaware PFML leave less than 30 days in advance, it should be practicable for the employee to provide notice of the need for leave either the same day the employee knows they need leave or the next business day. In all cases, however, the determination of when an employee could practicably provide notice must consider the employee's individual facts and circumstances. When the need for leave is foreseeable at least 30 days in advance and an employee fails to give timely advance notice with no reasonable excuse, the employer, insurance carrier, or third party administrator may delay coverage until 30 days after the date the employee provides notice. For the employer, insurance carrier, or third party administrator to delay the start of leave, the need for leave and the approximate date leave would be taken must have been clearly foreseeable to the employee 30 days in advance of the leave.

8.0 Leave and employment protection

8.1 A covered individual shall continue to be provided with and receive health care benefits that they would have had if they had not taken leave. However, to continue to receive health care benefits during the period of approved leave, the covered individual must continue to pay their share of the health care insurance premium to the employer. Failure by the covered individual to pay their share of the medical premium may result in the loss of coverage under the employee's group healthcare plan.

8.1.1 The Division will not withhold these amounts from the covered individual's benefit payments.

8.1.2 The covered individual is entirely responsible for paying their share of the medical premium as applicable.

8.2 At no time will the Division be responsible for sending a covered individual's share of the medical premium to an employer for employer's payment to the insurer.

8.3 For purposes of the Act, "willful violation" means whether the employer knows or shows reckless disregard for whether the conduct violates the PFML. If an employer acts in good faith and with due diligence, those factors weigh against a finding of willfulness.

9.0 Retaliatory personnel actions prohibited [Reserved.]

10.0 Coordination of benefits [Reserved.]

11.0 Notice

11.1 Nothing in this regulation shall create a cause of action for any person or entity, other than the Delaware Insurance Commissioner, the Department, or the Division, against an employer based upon a failure to serve the notice, or defective service of the notice. Nothing in this Section 11.0 shall establish a defense for any party to any cause of action based upon a failure by the employer to serve the notice, or by the defective service of

the notice. However, employees ought to notify the Division if they believe their rights under this program are being violated and the Division will investigate the situation and take all appropriate actions, if necessary.

11.2 [Reserved].

11.3 [Reserved].

12.0 Employee Claims, employer adjudication, and Divisional review

12.1 Employee claims process. If an employee in the public plan wishes to make a claim, they must use the claims application form provided on the Division's online portal. The claim form will include the following information:

12.1.1 Employee name;

12.1.2 Employee address;

12.1.3 Employee social security number or other identifying number;

12.1.4 Employee date of birth;

12.1.5 Employee email;

12.1.6 Employee telephone number;

12.1.7 Employer name;

12.1.8 Employee work location;

12.1.9 Employee job title and department;

12.1.10 Employee number (if any);

12.1.11 Type of leave requested by employee;

12.1.12 Whether the employee has more than 1 employer;

12.1.13 Whether employee eligible for any other type of benefits, including workers compensation and short-term disability; and

12.1.14 Any additional information as set forth in the claims application that the Division shall create.

12.2 The employee must complete and submit the form on the online system. The Division will not accept physical copies or scans of physical copies that have been completed by hand, manual typewriters, or similar devices.

12.3 The online portal will distribute the claims application form to the employee, employer, and Division.

12.4 Designated employee assistant in case of employee incapacitation or inability to manage claim. If an employee is unable to complete the necessary paperwork due to the serious illness that is the qualifying event under the medical leave provisions described in the Act, the employee's inability to access or operate the online system, or the employee otherwise needs assistance, then either a family member or another individual who does not directly benefit from the decisions they make or actions they take in this role may, through a signed, sworn assistant designation form created by the Division, be appointed to assist the employee.

12.4.1 While acting as the designated assistant, the individual is in fiduciary relationship with the employee.

12.4.2 If the designated assistant breaches their fiduciary duties, they will be subject to any applicable civil or criminal penalties. The Division, the employee, or the employee's estate shall have the authority to pursue any claims arising from the assistant's actions or decisions, through any appropriate legal means.

12.4.3 The employee may revoke this designation of an assistant at any time.

12.4.4 Only 1 assistant can be appointed at any 1 time, with the individual named in the chronologically applicable filing being recognized for that specific time period.

12.4.5 The online portal will distribute the assistant designation form and, if applicable, the revocation of assistant status form to both the employer and Division.

12.4.6 If requested, the Division shall provide reasonable assistance to all employees covered by the PFML insurance program and the employee's designated assistants to properly complete all online forms relating to this insurance program.

12.5 Employer's responsibilities, adjudication, protections.

12.5.1 Employers, insurance carriers, or third-party administrators shall adjudicate the employee's claims application form to the best of their ability, per the "reasonable person" standard."

12.5.2 The employer shall be expected to make a determination as to whether the claims should be paid, the amount of weekly benefit due to the employee, and the length of time the benefit should be paid out, according to the terms and provisions of the Act and based on the information provided by the employee and certified by the appropriate healthcare provider, in a manner and to the extent that a reasonable person would be expected to do so.

12.5.3 The employer shall not be required to make any substantive claims-related decision based on information not in the employer' possession. However, they must make a good faith effort to assist the employee in the gathering of all the required information from either the employee or the designated assistant to make an informed and reasonable decision on the eligibility and payment or ineligibility of the request.

12.5.4 Employers are required to provide reasonable assistance to their employees or the employee's designated assistants to properly complete all the online forms created by this Division or a private plan administrator for this insurance program, including claims forms and claims review forms. This requirement for employers to assist in the completion of these online forms is subject to the anti-retaliation provisions of the Act.

12.5.5 If the health care provider does not return a completed certification of serious health condition within 20 days, the system will notify the employer and employee that the certification is still outstanding. The employee has the responsibility of following up with the health care provider. If, after 30 days from the day the claim form was submitted, the health care provider has still not returned a completed certification via the online portal, the system will mark the claim as "Denied Due to Lack of Certification". This claim shall automatically be revived if the certification is received within 60 days after it has been marked "Denied Due to Lack of Certification" without requiring the submission of a new claims form.

12.5.6 For the PFML public plan, once all of the required information has been uploaded to the Division's online portal by the appropriate parties, the software system will provide an advisory notice to the employer regarding the approval or denial of a claim. The employer then has 5 business days to adjudicate the claim.

12.5.6.1 The length of the approved leave shall be based primarily on the recommendation of the appropriate healthcare provider, as supported by disability industry standards and best practices in this area.

12.5.6.2 After the claim determination is made, the employer will then have 3 business days to communicate their decision via the online portal system to the employee (or the employee's designated assistant) and the Division.

12.6 Division's responsibility to pay approved benefit. The Division shall be required to make the first payment of benefits to a covered individual within 30 days after the employer has notified the Division of the approved claim, with subsequent payments being required to be made every 2 weeks thereafter until the approved length of the employee's leave expires.

12.6.1 New requests for (or requested changes to) benefits payments shall be due 2 days before the day on which the Division pays out biweekly claim payments, to allow for claims to be reconciled.

12.6.2 A new benefit payment or an adjustment to a previously approved claim will be released by the Division between 2 and 16 days after the approval or adjustment is granted by the employer.

12.7 Employee's right to request a claims review by the Division. After an employer who is covered by the public plan or a self-insured plan issues its decision on a claim for paid family and medical leave benefits, the employee or the employee's designated assistant may request, within 60 days of issuance of employer's decision, that the Division review the claim.

12.7.1 This request for the Division to review the claim must be made via a claims review request form that shall be created by the Division and made available on the Division's online portal.

12.7.2 Neither the employer nor the Division shall be required to respond to either a handwritten (or manually typed) form submitted by any means other than the online portal or to a handwritten (or manually typed) form that has been scanned and then submitted through the Division's online portal system, as neither of those methods are acceptable and will not update the Division's electronic claims database/records system.

12.7.3 Both the Division and the employer are required to provide, without any prejudice or fear of retaliation, reasonable assistance so that the employee or the employee's designated assistant can complete, *inter alia*, the claims review request form.

12.7.4 After the claims review request form has been completed and properly transmitted to the Division, the Division shall undertake a review of the employer's claims adjudication decision-making process.

12.7.5 For first level appeals under private plans, employees have the right to request reconsideration of a denial or other decision by an insurance carrier or third-party administrator ("TPA") directly with that entity. If the insurance carrier or TPA upholds the decision, the employee may pursue an appeal with the Division.

12.8 Division claims review determination. If a claims review request form is filed by the employee, the Division shall review the claim and issue a determination, in writing, to the parties within 10 business days of receipt of the review request, either upholding or reversing the employer's initial determination regarding the claim.

12.8.1 If, after submissions from the parties, the Division determines an employer violated 1 or more provisions of the Act, or a covered individual received an overpayment or violated 1 or more provisions of the Act, the Division shall notify the appropriate party in writing, both by regular mail and by electronic means, within 5 days of its initial determination.

12.8.2 The notice shall provide, at a minimum: the date of the notice, amounts owed, civil penalties (if any) under the Act if a violation is determined, and an opportunity to appeal the Division's initial determination to the Board.

13.0 Family and Medical Leave Insurance Appeal Board

13.1 A covered individual or employer may appeal to the Board within 30 days from the date of the Division's or the private plan's internal review determination. At all times, a covered individual, employer, or witness are required to keep all information related to the claim or appeal confidential and take reasonable steps to ensure confidentiality.

13.1.1 A covered individual may request, when filing an appeal, a disposition of the matter on the record without a hearing and may submit additional documents or evidence without appearing at a hearing. The Board shall provide notice within 5 days of the filing of an appeal that a date has been scheduled for disposition of the matter on the record, subject to the Board's schedule.

13.1.2 If a hearing is requested, the Board shall provide notice within 5 days of the filing of an appeal that a date has been set for an appeal hearing subject to the Board's schedule.

13.1.2.1 All requests for continuances or postponements are within the discretion of the Board.

13.1.2.2 Any request for a continuance or postponement of any hearing must be made via the online portal no later than 12:00 p.m. the day prior to the hearing. All parties will be automatically notified of this request. The request shall state the reasons for which the continuance or postponement is requested.

13.1.2.3 All cases that have been continued or postponed shall be rescheduled at the discretion of the Board.

13.1.3 An appealing party may withdraw its appeal at any time prior to the hearing. All requests for withdrawal must be made via the Division's online portal.

13.1.4 Failure to appear at a scheduled hearing may result in an unfavorable decision. If the party who filed the appeal does not participate, the Board may proceed to make its decision on the record or may dismiss the appeal on the ground of nonappearance unless it appears that there is good cause for a postponement.

13.1.5 The Board shall make a decision on the appeal within 60 days of the hearing or disposition date.

13.1.6 Hearings are scheduled to last 30 minutes from the time the presiding member calls the case. The Board may extend the length of the hearing at its discretion.

13.2 The Board will have access to all of the Division's records regarding the matter under appeal. Either party may submit additional, relevant information that they wish the Board to consider. Any supplemental information shall be provided to the Board and all parties at least 5 business days before the hearing date. No party may submit more than 40 pages of additional documentation. All additional documentation must be filed electronically in the Division's online portal and all parties will be notified when additional documentation has been filed by either party.

13.3 A party may request subpoenas to compel a witness to appear at a hearing.

13.3.1 This request shall be in writing and shall be received by the Board at least 10 business days prior to the hearing or disposition date via the Division's online portal.

13.3.2 The issuance of subpoenas shall be at the sole discretion of the Board and its attorney.

13.3.3 A subpoena for a witness must state the full name and address of the person to be subpoenaed. The Board limits witness subpoena requests to 2 per party. Upon a showing of extenuating circumstances and the filing of a motion by a party, the Board may, at its discretion, permit additional subpoenas to be issued.

13.3.4 Service of a subpoena for a witness to appear at a hearing shall be made by personally delivering the subpoena to the witness. Service shall be made at least 4 days prior to the hearing or disposition date.

13.3.5 The parties must submit proof of service of the subpoena.

13.4 Discovery is generally not permitted. Any request for discovery is at the discretion of the Board.

13.5 A party may represent themselves, may utilize a designated assistant as described in this regulation, or may be represented by an attorney admitted to practice law in the State of Delaware. The designated assistant cannot be an employee of the Division of Paid Leave. A corporation or other artificial entity must be represented by an authorized owner, officer, or employee of the entity, or by an attorney admitted to practice law in the State of Delaware. Attorneys-at-law should enter an appearance with the Board's clerk prior to the hearing.

13.6 A series of individual requests for an appeal hearing may be consolidated into a single group hearing when the sole issue involved is one of State or federal law, regulation, or policy. The individual appellant in a group hearing will be permitted to present his case or be represented by an authorized representative. If, at any stage in a group hearing, the Board finds that any individual appeal involved questions of fact unique to an individual appellant, that appeal shall be severed and heard individually.

13.7 Board hearings shall be held electronically, with all parties or witnesses participating by telephone, video, or other electronic means. At the discretion of the Board, a hearing may be held in person, upon a showing of good cause.

13.8 Any party to a Board proceeding may file and serve a motion at any time unless otherwise provided. A written motion shall contain a concise statement of the facts and law which support it and a specific request for relief. Any case dispositive motion, including a motion to dismiss, should be filed and served as soon as possible prior to the start of the hearing. A written reply to a case dispositive motion may be filed. All motions shall be filed via the Division's online portal and all parties will be notified when this filing occurs.

13.9 The Board may permit oral motions and oral or written responses to be made during a hearing.

13.10 At least 5 business days before the hearing, the parties shall exchange proposed exhibits and witness summaries with copies to the Division; all documents shall be submitted electronically by 5:00 p.m. at least 5 business days prior to the hearing. Anything submitted after 5:00 p.m. shall be considered received the next business day. No documents or evidence will be accepted in physical form.

13.11 The Board has the authority to restrict the issues raised at the hearing to those raised in the appeal or any response to it.

13.12 A verbatim record of the proceedings before the Board will be made and archived electronically. The record will not be transcribed unless and until an appeal of the Board's decision is taken to the Superior Court of the State of Delaware.

13.13 All testimony before the Board shall be taken under oath or affirmation. Evidence, which is irrelevant, immaterial, or unduly repetitive may be excluded. Delaware's rules of evidence shall not apply to any documents submitted or testimony given.

13.14 After rendering an appeal decision, if the full Board concurs, it may suggest amendments to the Paid Family Medical Leave program regulations to the Secretary of Labor.

13.15 The Division of Paid Leave will provide reasonable administrative assistance to all parties involved in an appeal to ensure online forms are properly completed and supplement documentation is uploaded.

14.0 Family and Medical Leave Insurance Program

14.1 The Division shall establish and make available on the Division's online portal system, reasonable procedures, and forms for filing claims for benefits and other required or requested processes and shall specify the supporting documentation necessary to support a claim for benefits, including any documentation required from a health care provider for proof of a serious health condition.

14.2 The Division shall provide employers and employees with online tools, exportable reports, and forms to submit applications for leave, whether full-time, reduced, or intermittent, and to track the amount of leave taken and still available to be taken under the rules of the PFML insurance program. The Division shall provide all covered individuals or the covered individuals' designated assistants and employers with any necessary assistance completing all the Division's online forms.

14.3 In order to provide an incentive to healthcare providers to encourage the timely completion and submission of a claimant's medical certification documentation, the following schedule of payments to the healthcare providers shall be used for claims submitted through the public plan:

Medical certification documentation is completed in full and submitted to the Division via the online portal system within 10 calendar days of the Division's request:	$20 per claim
Medical certification documentation is completed in full and submitted to the Division via the online portal system within 11-30 business days of the Division's request:	$10 per claim

14.4 Healthcare providers may not charge employees or the employee's designated assistants a fee for the completion of this form.

15.0 Federal and state income tax

15.1 The Division shall withhold state and federal income tax from authorized benefit payments. The withholding shall be made at a single flat percentage, that will be applied to all benefits paid out during a calendar year. In December of each year and beginning in 2025, the withholding percent for the following year for federal income taxes shall be established based on the average federal effective income tax rate for the prior year, as calculated in accordance with the data series entitled "Average Federal Tax Rates, by Tax Source, Individual Income Taxes" published by the Congressional Budget Office's annual report entitled "The Distribution of Household Income," which was published in November 2022, for information gathered in 2019. State income taxes shall be withheld at a flat rate of 3.0% for all claimants.

15.2 By the end of January, the Division shall send each claimant an accounting of the benefits amounts paid out and the federal and state taxes withheld during the previous calendar year. The accounting shall be presented and follow the rules of IRS form 1099G and shall be sent both by regular mail to the last known address of the claimant and in electronic form, with a record also sent to the federal IRS and the Delaware Division of Revenue by the format and means that those agencies require.

16.0 Family and Medical Leave Insurance Account Fund; establishment and investment

16.1 For purposes of the Act and this regulation, the Division may use expenditures from the Fund to pay for the costs associated with administering the provisions of the Act. Administrative costs are those reasonable costs incurred and necessary for the Division to perform any of the functions under the Act or this regulation.

16.2 The deposits into and withdrawals out of the Family and Medical Leave Insurance Account Fund ("Fund") shall be tracked, accounted for, and verified on a calendar day basis.

16.3 The Office of the State Treasurer shall manage and invest the monies in the Fund as directed by the Act. The Division shall follow Government Accounting Standards Board ("GASB") rules in recording the transactions of the Division's account.

17.0 Private plans

17.1 An employer that elects to provide benefits through a private plan issued and administered by an admitted insurance carrier must ensure that the private plan being purchased has been filed with and approved by the Delaware Department of Insurance (the "DOI"). The Division will provide additional approvals that employers who "opt-out" (in whole or in part, as a hybrid plan) will need to meet in order to satisfy their obligations through a private plan.

17.1.1 Insured private plans. An employer must notify the Division through its online portal of employer's decision to opt-out of the state's public plan. Employers must indicate that they intend to purchase a DOI- approved PFML insurance plan, which may include coverage through a captive insurance plan approved by the Delaware DOI, for 1 or all of the required lines of coverage. As part of the process to provide notice to the Division of a decision to opt-out of the public plan, employers must submit proof via the online portal of the declaration page from a DOI-approved insurance plan as well as a copy of the policy.

17.1.2 For employers seeking approval for 2025, the opt-out form will be available on the Division's online portal from September 1, 2024 through December 1, 2024, at which point the opt-out window will close. Failure to obtain coverage or to provide a copy of the required documents via the online portal or both will mean

that employer cannot opt-out and must, instead, enroll in the public plan and remain in that until an approved private or self-insured plan, if any, is in place.

17.1.3 For all subsequent years, employers may seek to opt-out of the public plan or renew the approved private plan from October 1 through December 1, to be effective January 1 of the following calendar year, subject to plan approval by DOI and submission of the required documentation noted above via the Division's online portal by December 1. Failure to do so will, by default, deny approval of the plan and trigger enrollment in the public plan, which shall remain in effect until an approved private or self-insured plan, if any, is in place.

17.2 An employer shall impose no additional conditions or restrictions on the use of covered leave beyond those explicitly authorized by the Act or this regulation issued under that Act.

17.2.1 Required data. Within 30 days after the end of each quarter, employers will be required to send the Division updated weekly enrollment, wages, and hours information for each employee covered under the plan.

17.2.2 This information must be provided to the Division through the Division's online portal according to the technical specifications required at the time of submission.

17.3 The requirements for the private plan and internal administrative review process when a final determination is issued are subject to the appeal process consistent with the Act. That process is set forth in Section 13.0.

17.4 Self-Insured plans. An employer must notify the Division through its online portal of employer's decision to opt-out of the state's public plan by providing a private plan through a form of self-insurance.

17.4.1 Self-Insured groups must have at least 100 covered individuals in the plan at all times. Applicant groups with fewer than 100 covered individuals will have their applications declined. In addition, any employer seeking to self-insure must provide a surety bond.

17.4.2 For 2025 only, the opt-out form will be available on the Division's online portal from September 1, 2024 through December 1, 2024, at which point the opt-out window will close. By December 1, 2024, the employer must submit via the Division's online portal, the required surety bond in addition to any other required documentation. For all subsequent years, employers may seek approval to opt-out of the public plan or seek renewal of the self-insured plan during the period of October 1 to December 1, to be effective January 1 of the following calendar year. The employer must also submit the required bond by December 1 if not already on file with the Division.

17.4.3 If any self-insured employer falls below 100 employees at the time of the annual renewal, they will be decertified, will be required to enroll in the public plan immediately and remain in that plan until an approved private plan, if any, is in place. In addition, the employer must pay to the Fund, within 30 days from the date of decertification, an amount equal to the contributions that would have been due for the previous 12-months had the employer been a participant in the public plan.

17.4.4 The Division may waive this requirement of a minimum of 100 employees if the employer is able to demonstrate that it has the administrative capacity to adequately manage a self-insured plan. Each quarter, all self-insured plans must send the Division updated weekly enrollment, wages, and hour information for all the employees covered under the plan. This information should be provided to the Division through the Division's online portal according to the technical specifications required at the time of the submission.

17.4.5 Surety bonds. Employers that intend to provide the mandated coverage through a self-insured plan for 1 or more of the required lines of coverage must also provide the Division a surety bond.

17.4.5.1 The surety bond shall be issued by a surety company authorized to do business in Delaware, in an amount equal to 1 year of total contributions that would have been required to be paid by the employer had they participated in the public plan.

17.4.5.2 This bond shall be in the "continuous until canceled" bond on a form approved by the Division.

17.4.5.3 The contribution amount shall be based on the actual wages, adjusted for inflation by the "Consumer Price Index for All Urban Consumers, Philadelphia-Camden-Wilmington Metropolitan Area" that is published by the Bureau of Labor Statistics of the United States Department of Labor, earned by the employees in the 12-month period ending on October 31 prior to the December 31 due date of the plan approval.

17.4.5.4 Any change to the amount of the surety bond based on that calculation must be provided to the Division by December 1 of each year. Failure to provide the initial surety bond and documents supporting the initial bond calculation and any subsequent calculations supported by a signed

statement by either a qualified actuary (having met the American Academy of Actuaries' qualification standards) or licensed Certified Public Accountant ("CPA") will result in the employer self-insured plan being terminating effective December 31 and entering the public plan as of January 1, the following year.

17.4.5.5 The State of Delaware shall be named as the obligee of the surety bond and the employer shall be named the principal.

17.4.5.6 The State of Delaware is the only entity that has standing to pursue a claim against the bond if the employer fails to meet its obligations under these provisions.

17.4.5.7 The bond shall include a statement that the bonding company must give 90 days' notice of its intent to terminate liability to the employer/principal and the Division, except that if a bonding company is terminating liability because it is issuing a replacement bond, it may do so without providing prior notice. In the event of a replacement bond, the surety company and the employer must notify the Division no later than 10 days after its effective date.

17.4.5.8 The employer must maintain surety bond coverage for the plan approval period granted by the Division. The Division will review the bond annually, in connection with the employer's annual opt-out renewal, to ensure that the amount of the bond corresponds with the wage requirements described in this regulation. Employers must apply to renew their approval no later than December 1 of each year. At that time, the employer must provide the Division with any documentation necessary to review the bond amount. If the Division determines the bond amount must increase, the employer must do so to renew its self-insured plan approval. If the Division determines that the bond amount exceeds the actual wage calculation set forth above, then the employer may reduce the bond amount to correspond to the actual wages.

17.4.5.9 In addition to the bond review documents, the employer will provide the Division with any changes to the plan's Schedule of Benefits and report the current number of covered individuals under employer's self-insured plan. If the plan no longer "meets or exceeds" the provisions of the Act or if there are less than 100 eligible employees covered under the plan, the self-insured plan will not be allowed to renew for the next calendar year. Upon decertification of a self-insured plan, an employer must pay to the Fund, within 30 days from the date of decertification, an amount equal to the contributions that would have been due for the previous year had the employer been a participant in the public plan. The employer is then required to join the public plan beginning January 1 and remain in that plan until an approved private plan, if any, is in place.

17.4.5.10 The Division may execute on and collect the bond amount if the employer's self-insured plan approval is terminated, decertified, or withdrawn, voluntarily or involuntarily and the employer fails to pay, within the subsequent 30 day period, an amount equal to the contributions that would have been due for the previous year had the employer been a participant in the public plan. Upon execution, the amount to be collected by the Division will be the entire bond amount, less any funds received from the employer within the 30 day period after the effective date of the termination of the self-insured plan approval. Funds so received by the Division from the employer or surety or both will be deposited into the Fund and, if applicable, will be credited toward the employer's contribution obligation per this section.

17.4.6 Self-insured plan design. For any line of coverage that the employer provides under a self-insured plan, the terms and conditions of the plan must at least meet the requirements provided in the Act.

17.4.6.1 Beginning with the opening of the Division's online portal system on September 1, 2024, for self-insured plans not applying for grandfathering, the employer must provide a copy of the self-insured plan's schedule of benefits, terms, and conditions to the Division for its review and approval. The last day to submit this information and the required surety bond is December 1, 2024 for the initial benefit period beginning January 1, 2026.

17.4.6.2 The Division must either approve or decline the employer's application for self-insurance by December 31, 2024.

17.4.6.3 If the Division does not approve the employer's application for self-insurance, the employer must instead comply with the requirements of the Act.

17.4.6.4 For all subsequent years, employers seeking to self-insure must submit all of the required information to the Division no later than December 1 of the year prior to the start of the plan on the following January 1.

17.4.6.5 The Division will accept a sworn self-certification or attestation listing specific, detailed components of the plan design, signed by the employer, as initial proof that the plan design meets or exceeds the public plan requirements.

17.4.6.5.1 At its discretion, the Division will verify the attestation by comparing the submitted plan documents to the requirements of the Act.

17.4.6.5.2 If, at any time, the Division finds that the employer's self-insured plan does not meet or exceed the requirements of the Act, the Division shall have the power to immediately decertify the employer's self-insured plan, triggering the payment of contributions to the Fund by employer within 30 days from the date of decertification, an amount equal to the contributions that would have been due for the previous year had the employer been a participant in the public plan.

17.4.6.5.3 If the employer fails to make the required payment, the Division shall execute and collect on the employer's surety bond.

17.4.6.5.4 The employer will also be immediately added to the public plan with no lapse in coverage for the employers or employees and will remain on the public plan until an approved private voluntary plan, if any, is in place.

17.4.6.6 Any proposed substantive changes to any of the provisions of an approved self-insured plan must be approved by the Division in writing and must be equal or exceed the requirements of the public plan. The Division will review any requested change within 30 days from the receipt of the request via the Division's online portal. Changes to the plan can only go into effect at the beginning of each calendar year unless the Division approves a different effective date.

17.4.7 Self-insured plan claims fund. The Division reserves the right to audit the financials of any employer applying to administer a self-insured plan to verify that it has the financial ability to pay all expected claims. Employers with a self-insured private plan must have the financial ability to pay at least 6 maximum dollar claims per 100 employees per year, and each employer with a self-insured plan must prefund a claims reserve account in a separate dedicated bank account with at least 1/2 of that amount held in reserve to pay future claims. An employer must provide proof of the appropriately funded bank account as part of the opt-out process. This requirement does not apply to self-insured plans that have been approved under the grandfathering provisions of the Act.

17.4.8 Audits and claim review of self-insured plans. Employees and designated assistants shall be able to avail themselves of the claims review process as set forth in the Act.

17.4.8.1 The Division has the right to audit any and all claims or enrollment decisions made by the employer in any self-insured plan. The employer must make available to the Division any requested documentation, file, or system regarding any issue in connection with an audit of the self-insured plan within 24 hours of the Division's written request.

17.4.8.2 Self-insured plans that are found, either through the claims review or auditing process, to have an excessive number of mis-adjudicated claims, either due to error or arising from a purposeful attempt to deny claims for reasons including punitive, discriminatory, or financial, will be referred by the Division to the Delaware Attorney General for, at the Department of Justice's discretion, civil or criminal prosecution or both.

17.5 Grandfathering plans

17.5.1 Private paid time off benefit plans that employers had in place before May 10, 2022, the enactment date of the Act, and that are deemed by the Division to be comparable to the state's public plan, will be allowed to continue until December 31, 2029, 5 years from the start of contributions being collected under PFML. Employer paid time off benefit plans that are deemed comparable will qualify regardless of the risk transference provisions including any of the following arrangements:

17.5.1.1 Private insurance contracts through an admitted carrier including captives;

17.5.1.2 Self-insured plans regardless of whether they are backed by a surety bond; or

17.5.1.3 "Employee handbook plans" which continue paying an employee's wages in the same manner as it had been paying prior to the leave, while the employee is on a period of leave, that is defined by the contractual relationship between employer and the employee, usually as described in an employee handbook.

17.5.2 Grandfathering application. To qualify for the 5 year grandfathering period for existing plans, employers must apply through the Division's online portal by the January 1, 2024 deadline. The online portal will open for grandfathering requests on October 1, 2023. If an employer does not apply by January 1, 2024 through

the portal, grandfathering an existing plan shall no longer be an option. If the employer's application is declined, the employer will be subjected to the normal requirements of the Act. If the employer's application is approved, the employer and the employees will not be subject to the normal provisions of the Act until December 31, 2029.

17.5.3 Definition of a comparable plan. For an employer's paid time off benefit plan to be considered in existence as of May 10, 2022, the employer must submit a sworn affidavit via the Division's online portal stating that the plan was in writing and had been available to all of the employer's employees on May 10, 2022. The employer's paid time off benefit plan may qualify even if does not provide all 4 lines of coverage included in the state's public plan, as long as the plan provides comparable coverage on 1 or more of the lines of coverage. Only that line of coverage that is comparable will be grandfathered. Each application must include a copy of the employer's paid time off benefit plan for consideration by the Division.

17.5.4 To be considered "comparable," the employees covered under the existing plan must not be required to contribute more to the employer's existing plan than is required under the public plan. All employer paid time off benefit plans that offer benefits that equal or exceed the state's public plan in 3 specific components of the plan design will qualify under the grandfathering provision of the Act. An employer's paid time off benefit plan will be considered "comparable" if the plan's 3 main plan components (benefit percent, maximum benefit, and benefit duration) are within 10% of the equivalent state plan components.

17.5.4.1 Benefit percent: Unless the Act states otherwise, this benefit percent provides for 80% of the employee's wages, 10% less than 80% is 72%.

17.5.4.2 Maximum benefit: Unless the Act states otherwise, it provides for a maximum weekly benefit of $900 and 10% less than $900 is $810.

17.5.4.3 Benefit duration: For parental leave, the public plan allows up to 12 weeks of leave. If an employer's paid time off benefit plan allows 10.8 or more weeks (or up to 54 days) of parental leave, then it will be considered comparable. For all other types of leave, the public plan allows for 6 weeks of leave. If the employer's paid time off benefit plan allows for all employees to receive up to 5.4 weeks, or 27 days, of leave or more, then it will be considered comparable.

17.5.5 An employer's paid time off benefit plan must be within 10% of all 3 of these plan components for the employer's grandfathering application to be accepted by the Division. If the application is not accepted, the employer must enroll in the state's public plan and remain in that plan until an approved private or self-insured plan, if any, is in place.

17.5.6 In addition, for an employer's existing paternal leave plan to be comparable to the public plan for the paternal leave line of coverage, an employer's paid time off benefit plan must:

17.5.6.1 Provide coverage for birth, adoption, and fostering of a child; and

17.5.6.2 Offer these benefits regardless of the parent's sex or gender or marital status.

17.5.7 Any grandfathered plan cannot be altered unless the change improves the benefit offered to employees and is approved by the Division.

17.6 Short term disability plans. Employers with short term disability ("STD") plans that meet the 10% test are eligible to be grandfathered.

17.6.1 Once a plan is approved, all of the provisions of that plan continue as prior to May 10, 2022, including any applicable elimination period.

17.6.2 Due to the number of STD plans in force in the State of Delaware prior to the enactment of the Act and the number of which may be successfully grandfathered by employers, there is a significant potential for them to adversely impact the solvency of the Fund. The Division will undertake an analysis of the impact of STD plan grandfathering on the future solvency of the Fund based upon the actual experience of the medical leave line of coverage in each of the initial years of the program. If the grandfathered STD plans are determined to be a threat to the solvency of the Fund, the grandfathered status will be terminated earlier than normally provided by the Act.

17.7 Notice and appeal process

17.7.1 If the Division terminates, decertifies, or withdraws approval of an employer's private plan, the Division will notify the employer, with an effective date 15 days after the date of the notice. Prior to the effective date, the employer may file appeal this decision, on an appeal form found on the Division's online portal to the Board. The decision of the Board is final unless appealed to the Superior Court within 30 days.

17.7.2 The employer is required to provide notice as set forth in the Act to all employees affected by any changes in the plan.

18.0 Small business opt-in

18.1 Voluntary. For all small businesses, the ability to opt-in to provide parental leave benefits, medical leave benefits, or family caregiving leave benefits, any or all of them, is voluntary. However, once an employer opts-in, compliance with the terms of the program is mandatory and applies to all covered individuals.

18.2 Notice to the Division. For all opt-ins and opt-outs of any of the benefits, a small business must provide notice to the Division and its employees on the appropriate forms to be created by the Division and available on the Division's online portal system. All forms and processes shall take place in or by electronic means as established by the Division. Notwithstanding any provision to the contrary, employers who opt-in or opt-out of the State's public plan will do so on an effective date at the beginning of each calendar year. If the employer decides to opt-in to the public plan, they must do so for at least 3 years. If the employer then decides to leave the State's public plan, they must provide the employees with at least 12 months advanced notice before exiting the plan, which exit shall take effect not sooner than the end of the initial 3 year period.

19.0 Powers of the Division

19.1 Forms. The Division shall create forms, including a form for a complaint, that may be filed with the Division for a claim of non-compliance with the Act. The forms will be on the Division's website. All forms shall be produced and be made available on the Division's online portal and website in both English and Spanish. The website itself shall be available in both languages, as well. If additional languages achieve a level of common usage where it is primarily spoken by 5.0% of the state's population (as established by the U.S. Census Bureau), those languages shall also be used in all forms and communications, in addition to English and Spanish. All material released by the Division shall be formatted so that it can machine read for purposes of improved accessibility for people with disabilities.

19.2 Audit. In addition to those powers stated in the Act, the Division may audit employers for compliance with the Act, as the Division determines. The Division reserves the right to examine any adjudicated claims application, whether they have been approved or denied, on a random basis. Admitted private insurers with approved PFML coverage plans shall provide the Division access to their records systems, along with the training and assistance necessary to understand the materials therein, so that the Division may audit claims adjudicated by those insurers. The records and systems of self-insured private plans shall likewise be made available to and intelligible by the Division for auditing purposes.

19.3 Division audit and investigative authority. The Division may enter and inspect an employer's premises or place of business or employment. In so far as possible, the Division will attempt to arrange a mutually acceptable time for this inspection, providing at least 24 hours' notice to the employer.

19.3.1 All employers shall keep and preserve any or all books, registers, payrolls, and other records, including those required by the Act, for at least 3 calendar years. Items preserved or archived in electronic form (rather than in physical form for 3 years shall be considered to satisfy this requirement.

19.3.2 The Division may deem it necessary or appropriate to prescribe or approve forms, which may be used by an employer for statements, sworn statements, or other information the Division determines.

19.4 Division initial determination. If, after submissions from the parties, the Division initially determines an employer violated 1 or more provisions of the Act, or a covered individual received overpayment or violated the Act, the Division shall notify the appropriate party in writing within 5 days of its initial determination. The notice shall provide, at a minimum:

19.4.1 The date of the notice;

19.4.2 Amounts owed;

19.4.3 Civil penalties accessed, if any;

19.4.4 Notification of the ability to appeal the Division's initial determination to the Board.

19.5 Appeal to the Board. A covered individual or employer must file an appeal, if any, to the Board within 30 days from the date of the Division's claim review determination. Within 5 days of receipt of the appeal, the Board shall provide the parties with a hearing date.

19.6 Nothing in these regulations limits the Department of Insurance's jurisdiction over an insurer issuing an approved private plan and the Division shall have authority to pursue any issues in its jurisdiction that the Department of Insurance declines to pursue.

20.0 Erroneous payments; disqualification for benefits [Reserved.]

21.0 Penalties

21.1 Penalty. If the Division deems an employer in violation of the Act, the employer will receive 1 written warning of this violation and will be given 30 days to correct the violation. If the violation is not corrected within 30 days or this is a subsequent violation, then the employer may be subject to a civil penalty. This penalty shall not be less than $1,000 nor more than $5,000 for each violation. The Division has determined that "each violation" means each alleged action against each employee.

21.2 [Reserved].

21.3 Anti-discrimination. All provisions of the Act are subject to the state's anti-discrimination laws and regulations. While an employer may be granted discretion to make decisions in regard to certain aspects of employee eligibility, claims adjudication, or any other aspect of the PFML insurance program, this grant of authority does not allow them to violate any provision of the state's anti-discrimination laws or regulations.

22.0 Reports [Reserved.]

23.0 Public education

23.1 When making outreach information available, the Division may determine those languages, other than English and Spanish, that are spoken by more than 5.0% of the state's population at the time. Under the terms of the Act, the Division may use a portion of the monies collected in the Fund to pay for a public education plan.

23.2 The Division may also use other funds, once properly authorized by the Secretary of Labor or other appropriate officials, from the State of Delaware or other sources to pay for a public education program.

24.0 Sharing technology [Reserved.]

25.0 Departmental Report [Reserved.]

26.0 Effective Date of Regulation

In accordance with the Act, the Regulations adopted herein take effect 10 days after their final publication.

27 DE Reg. 51 (07/01/23)